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HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP
Mr SE Cramp MP
Mr AD Harper MP
Mr JP Kelly MP
Mrs T Smith MP

Staff present:

Ms S Cawcutt (Inquiry Secretary)
Mr J Gilchrist (Principal Research Officer)

PUBLIC BRIEFING—INQUIRY INTO THE ABORTION LAW REFORM (WOMEN'S RIGHT TO CHOOSE) AMENDMENT BILL AND INTO LAWS GOVERNING TERMINATION OF PREGNANCY

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 12 JULY 2016

Brisbane

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TUESDAY, 12 JULY 2016

Committee met at 10.48 am

CHAIR: Good morning. Before we start can I request that mobile phones be turned off or switched to silent. I now declare open this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into laws governing termination of pregnancy and the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016. I would like to acknowledge the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee here are Mr Mark McArdle, deputy chair and member for Caloundra; Mr Joe Kelly, member for Greenslopes; Mr Sid Cramp, member for Gaven; Mr Aaron Harper, member for Thuringowa; and Mrs Tarnya Smith, member for Mount Ommaney.

The committee's terms of reference require the committee to consider and report on aspects of the law regulating termination of pregnancy in Queensland. The terms of reference include examination of a bill introduced by the independent member for Cairns, Mr Rob Pyne, which was referred to the committee on 10 May 2016. However, the committee's terms of reference are broader than the bill. The parliament has asked us to consider and report on aspects of the law including existing practices in Queensland concerning termination of pregnancy, existing legal principles that govern termination in Queensland, the need to modernise and clarify the law without altering current clinical practice, legislative and regulatory arrangements elsewhere in Australia including regulating terminations based on gestational periods, and provision of counselling and support services for women. Copies of the terms of reference have been provided to those who are briefing us today. I understand copies are also available in the public gallery.

I will deal with a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee which takes a nonpartisan approach to inquiries. This briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath but I remind witnesses that intentionally misleading the committee is a serious offence.

Witnesses have previously been provided with a copy of schedule 3 of the standing orders, 'Instructions to committees regarding witnesses', and we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript. This briefing will also be broadcast live on the parliament website.

For any media present, I ask that you adhere to my directions as chair at all times. I remind those in the public gallery today that these proceedings are similar to parliament to the extent that the public cannot participate. Members of the public are reminded that the public may be admitted to or excluded from the briefing at the discretion of the committee. Please note that this is a public briefing and you may be filmed or photographed.

The purpose of this morning's briefing is to hear from representatives of the Royal Australian College of General Practitioners and from Queensland Health about current practices concerning termination of pregnancy and the professional standards and guidelines that apply to medical practitioners. Unfortunately, a representative of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists was not able to join us this morning. However, we will arrange a briefing from the college on another date. I welcome Dr Wendy Burton representing the Royal Australian College of General Practitioners; Dr John Wakefield, Deputy Director-General, Clinical Excellence Division, Queensland Health; and Associate Professor Rebecca Kimble, Chair of Statewide Maternity and Neonatal Clinical Network, Queensland Health.

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BURTON, Dr Wendy, Royal Australian College of General Practice

KIMBLE, Associate Professor Rebecca, Chair, Statewide Maternity and Neonatal Clinical Network, Queensland Health

WAKEFIELD, Dr John, Deputy Director-General, Clinical Excellence Division, Queensland Health

CHAIR: Can I please remind witnesses to speak into the microphone when they speak. I remind members that public officials Dr Wakefield and Professor Kimble are here to provide factual and technical information. The responsibility for government policy rests with the relevant ministers, and officials should not be asked to defend or advocate for government policy. Dr Burton, can I ask you to start, please. After your briefing I will invite members to ask questions and we may wish to return and ask further questions after we have heard from Dr Wakefield and Professor Kimble.

Dr Burton: First up, I would like to thank you for extending to the Royal Australian College of General Practitioners the invitation to be part of this important discussion. For your information, nationally the college has a membership of around 23,000 GPs out of a total of about 28,000 to 30,000 for the nation, and there is more than that engaged with the college via training. We represent a significant proportion of general practitioners in the land.

The College of General Practitioners does not have a specific guideline regarding termination of pregnancy. However, it does have a position regarding the views of members, and simply put that is this. The RACGP reserves the right of our members to hold an opinion regarding termination of pregnancy and to practise within the dictates of that opinion and their conscience. Notwithstanding this position, the standard that GPs are held to regarding the care of all women considering termination of pregnancy is the same standard of care which GPs are expected to demonstrate when providing care to all. Here I will quote from the RACGP's statement on what is general practice. It states—

General practice provides person centred, continuing, comprehensive and coordinated wholeperson health care to individuals and families in their communities.

It then goes on to list a number of subsections, but the element that I think is most relevant to today's discussion is that of person centredness, and again I quote directly—

... general practitioners understand that health, illness and disease are ultimately personal experiences, and that their principal role is to relieve personal disease in all its forms—

not that pregnancy is a disease state—

in the manner best suited to each individual. The patient's needs, values and desired health outcomes always remain central to the general practitioner's evaluation and management processes.

That is more or less where the college itself is coming from. However, mindful that this is a committee specifically looking into law reform and termination of pregnancy, I looked a little bit broader. Although I am here as a representative of the RACGP, would it be helpful to let you know what the AMA has to say? The AMA has a position statement on women's health which is from 2014. Again, it is quite an extensive statement, but I have condensed it down to the nitty-gritty. It states—

The non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies. In addition to ensuring access to safe and legal termination services, women should as have access to appropriate support to maintain a pregnancy to term and subsequently to raise a child, and access to services for adoption where a women chooses to continue the pregnancy to term but not to raise (or care for) the child. Access to such services should be on the basis of healthcare need and should not be limited by age, socioeconomic disadvantage or geographical location.

One of the things that we are trying to promote is that wealth should not dictate your health. Unfortunately, I think we see inequities in health that are determined by socioeconomic status. Both the college and the AMA strongly support the provision of equality of healthcare provision across the nation and certainly within our state.

The other thing that I have done, considering the needs of this committee—and here I will be led by yourselves if this would be helpful to you—is that the college made the statement about reserving the right of members to hold an opinion regarding termination of pregnancy and to practise within the dictates of that opinion and their conscience. It is a handful; it is not scientific; it is not robust, but I sent the word out to especially some of my regional and rural colleagues and asked them what their opinion was so that you could get a sense of what it is that GPs are actually doing, both here in Brisbane and across the state, and how this plays out in real time for families and women in the state of Queensland. Would that be helpful to you? I will just go through a few things.

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The changing face of our population is mirrored in the changing faces of our general practitioners, with an increasing proportion of international medical graduates making up my profession. My city comprises people of various ethnic backgrounds with variable religious or philosophical views and different teaching to what I received, reflecting the societies they are from. Regardless of their backgrounds and original training, we are all held to the same standard, and that is to keep the woman at the centre of the journey.

In preparation, as I said, I have canvassed the opinions of people whom I knew. In addition to asking people whom I knew who then asked people whom they knew and getting feedback from them, I also bring to this committee my experience in the last eight years where I have a role educating GPs primarily in the antenatal part of our profession. In that role, I have stood in front of 2,000-odd GPs around the nation, mostly here in Queensland. Although principally we are talking about pregnancy care, termination of pregnancy is briefly mentioned. I am reflecting also the tone of the conversations—the feedback that I have experienced from GPs in my role there.

As you would expect, given the topic, the views varied considerably and I have certainly heard from both sides of the argument. There are those GPs who consider termination of pregnancy to be a sin against God and who could never be part of assisting a woman to access such a service. I have spoken to a colleague who worked in a practice with a GP who was not only opposed to termination but also to the provision of contraceptives, and this was handled sensitively by directing women to GPs who could assist them with their health needs.

There are also GPs who provide termination services, both medical and surgical, and who are passionate about the need for law reform in Queensland as they consider the current laws create unnecessary delays and add to the cost and distress of women accessing termination services. The majority of GPs, however, fall between these two positions and have discussions with women around their full range of options including termination, with further information provided or referral given should a woman choose termination.

I will summarise what I heard. I heard from a recent graduate and she informed me that abortion information and guidelines were taught to her directly from the Queensland clinical guideline: therapeutic termination of pregnancy. That information was given to her during her obstetrics and gynaecology rotation. She commented that there was, sadly, limited coverage of contraception which occurred in her GP rotation.

I heard from a rural GP who is involved in training GP registrars. He prefers not to refer directly for termination but he gives patients options. He might refer them to an information source, assuming they will give a variety of options including termination or an alternative source, assuming they will offer other options mainly associated with continuing the pregnancy or give women the contact details for clinics where terminations may be obtained. He does not have a practice policy as such, and if the registrars ask he tells them what he does and suggests that they chat to a few colleagues before settling on their own path.

One of our regional colleagues who is philosophically opposed to participating in medical terminations also raised safety issues about people getting online treatment. I am not sure if the committee is aware, but women in our regional, rural and remote areas of the state may obtain medical terminations online, including from providers in the state but also from providers as far afield as Tasmania. He maintains there are safety issues with people receiving online treatment, especially in rural and remote areas where emergency care is not 100 per cent accessible. He said that he would support a person who chose this, though. I asked how he would handle a request for termination, and he refers them to a private provider in the closest coastal centre. He commented that he does not have a problem in that respect; he just does not wish to be an abortionist.

Another regional colleague is again happy to refer to a private provider. Women are having to travel quite some distance for these providers. In this particular GP's experience, he provides supportive counselling and then a referral letter with a recommendation from him that they are requiring termination for the mental or physical health of the mother. His nurses will make the appointment for the woman while they are still in the practice if the woman has made that decision, so that simplifies things for the woman to proceed with the appointment. He also commented that later ones with abnormalities—so these would be women further along in their gestational journey—not consistent with life are usually public, meaning they would be directed to their local public service and medical and surgical probably happening directly, so women might self-refer for termination services. Again he raised the concern that quick access to a D and C can be an issue. Sometimes if things go awry, just as things can go awry with a miscarriage, women can bleed dangerously and need to be able to access surgical services. As this committee would appreciate, for a state as geographically challenged as we are this can create safety issues.

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Most GPs really fell into the category of 'I don't do it myself but I will refer women' or 'If I don't refer, I will provide women with information'. The GPs who took the time to write back to me are a small sample, but they all knew what the referral pathways were. I do have further information from GPs. Do you want to hear some of the more passionate words? These are direct quotes—

The Queensland situation is ridiculous compared to other states. I have worked in Victoria in the public termination of pregnancy clinic in Geelong Hospital, where women had public access to termination and long-acting reversible contraceptives with social worker support and psychologist support if they had not made up their minds and wanted to talk options. My understanding in Queensland is there are only two or three possible places to access private/any termination services north of Brisbane in the whole state.

What I found from feedback from other GPs is that that is not quite correct, but the capacity across the state is limited. 'Because of the Criminal Code issue, while many GPs would be willing to explore medical termination training there is great difficulty creating routine care pathways with public gynae services afterwards in case of failed medical termination of pregnancy.' This was a recurrent theme and a concern that a number of GPs raised. 'If women do not have private cover, a private D and C is financially out of the question.' Other GPs found their local gynaecology services were very supportive and provided them with backup. Interestingly, these were verbal arrangements; nothing is in writing. A GP who gave an example from Geelong again said—

Due to a number of GPs in Geelong and surrounding areas providing medical termination services, the public clinic has now started providing medical termination of pregnancy as well—a great example of GPs leading the way. Given Geelong was sending more than 25 per cent of patients to Melbourne for surgical termination due to demand, this has undoubtedly provided better access to services. If you have access to a public hospital that has O&G services and they don't provide a routine care pathway for supporting primary care medical termination, then start prescribing. They will have to adapt.

Another one stated—

Queensland public gyne services are in general very gun-shy about termination of pregnancy, even medically indicated. I have worked in a Queensland hospital where the only person who was willing to administer Misoprostol to a patient with a severe foetal deformity out of an entire department, including four consultants and five registrars on the day, was the intern.

That is the most junior staffer. He continued—

Of course some had personal beliefs and understandably deferred, but others outright quoted, 'I don't get involved with termination of pregnancy. The law is just too murky.'

CHAIR: Thank you, Dr Burton. I might open it up for questions now. You made a mention of training, and I am very interested to know a bit more about that. For a GP who is coming through their training, is there any consistent training that they receive before they are on their own seeing patients if someone comes in seeking a termination?

Dr Burton: Not that I was able to find. I did ask the college, for example, in the fellowship path what there was. They referred me on to additional documents through the Royal Australian and New Zealand College of Obstetrics and Gynaecology. The college of GPs works with our RANZCOG colleagues for a women's health certificate diploma of obstetrics and gynaecology and an advanced diploma; however, most GPs do not hold these certificates. I would have to say that, to the best of my knowledge, no, and disappointingly reflecting the graduates' knowledge, the only thing she was taught about termination in the state of Queensland was directly from the excellent document which is our statewide guideline. That was it, really.

CHAIR: When you say the 'guideline', do you mean the Therapeutic Termination of Pregnancy Guideline?

Dr Burton: Most GPs are unaware of that document.

CHAIR: If someone were to present to me as a GP, I may not know where to go or have any sense of how I make that decision?

Dr Burton: These are some of the conversations that junior GPs do have as they train. The GP who does registrar training, interestingly enough, said 'if it were raised' rather than that he necessarily raises the issue himself. 'Yes, if registrars ask I tell them what I do and suggest they chat to a few colleagues before settling on their own path.' This is one of those difficult topics. We deal in difficult topics all the time. Death and dying are difficult topics, but these are not necessarily handled particularly well during our training so most of us learn on the job, or we learn by, 'Oh my goodness, suddenly I need to know this!' We might then have to get back to a woman with information, so we will go to the tearoom and consult with more senior colleagues and ask what the referring options are. In this day and age we may even use Google.

CHAIR: Of courses GPs operate in a complex legal environment, and I imagine there is significant focus within your studies about operating within privacy legislation and the legal environment, but there is no specific training for them. Essentially they need to go and do their own research around understanding this environment.

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Dr Burton: From what I was able to discern, yes.

CHAIR: If they are not aware of this document, the Queensland Health guidelines, with regard to a woman who may come and see them who may be exhibiting some ambivalence around her decision, and looking at some of the reports around ambivalence and how that can affect later mental health et cetera, there would be no consistency in how they may refer or try to support that woman with counselling services; is that also the case?

Dr Burton: Not necessarily. These are complex conversations which are definitely within the general practice domain. We have very well-established processes for assisting women to access, for example, psychology services. There is also a specific Medicare item number for non-directive pregnancy counselling, and there are those who have trained in its use so we can direct a woman in that way. There are a number of private providers. Private providers might lean one way or the other in terms of their philosophy, but these are organisations that can be sought out. As a GP now for 27 years, certainly when I have moved practices it is finding who my local service providers are and how women access these services that becomes very much part of my necessary repertoire, just as I need to know my referral pathways into my local public hospitals and who my private providers are. This would be part and parcel of my everyday work. There is no specific training or a book that we can look up, no.

CHAIR: The member for Cairns, who introduced the bill, Rob Pyne, stated to the committee that the termination of a pregnancy really should be between a doctor and a patient, but it seems that a patient who may present—depending on where they present and to whom—may get a very different hearing response, level of expertise, understanding and support. Would that be fair to say, given they do not even know there is a therapeutic guideline?

Dr Burton: I think that is fair to say, and I think also that reflects the split within the professions on where people sit regarding how comfortable they are having these discussions—from those who are absolutely opposed to those who not only can have the discussion but also can provide the service. Yes, it could vary significantly depending on the expertise.

CHAIR: A number of medical professionals have raised with me that one of the key issues for them is that—and I appreciate that it depends on how you look at it—the oath that general practitioners take obviously is about the health of the individual and they feel that this is not a medical issue or a health issue. I do not want to put a label on it, but it is a different issue because it is a termination. I am sure that you have had many views communicated to you, both for and against. I would like to hear your comment in response to that.

Dr Burton: It is extraordinarily complicated and there is no one-sentence answer to such a complex question. Just as every consultation is different, every situation is different and every woman's presentation is unique. I guess some of that comes down to 'first do no harm'. As doctors we try to save lives, not take lives. Some of this then also comes to the definition of life which, as I am sure you are only too aware, is quite a fraught discussion. I will try and make this as clear as I can in my own head.

We are always aware that, with a woman who is pregnant, it is more than one life that you are looking out for, so when I prescribe a medication or when I order a test I am mindful of not doing anything that would be helpful to the woman but harmful to her child unless needs dictated that it must, so unless the needs of the woman outweighed concerns for the child. When it comes to discussions on termination of pregnancy, I guess it is whether you consider that the woman's life in front of you is the paramount definitive life, or whether her life and the needs of her unborn child have equal weighting in your eyes and in the eyes of the law. This is difficult, and you will find that different general practitioners will give you different weightings. Some of the weightings do depend on gestational age and whether a child would be viable or non-viable. I think in the real world—not the theoretical world—there are weightings that are attached depending on the personal situation and circumstances.

Mr McARDLE: Dr Burton, thank you very much indeed for your opening comments. At the end of your opening comments you referred to a GP who—if I am wrong, let me know—believed the Queensland law was not what it should be. Does the college have a point of view as to where the law is at fault or not where it should be and what it should be in this state?

Dr Burton: No, it does not.

Mr McARDLE: You mentioned the issue of regional and remote issues as well. You made the comment that Queensland is a diverse state demographically and geographically. You also mentioned the issue of telemedicine or telehealth or use of a computer. If the law was changed to

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follow suit with, say, the Victorian model, which has a gestation period included in the legislation, how would that work in a place where you have the one GP in the town who has an objection by way of conscience in relation to treating or being involved in an abortion?

Dr Burton: While I cannot say with absolute certainty what outcomes would flow from a change to the law, from feedback that I have received from a number of GP colleagues and based on the experience of what happened in Victoria after termination was decriminalised, I suspect that you would see more GPs providing medical termination of pregnancy which would mean for women in a one-doctor town whose doctor was opposed to providing termination services it perhaps would not be as far to travel to access a medical termination of pregnancy.

Mr McARDLE: Would it be right to say that in Queensland there are not that many GPs in a private practice who actually offer termination services and that they are mainly in clinics and very few in the hospital systems?

Dr Burton: That would be quite correct to say, yes.

Mr McARDLE: Would you also agree that the state of law in Queensland at the moment is prohibiting the private sector hospitals from taking on terminations because of the uncertainty of the law?

Dr Burton: Of that I have no direct knowledge, but I imagine that it would hit that sector the same way that it hits mine. The concern is that what you are doing is outside the law. In fact, if you read through the document on the therapeutic termination of pregnancy—I am sure you all have—it makes very clear that this is not legal advice and to seek legal advice from your health and hospital service or go to your EDMS before making some of these decisions. The law is complicated and the law is difficult, so I imagine that would hit the private sector as it does the public.

Mr McARDLE: Does the college seek and retain statistics from their members in relation to terminations that they perform?

Dr Burton: No. It is one of the difficulties I think for the nation. We do not have accurate statistics.

Mr McARDLE: Would the college consider that, if the law was reformed, questions of counselling and cool-off periods are important in relation to the final determination by a lady to terminate?

Dr Burton: That is an excellent question, and I guess it comes back to the college not particularly wishing to take one position or the other but to support the rights of its members to have their own opinion and to practise within the confines of that opinion and their conscience. You will find, as I found when asking my colleagues, that there is a divergence of views. Part of our role in general practice does tip into counselling. I am not a psychologist or a psychiatrist, but I certainly do counselling. It tips into that, but some women have made up their minds. Some women are seeing you after the fact. For some women this is not necessary for them; they are quite okay about it.

The mandatory waiting times and that cooling-off situation may potentially create some issues where, for example, a medical termination of pregnancy must be commenced before nine weeks. I talked to a colleague who does provide termination services. She had a woman fly from Rockhampton to see her in Brisbane. There is a Rockhampton option, but it is once a fortnight. The fortnight would have taken her beyond her nine weeks, so she incurred the additional expense and travel time to come to Brisbane to acquire her termination. This is one of the other complicating factors if you put in a mandatory cooling-off period, and counselling I think should always be offered—always be offered. There are women who carry scars regardless of which choice they make. There is a consequence. There is a cost as well as a benefit, regardless of what a woman will choose. I think always, yes, you have to allow that there is some counselling provision, but to make it mandatory is more difficult.

Mr McARDLE: Does the college have a point of view on the impact of abortion on the mother? I know you are not qualified as a psychiatrist, and I accept that; I am asking on behalf of the college. Does it have an opinion as to what the effects of abortion are on the mother post the abortion?

Dr Burton: I would have to say that I am not aware of a position the college has taken. I am certainly aware that the college is very mindful of the mental health needs of all women in the perinatal situation, so that would include women who have terminations. To the best of my knowledge I have not seen anything regarding termination specifically.

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Mr McARDLE: With regard to the issue of the abortion or termination being performed, do you have any data on the medical complications that could arise from haemorrhaging, readmission to hospital and those sorts of things?

Dr Burton: Not with me, but that information is available. There are most certainly complications that can arise associated with termination, be that medical or surgical. My understanding—my gynaecology colleague here may have a better understanding—is that the bleeding rates are lower, I believe, after surgical and you will bleed longer after medical than you will after surgical.

Mr McARDLE: I will be asking the professor and doctor as well.

Dr Burton: However, my understanding is also that the complication rate after medical termination is lower than the complication rate after a miscarriage.

Mr McARDLE: Thank you.

Mr KELLY: Going to the specifics of the bill, it proposes to remove three sections of the Criminal Code. Do you have any general concerns around how the practice and the procedure of abortion will occur moving forward in the absence of any other guidelines from a legal perspective?

Dr Burton: Great question. I guess it would come down to how confident I felt in the ethical standards of my profession, and I actually still believe in the ethical standards of my profession. I believe that it would uphold a very high standard. If termination were taken out of the legal aspect and put into medical procedure hands then I am sure at some point there would be oversight. It would become regulated as a medical or surgical procedure and therefore we would be answerable to AHPRA and our respective colleges, for example. I personally feel confident that the profession can handle this.

Mr KELLY: In terms of something like, say, conscientious objection, which I think you touched on, the bill removes three sections of the Criminal Code. What does the bill do in terms of requiring a general practitioner to notify that they have a conscientious objection or a requirement on that conscientious objector to advertise that and then refer people on?

Dr Burton: I am unclear whether the bill specifically requires that. I know in Victoria there were provisions that a GP had to specifically state and to refer on. That would create issues for some of our members and I think would be contrary to the college's position of respecting the rights of GPs. What I found in canvassing the views of my colleagues was that even those who were opposed to termination themselves were able to move beyond their own philosophical belief and make other arrangements, so I think in theory it could create a great challenge but in practice that has not been the case.

Mr KELLY: It is not dealt with in this bill, so effectively the answer is that it would be down to the individual practitioner and the college to develop guidelines; is that right?

Dr Burton: I imagine so, yes, and that would then reflect the position of the college.

Mr KELLY: Okay. With regard to gestational limits, again the bill merely removes three sections of the Criminal Code. Is there anything from a legal perspective, if that is the case, preventing a woman seeking an abortion at 33 weeks for any reason at all?

Dr Burton: I am not sure that I have sufficient knowledge of the legal processes of that law to answer that question honestly.

Mr KELLY: Thank you. With regard to the issue of counselling for women who are considering their options regarding pregnancy, in relation to this existing bill is there anything that compels a general practitioner from a legal perspective to provide the opportunity for counselling? They may not be able to force people to be counselled, but they can certainly provide the opportunity. Is there anything from a legal perspective?

Dr Burton: Not to the best of my knowledge.

Mr KELLY: Thank you.

Mrs SMITH: Thanks very much for coming in. Are you aware of any late-term abortions, such as from 20 weeks, occurring in private clinics currently?

Dr Burton: In terms of the GPs that I spoke to, everything stopped from 19 weeks, so no. The sense that I got from speaking to colleagues was that anything 20 weeks and above became the public sector.

Mrs SMITH: Are you aware, then, of any of your members in Queensland ever going to jail for carrying out termination procedures?

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Dr Burton: No. One did talk of her concern—her fear—that what she was doing in terms of the law as it stood in the Criminal Code meant that she was relying on case law for her legal protection which meant that the patient records might be opened in order to base her defence upon should she ever be in that situation. That was an ongoing concern to her. With regard to the 2009 prosecution of the Cairns couple, actually I think that perhaps surprised some of my profession who had thought that perhaps this was no longer in the Criminal Code. That was a wake-up call that, yes, it certainly is and it raised the profile of abortion law in this state.

Mrs SMITH: I am aware—and I have only been made aware of this in the last little while after being on this committee—that there have been occasions—I think last year it could have been 27—when people have ended up giving birth after having a failed abortion procedure. Can you give me a little bit of context or understanding around that? Is that a common thing? What has gone wrong? I ask for just a little bit more of an understanding on that particular issue.

Dr Burton: Again, I am probably not the best person on the panel to take those questions, but I am aware that, like any procedure, it is as competently performed as the practitioner who is performing it. I am aware, for example, of a woman who had a surgical termination only to go on to have an ectopic pregnancy, which was quite a dangerous situation, and that had been missed by her provider of care. That should be covered in the follow-up, but these are important issues and they are issues of great danger to the woman.

Mrs SMITH: Did you say in your opening statement that the college actually does not have a position—

Dr Burton: It does not have a guideline, and the position that it has is that it respects the rights of its members to have an opinion.

Mr HARPER: Thank you, Dr Burton, for your contribution today on what is, no doubt, an ethically and morally challenging and delicate subject for all of your members.

Dr Burton: Thank you.

Mr HARPER: I did not quite hear the number of members you represent, but it is in the thousands?

Dr Burton: The college itself across the nation is 23,000 out of about 28,000 GPs.

Mr HARPER: I turn to the terms of reference in terms of the need to modernise and clarify the law. I want to get your opinion on whether you believe the college needs certainty under current Queensland law for the woman's right to choose?

Dr Burton: Notwithstanding the great diversity of opinion that college members hold and the passionate positions which many have, I believe clarity in the law would be of benefit to my profession and to the college.

Mr HARPER: Thank you very much. As parliamentarians, we respect everybody's views and I take it that the college does similar with its members. I am interested in the gestational age. You mentioned 19 weeks. Is that in your current guidelines?

Dr Burton: There is no current guideline that I am working on. This was the feedback that I got from providers of termination services. Some of them will not provide termination services beyond 15 weeks. For others, the cut-off was 19 weeks. That was, again, I think to do with the level of experience and expertise and what they were able to safely provide.

Mr HARPER: In terms of conscientious objection, the 2008 Victorian law reform included that clause. Do you believe that we should have something similar in Queensland?

Dr Burton: No, I do not.

Mr HARPER: Thank you very much.

Mr CRAMP: Thank you very much, Doctor, for your input today. Regarding the gestational age, do you think clearer legislation would allow your organisation to take a position around abortion? I do respect the fact that you are allowing each individual doctor to set their own guidelines, but I would have expected a peak body would form its own guidelines to help guide its members.

Dr Burton: I think this is a really important conversation for us to be having as a profession. I suspect that, whatever the outcome of this law reform, we will be looking to provide some form of position or guideline.

Mr CRAMP: I probably know the answer, but I will just ask for my own clarity. In terms of the gestational age of a foetus, is there a general consideration by the medical profession, or your members, that a healthy foetus has the rights of a child? Is there any consensus around that, or is there a position taken by the organisation?

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Dr Burton: I think you will find that there are a variety of different views about that. My sense of this from my experience in front of thousands of GPs and the feedback that I have is that, by and large, yes, the older a child the more viable a child would be and the more concerned members would be about a termination procedure. It usually, however, only arises in the context of a grave foetal anomaly or some significant risk to a mother's health. That is usually our experience.

Mr CRAMP: Right. Based on that last comment, abortion still occurs even though a mother's life is not in immediate danger?

Dr Burton: It depends how you define 'danger' and whether you consider 'immediate' the descriptor.

Mr CRAMP: Physical health danger, not so much psychological at this stage. I will have a question on that in a moment.

Dr Burton: Right. Under the existing legislation in the state of Queensland, women are able to access termination services. That is where there is a physical, psychological, mental issue that brings that, so, yes, a woman might not be in immediate life-threatening danger and be able to access termination services in Queensland.

Mr CRAMP: It was very interesting that you bring up that point. Women in Queensland still regularly access termination of a foetus at various stages of gestation?

Dr Burton: Yes.

Mr CRAMP: What is the college's position? Why is there a need to look at this legislation and change what is already there?

Dr Burton: Some of this comes back to the inequalities, though. One of my colleagues who has worked in a remote Indigenous community penned these words, 'For women in remote Indigenous communities, their access to termination of pregnancy is virtually non-existent thanks to the arcane laws in Queensland and lack of publicly funded services. I have seen an adolescent girl unable to access termination when she wanted it and go on to have a hysterectomy after almost dying due to obstructed labour.' Clarifying the law would, I suspect, increase the geographic availability of medical terminations. Women would not have to fly from Rockhampton perhaps to Brisbane. Another provider was saying that women were flying from Darwin to Mount Isa to a private provider to access services. This is very expensive, this is very traumatic and if it could be done—perhaps not in your own town but perhaps 300 kilometres instead of 3,000 kilometres.

Mr CRAMP: Okay. My last question is about psychological assistance. You talked about doctors who look for the guidelines. You assist them and provide them with information on services available to the mother. I take it that a part of that would be psychological advice?

Dr Burton: Absolutely.

Mr CRAMP: How direct is that? From my understanding, that would have to be extremely important.

Dr Burton: Yes.

Mr CRAMP: Is it given prior to the mother making the decision to terminate that foetus or is it only post?

Dr Burton: I think it depends entirely upon the situation. Certainly there are those women—and not just women; sometimes, of course, this involves their families as well—who are incredibly distressed by the situation that they find themselves in, regardless of why they are considering a termination, whether it is their own physical health or whatever it is. Sometimes, indeed, that assistance will be required prior to and be part of their decision-making process. Prior to and after, both are important for some but not for all women has been my experience. Some women do not want to talk about it. Some women refuse the offers of psychological assistance and counsel. Others most certainly need it and may not need it immediately after; they may need it some years later.

Mr CRAMP: Do you think, if new legislation were enacted, we should put some safeguards in to make sure it is not just a simple decision—although it would never be—that a person cannot make it on an emotive occasion to terminate a pregnancy? Should there be some safeguards in that they should have to consult a member of your organisation—a doctor, a professional, including psychological services—before making that decision or should a mother just be able to go into the surgery, make that decision and have it occur?

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Dr Burton: In my experience and in the experience of the voices of the GPs who wrote back to me, the latter just is not something that we see. Women typically come in and they have considered thoroughly their options. They will discuss that with us. As the law currently stands, to access these services they will need to be seen by a medical practitioner. I think it is just impossible to make it one size fits all. The devil would be in the detail.

Mr CRAMP: Okay. It would not be because it is currently restrictive—that a lot of the mothers will go to see a doctor beforehand and take their time to make that decision?

Dr Burton: Unless the bill is proposing that this be an over-the-counter situation, a medical termination would require a prescription, which means seeing a medical practitioner and a surgeon likewise.

Mr CRAMP: Thank you very much, Doctor. I appreciate it.

Dr Burton: You are welcome.

CHAIR: With regard to performing surgical terminations, what training or additional training do GPs do?

Dr Burton: Very few GPs provide surgical terminations, but indeed GPs who have done additional DRANZCOG or advanced DRANZCOG training—that is the diploma at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Some of our GP proceduralists—for example, GPs who are working as a GP obstetrician throughout our state—you will be familiar, I am sure, with the rural generalist program and the success that there has been in returning surgical services and safety services to outlying areas. Those GPs would have the physical skills. It is not something that a general city GP like me would ever be involved in but those who have additional skill sets.

CHAIR: They would be required to have that additional training to do that?

Dr Burton: You would certainly require additional training and you would certainly require additional indemnity insurance. I am sure our indemnifiers would ensure we have additional training.

Mr McARDLE: Thank you for your patience. I take it that the college would concur with the bill in that it removes the issue of termination as a criminal offence and you would rather see it placed under the health law?

Dr Burton: There will be members of the college who would oppose that, but I think the majority would be in favour of what you have just said.

CHAIR: Would you also think practitioners would feel safer that, if a bill like this were to succeed and the decriminalisation of abortion occurred, there would be some clear guidelines that are perhaps enshrined in legislation around issues like conscientious objection and gestational period? I know that it is very hard to ask you this, but do you feel the colleges themselves should formulate those views?

Dr Burton: The devil is always in the detail. It would just depend on what you put in that and how that reflects Queensland in 2016 and whether that will be relevant for Queensland in 2060. I just cannot really answer that question, I am afraid.

CHAIR: Thank very much. Dr Wakefield and Associate Professor Kimble, can I now invite you to make some brief opening statements? Then we will open to the committee to ask questions. Thank you.

Dr Wakefield: Thank you, Madam Chair. Thank you for the opportunity to brief the committee on the current clinical practice of termination of pregnancy, our current professional standards and guidelines and the ways that current practice relates to those standards and guidelines. I run the Clinical Excellence Division of the Department of Health, and one of my roles is to host statewide clinical networks, of which my colleague Professor Kimble is the chair and is an obstetrician and gynaecological expert. Hopefully, between the two of us we will be able to assist the committee today.

Perhaps an appropriate place to start with this information to the committee is with some data regarding the provision of what we would call medically induced terminations of pregnancy. For the purposes of today, I will be referring to those also as therapeutic terminations of pregnancy. In respect of the calendar year 2015—and this is based on what we call our admitted patient data collection, which pertains only to patients who are classified as admitted patients in hospitals, or day surgery centres; it excludes ambulatory and I will come to that in a moment—in the public hospital sector our data suggests that there were 295 terminations of pregnancy under a medical reason. In the private sector, our data suggests that that is 10,403 cases of medical therapeutic termination of pregnancy.

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Just to add to that data, I note there was a question previously about, as a subset of those data, terminations of pregnancy where the gestational period is greater than 20 weeks. These data are a subset of what I just gave to you. In 2015 in the public hospital sector we have noted 112 terminations of pregnancy and in the private sector 18. Hopefully that gives some perspective on medically induced or therapeutic terminations of pregnancy where the patient is admitted. We do not have data on those patients who may access termination of pregnancy as part of an ambulatory or outpatient setting. That, by and large, would be prior to nine weeks where literally medication in an outpatient setting can be given. These numbers exclude patients that would fall into that category so I cannot shine a light on that for you.

In Queensland it is unlawful to administer a drug or to perform a surgical or other medical procedure intending to terminate a pregnancy unless such conduct is authorised, excused or justified by the law. A defence in the legislation provides that criminal responsibility will not attach if a surgical operation or medical treatment—where the intention is to adversely affect the unborn child—is provided in good faith, with reasonable care and skill, to preserve the mother's life and performing the operation or providing the medical treatment is reasonable having regard for the patient's state at the time and to all the circumstances of the case. This is covered in section 282 of the Criminal Code.

With this in mind, there are some situations that may warrant what has been termed a therapeutic termination of pregnancy. We have already seen, and the committee has a copy of, the therapeutic termination of pregnancy guideline, which I will refer to as the guideline, and this was developed by the Queensland Clinical Guidelines Program of which Professor Kimble is the lead, to assist health professionals, obviously in the public sector but beyond into the private sector and beyond the state, in fact, in providing care to women requesting therapeutic termination of pregnancy. Development of the guideline commenced in 2010 at the request of the former director-general of Queensland Health, and in March 2013 the guideline was endorsed by the Statewide Maternity and Neonatal Clinical Network and it was published on the Queensland Clinical Guidelines website the following month and has been accessible to anyone worldwide since that time.

At the development stage of the guideline—this was not something that was done by a person, by Rebecca or her team alone—a working party was formed and members were approached individually and asked to participate, with the aim of achieving a balance across geographical locations across the state, professional disciplines and specialist content areas, for example. There were legal, ethical and clinical experts, and also a consumer was included in the working party. Development and consultation with regard to the guideline were undertaken as per the processes of the guidelines program which are laid out in writing, and that includes two rounds of consultation with the working party and a broad round of consultation statewide. This is a very deep and broad consultation process to arrive at the guideline. Clinical recommendations for achieving safe therapeutic termination of pregnancy outlined in the guideline and including both medical and surgical methods are consistent with the best known evidence internationally.

Madam Chair, may I ask if you also have the supplement to that guideline? If not we would be happy to tender that.

CHAIR: Would that be on the website?

Dr Wakefield: It is available on the website, yes. It provides supplementary information regarding guideline development, it makes summary recommendations and suggests measures around implementation. The supplement articulates the key components of the evidence with references but, most importantly, it also helps hospital and health services and clinics know what to do to implement the guidelines. In particular, that articulates the summary recommendations and levels of evidence contained in those. It is very explicit about the linkage of the guidance and advice with the contemporary evidence.

The Queensland Clinical Guidelines Program has also produced an information sheet for consumers and patients that contains general information about commonly asked questions. Again, all these are available on the website for the use of anyone in Queensland and beyond. As per the guideline, a therapeutic termination of pregnancy refers to the deliberate ending of a pregnancy where necessary to preserve the woman from a serious danger to her life or physical or mental health. In all cases, a decision to provide a termination of pregnancy is made in partnership with the woman and her family, where appropriate, and her healthcare professional and is led by the woman's health needs and concerns. The guideline recommends that the women's treating obstetrician observe requirements with regard to gaining relevant approvals as determined locally via an approval structure, and that occurs in our hospitals, and with mechanisms appropriate for the individual service.

What might be appropriate in a very big hospital may not be appropriate in a smaller place. That allows for an appropriate process and the documentation of that process to occur and provide reassurance both to the woman and to the doctor around the appropriateness of the care being provided.

For all cases the guideline suggests the following approval mechanisms—and that is specific to the guideline. That is, two medical specialists, one of whom must be a specialist obstetrician, consider the circumstances of each individual case. Ideally, one specialist should be the practitioner performing or overseeing the procedure and the second medical practitioner should be relevant to the circumstance. Consideration of local facility approval requirements must also be taken into account and may include notification to or approval from the executive director of medical services which is as per local clinical governance requirements.

For very complex cases, which are defined in page 4 of the guideline, a case review is recommended to consider all those complexities specific to that case. These include, in addition to the treating obstetrician, a minimum of one of the health professionals in the case review as appropriate. Other health professionals may include but are not certainly limited to social worker, a psychiatrist, an obstetrician or GP or in some cases a maternal foetal medicine specialist or paediatrician. I guess that particularly pertains to cases of potential foetal abnormality. Other members of the case review may include a lawyer, ethicist, religious officer or sexual assault worker. The members of the case review consider of all the circumstances and provide an opinion to the treating obstetrician and the executive director of medical services or equivalent on whether or not the criteria for termination of pregnancy under section 282 of the legislation are met. In other words, clarity is gained about the issues in relation to the law, the current Criminal Code, and also the issues in relation to appropriate clinical care of the woman.

The guideline recommends that consideration be given to each woman's circumstance on an individual basis, with the following legal test to be applied: whether a termination of the pregnancy is necessary to preserve the woman involved from a serious danger to life or to physical or mental health and that in the circumstances the danger of the medical treatment or surgical operation is not out of proportion to the danger intended to be averted. There are two components to that. The guideline further recommends that the legal test be applied in light of the woman's social, economic and medical circumstances.

The guideline also provides that an abnormal foetus with high likelihood for disability or death is not of itself a basis for termination being lawfully performed. It is recommended that this issue be explored as to how it affects the woman. Again, just repeating: foetal abnormality in and of itself is not sufficient on its own to satisfy the lawful termination under the law.

As with all other medical or surgical procedures, where a termination of pregnancy has been agreed, informed written consent must be obtained prior to commencement of the medical or surgical procedure. Again, I think this is a very important step in terms of making sure that, after all of that preparation, whatever has been discussed, there is still an obligation upon us as a provider to make sure the patient is appropriately informed and we meet our duty in common law. This process involves ensuring the patient has the capacity to consent to the procedure, a discussion on the available methods of termination of pregnancy and discussion on the risks and complications of each method of a termination of pregnancy. Capacity to consent can be very important particularly in cases of intellectual impairment but also in cases of very young girls. When both specialists have considered all the circumstances of the individual case and reasonably believe that termination of pregnancy meets all of these requirements under the legislation and recommendations in the guideline, the guideline recommends how this is to be documented.

A women requesting a therapeutic termination of pregnancy also, of course, has access to support services: social worker, counselling et cetera. Additional mental health services may also be appropriate at this stage and are applied as needed. A pre-termination assessment is then carried out with a number of recommendations. What this should encompass is outlined in the guideline. That includes obtaining a full picture of the circumstances leading to that request, a medical history, a physical examination as indicated by that history and consideration of any opportunistic intervention such as pap smears and smoking cessation et cetera. Coordination of referrals to other specialties, such as mental health or cardiology, along with arrangements for follow-up appointments et cetera and contraceptive advice are given—again where clinically appropriate. The choice of method of therapeutic termination of pregnancy is then made after that stage. This may involve a medical or surgical approach—in other words, medication or some sort of procedure or the combination of the two. That really depends upon the clinician's expertise, the service capabilities, the availability of pharmacological agents and, most importantly, the woman's choice.

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Medical termination of pregnancy involves the administration of drugs to induce the termination which may occur during admission to hospital or in an outpatient setting. Again, my colleague can answer questions specifically about that. Surgical termination is the other method and may also include an adjunct of drug administration. There are a number of considerations for surgical termination which are outlined in the guideline.

The guideline also outlines a number of considerations for post-termination care which includes the histopathology of the foetus, what we call rhesus prophylaxis, which is important to prevent damage to subsequent pregnancies in certain women with antibodies, analgesia, post-procedural care et cetera. It does not stop at the termination; there is after-care that is required and necessary. In some cases that involves assistance with birth registration and funeral arrangements. Again, the law deals with that. There are some specific requirements in relation to gestational age and birth registration. Post-treatment care is provided based on the individual needs of the woman.

As previously stated, in all cases a decision to provide a termination of pregnancy is made in partnership with the woman and her family and her healthcare professional and is led by the woman's individual needs and concerns. Everything that I have just said pertaining to the guideline is what we expect and oversee within the public health system in public hospitals. Again, I cannot comment specifically on just how that guideline may or may not be used in private settings, as I outlined at the beginning. Thank you for the opportunity to provide this overview to you. As I said, my colleague Associate Professor Rebecca Kimble and I are very happy to answer any questions that you might have.

CHAIR: Thank you very much for giving us a very fulsome opening statement about the process. I cannot promise that I will recall all of it, but I appreciate that we will have it in the transcript. Thank you very much. We can refer to that detail. The bill before the committee omits three clauses in two different acts. It would appear to me that your therapeutic guidelines are quite detailed. What impact do you think simply decriminalising, without any clarification around restrictions or operating practices, may have?

Dr Wakefield: That would be speculating. In terms of the public hospital system, our guidelines provide the frame for therapeutic terminations within the law as it currently stands. We do not really know what the consequence of simply removing those sections from the Criminal Code would be. One potential outcome would be that there would be an expectation that the public hospital system would provide many more therapeutic terminations, but that is purely speculation on my part.

CHAIR: One of the comments made earlier by Dr Burton, and it has come through in a number of different submissions, was about access to services, particularly in regional and remote locations. Can you speak about the accessibility of these services in public facilities across the state, please?

Dr Wakefield: In terms of access to therapeutic termination in the public hospital setting, we use the guidelines as a means for determining what is conducted in the public setting. You are privy to the numbers that I put forward earlier in my presentation. For the most part, our provision of service in the public hospital setting pertains to foetal abnormalities and/or maternal illness, for example, or complications. Therefore, our role in the public hospital system for early therapeutic terminations is probably limited. I might ask my colleague Professor Kimble to add to that.

Prof. Kimble: The guidelines are fairly clear when it comes to women seeking therapeutic termination under the current law. I suppose we really need to be clear about using abortion as a means for birth control versus one required for genuine therapeutic termination, as the situation currently stands. If we are going to talk about access to termination of pregnancy, are we talking about access to therapeutic terminations or using terminations as a method of birth control? There are plenty of contraceptive modalities and methods available for people to access planned parenthood. As a clinician, I would expect that what we emphasise is access to contraception and good birth control rather than use termination as a method of birth control, really.

CHAIR: Professor Kimble, in regard to accessibility, if someone in a regional location required a therapeutic termination, would they have to travel to Brisbane or would it be accessible in a regional public health facility?

Prof. Kimble: It is very accessible in regional public facilities. As the guideline currently stands, the local regional hospital or anywhere where there is a specialist obstetrician, which includes GP obstetricians—that is, level 3 to level 6. In Queensland, we have levels of clinical services capability built, between 1 and 6. Beyond level 3, GP obstetricians who have their RANZCOG and are quite capable of providing obstetric care and within the guideline are regarded as 'specialist obstetricians' for the purposes of the provision of therapeutic termination ought to be capable of providing the care. If they are not or if they are objectors then they have a duty to refer to the next level, which is the

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closest regional hospital. No, they do not have to come to Brisbane. The only situation where they do need to come to Brisbane is when the gestation has reached beyond 22 weeks, where they require feticide. Currently, the Royal Brisbane is the only place where they can have access to that. After the feticide, the woman is then able to go back to her local hospital for an induced labour and delivery.

CHAIR: In regard to your guidelines and psychological support, I notice that under counselling it is to someone undertaking the care of women requesting or accessing termination of pregnancy services who has no vested interest in the pregnancy outcome. One of the issues raised throughout the process has been that some women anecdotally have come in to their GP to talk about wanting to have a termination. There may be ambivalence; they may be trying to make a decision. They are referred perhaps to somebody who will perform that operation. I do not know how much it costs in the private system, but I understand that they get paid. I imagine where it says 'has no vested interest in the outcome', that would take into account situations such as that, where somebody who gives counselling is the person receiving payment for the procedure. Do you have any comments in that regard? Was this meant to pick that up? What was the intention of that statement?

Prof. Kimble: Is the question: are they paying for the psychological advice or the entirety of the care?

CHAIR: In your guidelines you say that they should be sent to somebody who provides non-judgemental support and counselling but also has no vested interest.

Prof. Kimble: That is available within their regional and closest public facilities, if they do not wish to pay for that separately.

CHAIR: Could you provide more information around birth registration? Dr Wakefield, you commented on the law around the requirement to register a birth. I notice here that a foetus any greater than 20 weeks, whether live born or not, requires birth registration, a death certificate, burial or cremation et cetera, and also if it is live born less than 20 weeks. Can you explain a little the requirement around that, please?

Prof. Kimble: It is an anomaly of the births, deaths and marriages current legislation, which has been talked about previously. A baby born above 20 weeks and above 400 grams, whether they are born alive or dead, is required to be registered. The birth has to be registered, the death has to be registered and a burial or cremation is required. Below 20 weeks, if they are not born alive—that is, there are no signs of life, and that includes any sign of life, which could be a single gasp or a heartbeat, that is considered a live birth. As a consequence of that, they are then required to be registered as a live birth. With a termination at 14 weeks, if the baby were to be born and gasped, that would be recorded as a live birth, even though it is a non-viable foetus. This side of 24 weeks, if it were to gasp or show any signs of life, the legislation currently requires that it be registered as a live birth. It does skew the figures when you look at it.

CHAIR: Of the 10,400 that you spoke of in the private system just for admitted patients, they would have been required to do the same thing if it met that guideline?

Prof. Kimble: I would expect so, yes.

Mr McARDLE: Thank you, Dr Wakefield and Professor Kimble, for your commentary. In regard to the 2015 figures, Dr Wakefield, you use the term 'medically induced'. Does that include surgical abortion and medical abortion, or only surgical abortion?

Dr Wakefield: That includes both medical and surgical, and both together. The term 'medically induced' really refers to a doctor performing a termination—

Mr McARDLE: Prescribing—

Dr Wakefield: Prescribing—yes, that is right—a medication, as distinct from a procedure.

Mr McARDLE: On the total figure of around 10,700 in 2015 public and private, do you have any idea of how many of those foetuses were born 'live'—taking the word 'gasped' with reference to Professor Kimble.

Dr Wakefield: The short answer to that is no. The best way of perhaps getting some sense of the mix here is to go to the subset of those data that I put forward about those greater than 20 weeks, where perhaps there is a slightly different scenario of a more developed foetus. The numbers in the private sector are very low: 18, 19. The conclusion I draw from the data is that, although there are significantly more terminations of pregnancy in the private sector, they would tend to be far earlier in the gestational period, whereas in the public sector we tend to take those that are later—

Mr McARDLE: So late term?

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Dr Wakefield: Yes, late term. The reason for that is that, once the morphology scanning has been done and other tests, it is around that 20-week period when we start to be able to diagnose problems with the baby—congenital problems or foetal abnormalities—which—how can I put that? These may be more likely to be wanted pregnancies that subsequently are terminated because of a problem with the mother or the baby.

Mr McARDLE: I will come back to that in a moment. The private clinics are required to file a report annually to the Chief Health Officer in regard to their activities, if I can put it that way. To my knowledge, those reports are not publicly available; would that be right?

Dr Wakefield: That is my understanding.

Mr McARDLE: Would those reports contain the details I am seeking, in that there would be a number of foetuses that were born live or gasped post the termination? Would that data be contained in those reports to the Chief Health Officer?

Dr Wakefield: I can answer that in a couple of ways. The first thing is that there is an obligation for private facilities that are regulated to provide data to the Chief Health Officer the content of which is not publicly available. However, there is data that I have presented to you that private hospitals are required to provide—admitted hospital data, for example—which allows us, in the same way as we do for public hospitals, to be able to say how many therapeutic terminations there are and at what gestational level they are, particularly if they are post 20 weeks. On the specific question that you had, as a subset of those which have signs of life at birth, I would have to take that on notice. I am not sure whether that is either publicly available in those data or whether it is contained within a report that the law protects or precludes us from making public.

Mr McARDLE: Could you take on notice a request that you look at the reports to see whether they contain that data and then advise the committee whether it can be released or whether the law protects the content thereof? Is that possible?

Dr Wakefield: Yes.

Mr McARDLE: The figure you gave of 10,700 is the public and private hospital figure. With the use of medical abortion now, that figure would not be accurate for all terminations because not everybody is required to go into hospital for a medical termination?

Dr Wakefield: That is correct. That data only pertains to where the patient has been designated as an inpatient.

Mr McARDLE: Do you have any ABS or Medicare data or any other data set that would give us a broader picture as to what the termination figures could be across the state?

Dr Wakefield: We have sought, as a consequence of preparation for the committee hearing today, data which is not held by Queensland Health. It is actually in the pharmaceutical benefits system. Subject to us obtaining such data, we may be able to identify nationally but certainly for Queensland how many prescriptions for, in this case, RU486 have been prescribed. That would be a proxy measure for abortions—for those ambulatory cases that are not captured in the data that we have. I have asked our data team to see whether they can get hold of that data. They do not currently have it, and certainly not in a form that they can extract that data. Again, on notice, I am happy to see if that is obtainable.

Mr McARDLE: Thank you. You mentioned under section 282 that a termination will focus on whether or not the woman's life or physical or mental health is threatened. At the ground level, how is that assessed? If a woman comes into a clinic, what steps are taken by the clinic and/or the public health facility to make certain that that is a requirement that is substantiated before the termination? What steps does the clinician take?

Dr Wakefield: It is not possible for me to answer that for private clinics. We provide guidance, obviously, but I cannot answer that. We can answer that for our public hospital services because we have done a lot of work in that area. I think Professor Kimble would be best placed to answer that. The guideline that I spent a fair bit of time going through lays out very clearly the steps and the due diligence, if you like, for both the doctor and the woman about the process. We do not take this lightly. The law is the law. I guess one would say that our threshold in the public system is fairly high. We take a view that our threshold for how the law deals with this is fairly high. This is not termination on demand. This genuinely has to be considered in the context of how the law has been set. At a practical level, Rebecca, is there anything that you want to add to that?

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Prof. Kimble: I will refer you to page 9 of 31 of the guideline, which stipulates the requirements at a facility level for approval prior to a termination. It reads—

For all cases—

this is excluding complex cases, and I will come to that—

Two medical specialists, one of whom must be a specialist obstetrician, consider the circumstances of each individual case

- Ideally, one specialist should be the practitioner performing or overseeing the procedure
- The speciality of the second medical practitioner should be relevant to the circumstances of the individual case

Usually this is a psychiatrist. In complex cases—and there is a definition for complex cases—the guideline reads—

In addition to the treating obstetrician, include a minimum of one other health professional in the case review *as appropriate for the individual case*

If there is not a psychiatrist, for instance, the guideline reads—

- Other health professionals *may* include (but are not limited to) a social worker, psychiatrist, obstetrician, general practitioner, maternal fetal medicine specialist or paediatrician,
- Other members of the case review *may* include (but are not limited to) a lawyer, ethicist, religious officer or sexual assault worker

Depending on the facility, depending on who is available—most regional hospitals have social workers and psychologists—there is at least one other person other than the obstetrician, which includes the GP obstetrician, who is able to provide the psychological assessment.

Mr McARDLE: I accept what you are saying, Professor Kimble, but what I am trying to get at is: if a woman goes to the RBH or Townsville Hospital or Cairns Hospital and she is not post 20 weeks, what physical steps and what questions are posed to actually come to a determination that, mentally, termination should occur? I accept the hierarchy and I accept the principles, but on the ground—taking your point that this is not a roundabout way of getting abortion by way of not getting pregnant, shall we say—what happens? As the mother, what is she asked?

Prof. Kimble: The request is generally the mother's request because of her inability to look after the baby and the impact of the disability of the child on her mental and consequently her physical health is one scenario.

Mr McARDLE: I will put it this way: am I asked about my prior mental history? Have I had a mental illness; have I been diagnosed—

Prof. Kimble: Absolutely.

Mr McARDLE: They are the sorts of questions we are talking about.

Prof. Kimble: Once again, the guideline is quite clear on this. During the physical examination and overall assessment of the woman's condition her psychological condition is assessed and her psychiatric history is looked into. There is a holistic assessment of the woman's psychological condition at that point in time. The pregnancy is one thing, but the psychological assessment of the woman, be it for the request for termination or otherwise, is made as part of this assessment.

It is a surgical or medical procedure. As with any procedure, one would go through in detail her psychological ability and consequently her ability to consent to the procedure and her capacity to do so. If the obstetrician, for instance, is out of their depth then the psychologist or the psychiatrist is involved.

Mr KELLY: The current guideline is clearly written on the basis of the current legal status of abortion in Queensland. The bill removes three sections of the Criminal Code. Will your guideline have to be rewritten if the bill successfully passes?

Dr Wakefield: I think it is fair to say that any material change in the law would cause us to revisit the guideline as a matter of course. As far as whether that would change practice within the guideline, given that most of the guideline pertains to clinical evidence and its application to this, I would have to ask Rebecca her view on that as the custodian of the guideline and the expert.

Prof. Kimble: I will come back to the original answer that I had given in relation to whether termination of pregnancy is sought for the purposes of birth control or for the purposes of therapeutic termination because of either a foetal abnormality or the maternal psychological condition. To answer your question, there would have to be significant change to the guideline. However, the therapeutic component will not change. The therapeutic component is based upon current therapeutic evidence. The real question is: are we using this change in the bill for a different purpose, because contraception is available very easily and very freely? To use termination of pregnancy as a method of birth control is an entirely separate question. We really need to look at both separately, in my clinical opinion.

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Mr KELLY: What are the rates of failure of contraception?

Prof. Kimble: Relatively low, if used appropriately. We are talking about below two per cent and mostly below one per cent.

Mr KELLY: Your guideline obviously relies on the law as it currently stands, but it also touches on a range of other issues, particularly around conscientious objection. That matter is, to my knowledge, not in any laws in Queensland. Will those sorts of things continue in your guideline if this legislation is successful and there is no requirement under the legislation for conscientious objection?

Prof. Kimble: It would have to, really. Conscientious objectors will continue to object regardless. Whatever you do with the law, people who have an objection to termination of pregnancy for whatever reason are obliged to refer to a colleague who is able to provide services. Does that answer your question?

Mr KELLY: The guideline requires you to act within the boundaries of your ethical considerations. What are the penalties from Queensland Health if you do not do that?

Prof. Kimble: I shall have to defer to our legal colleague behind me.

Mr KELLY: There are submitters who have indicated that small numbers of doctors in key positions have been able to significantly discourage the practice of termination of pregnancy. It is important from my perspective to know what the penalty is in Queensland Health if a conscientious objector does not identify as being someone who conscientiously objects and does not refer a person on to another practitioner?

Dr Wakefield: I can answer that. There is clearly no specific penalty in relation to the current law as it pertains to termination of pregnancy. There are two other levels of consequence. The first one is for employed doctors. In the Public Service one is bound by a code of conduct. Within that there are definitions of misconduct and so on. If a person is found to have acted inappropriately in the context of our code of conduct then there are consequences set out in our public sector legislation.

The second one, and probably the one which is more applicable, is the professional regulation. If any person is deemed to have acted inappropriately in a professional sense then that is governed by profession registration, AHPRA and the Office of the Health Ombudsman. My understanding of that scenario would be that it would be very rare to be called to account on that because it would be fairly challenging to establish the facts.

In relation to your prior question, if I may, our guideline provides really extensive guidance to practitioners for what we would regard as evidence based clinical care for women seeking termination of pregnancy and all that that entails. Clearly, that has to occur within the law. If merely there is a decriminalisation—that is, if the law is changed to remove termination of pregnancy from the Criminal Code—we are still left as Queensland Health, for example, with both a right and an obligation to provide guidance to our workforce and our health services in terms of what good clinical care looks like in termination of pregnancy. My colleague has outlined the fact that that is unlikely to change in the context of what good clinical care looks like. It clearly has to occur within the law, but it goes well beyond those specific provisions about the Criminal Code. I think merely removing termination of pregnancy from the Criminal Code leaves a question for providers in terms of how that helps.

Mr KELLY: For example, you have two medical specialists required for all cases and then a very large grab bag of people for complex cases. Again, that is not required by any law, is it?

Dr Wakefield: No.

Mr KELLY: That is an internal clinical guideline. The removal of these three aspects of the Criminal Code will simply mean that you have to reformulate your guidelines based on your normal internal clinical processes; is that correct?

Dr Wakefield: In short, yes. We would review our clinical guidance in the context of the law.

Mr KELLY: There is clearly a huge discrepancy in the numbers of terminations occurring between the public and private sector. The public sector would dwarf the private sector in terms of separations and number of employees, yet there are 10,700 terminations conducted in the private sector and only 295 in the public sector.

Dr Wakefield: Yes.

Mr KELLY: Will the removal of these aspects of the Criminal Code change that, in your opinion? Are you able to formulate an opinion on that?

Dr Wakefield: It is pure speculation on my part and on the part of the department to determine whether that would change. For the public hospital system, I think it would depend upon whether our threshold for termination of pregnancy changes. Our thresholds are predominantly clinical, although

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they are obviously guided by the law. As we have said, the data that we have excludes the pre-nine-week prescribed medication as a form of termination of pregnancy. In short, I cannot confidently say what would change by way of those numbers.

Mr KELLY: Many of the submitters have said that there are significant barriers to obtaining a termination in Queensland Health. Are there other factors beyond the current legal situation that makes that a reality? By these numbers, it is a reality: 295 versus 10,000. Are there other factors?

Dr Wakefield: I can only speak for our current practice, and our current practice is to the extent that we know exactly what happens at every front line is consistent with our guidelines. I think the evidence is clear just from the data that, if you have an early-term unwanted pregnancy and you want a termination, you do not go to a Queensland Health hospital. You access that through another provider. I do not think that is my opinion; I think that is clear from the data.

Mr KELLY: I have a final question in relation to page 11 of the guidelines in regard to the need to acquire authorisation from a court for a young person not deemed competent to have a termination. Will that change if the private member's bill is successfully passed?

Dr Wakefield: The requirement for informed consent for any procedure is irrespective of the matter of the Criminal Code. If we are performing a procedure on a patient, we must obtain informed consent and we have to turn our minds to whether the person has capacity. I am a doctor; I am not a lawyer, but I think it is fairly plain that merely removing a termination from the Criminal Code does not change our obligation in common law to obtain informed consent. If we deem a person not to be capable, not to have capacity, then we are required to comply with the substitute decision-making law, for example. Those cases usually end up in the public sector. Those cases of intellectual impairment where one has to go to court, or for very young girls that do not have Gillick capacity, currently cannot be dealt with in private clinics so they end up in the public sector. We currently look after those cases.

Prof. Kimble: I cannot see that changing.

Mr KELLY: To be clear, the legislation will not in any way change that?

Dr Wakefield: No, I do not believe so.

Mrs SMITH: I have three areas I want to explore with you. No. 1 is the cost implication. If I go to a private clinic—and this follows on from the member for Greenslopes—and have a termination procedure, what are the costs involved, roughly?

Dr Wakefield: I am sorry, I am not able to do that. From a prescribed medication perspective outside of a clinic, the cost is the cost of the medication but I cannot provide that.

Mrs SMITH: Can you, Dr Burton?

Dr Burton: I was wondering if you would be interested in this so I checked it out. For a medical termination at one of the largest providers, it is $610. For a surgical termination, it is $580. At another one of the big players, it is $300. There are some GPs who provide medical termination of pregnancy who discreetly and where necessary will bulk-bill a woman. The medication itself is PBS listed. If they have a healthcare card, it is $6.10. If they do not, it is closer to $40. Madam Chair, in regard to your question previously about vested interest, sometimes that is also where we refer a woman to. There are services that will provide women with counselling and support that will include termination of pregnancy as an option and services we can refer to where that would not be put on the plate xx. Sometimes a vested interest can also be the belief system that that service or that practitioner is coming from.

Mrs SMITH: If there are those costs involved, it would be logical to think that if the changes occur in this proposed bill we would see an increase going through to public hospitals in regard to Medicare.

Dr Wakefield: Again, I think that is speculation.

Mrs SMITH: If people do not have to pay for it, if they can go to a public hospital and have the same service provided, based on other areas we could safely assume that.

Dr Wakefield: That is certainly one outcome which we are considering, yes.

Mrs SMITH: You made a comment earlier—and, again, I am not putting words in your mouth—that you were aware of clinics which had to provide such reports. Would that indicate there is a possibility there are backyard abortion clinics operating in the state that we are not aware of?

Dr Wakefield: Thank you for your question. I really cannot answer that; I do not know. The only thing we do know is the data that we have from our hospital system and the data that we get through the regulatory system for private hospitals and day clinics which we have had in the last few

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years. Anything that happens outside of a licensed day surgery hospital or hospital we have no line of sight of. If a GP prescribed RU486 or if there is some 'backyard' system, it is unregulated and we have no line of sight of that.

Mrs SMITH: My last question is on late-term abortions. You said there have been 112 over 20 weeks in public hospitals and 18 in private clinics. What is the youngest surviving baby? Is it 22, 23 or 24 weeks?

Dr Wakefield: I would have to flick that to the clinical expert.

Prof. Kimble: In Queensland it is 23 completed weeks. That is survival you are talking about, not quality of survival?

Mrs SMITH: No, survival. Years ago that would have been unheard of. Each year with improved research and science, that could even reduce to 21 or 20 weeks in years to come.

Prof. Kimble: Possibly, but when we are talking about survival we are talking always about that grey zone of the quality of survival. The threshold of viability spans currently between 23 completed weeks and 26 completed weeks, and the pregnant woman is entitled to determine herself whether or not she will agree to resuscitation of that baby, and we have a separate guideline on that as well. Of course medical science will progress to attempt to keep foetuses alive from any gestation, but you have to look at the quality of survival. It is not insignificant, the morbidity associated with survival. Mortality is one thing, but morbidity is considerable.

Mrs SMITH: What is the latest late-term abortion that has occurred in Queensland? Is it around the 26-week mark?

Prof. Kimble: It largely tends to be at the 22-week mark but then we have had to have terminations—and we are talking really rare situations—where continuation of the pregnancy of an undiagnosed cardiac condition in the mother, for instance, may require termination of pregnancy beyond 22 weeks because continuation would kill the mother. We really are talking very, very small numbers—one or two a year if even that.

Mrs SMITH: I understand the time pressures so I will leave my questioning there.

Mr HARPER: We only have a few minutes so I will make it brief. Thank you very much for your contribution today. The clinical guideline you have produced is a significant body of work with a lot of stakeholders over a period of time. Similar to the question I asked Dr Burton in relation to the terms of reference, I seek your opinion, firstly, on the need to modernise and clarify the law. From a Queensland Health perspective, do you believe that will provide some certainty for employees of Queensland Health in delivering the interventions required in the therapeutic termination of pregnancy?

Dr Wakefield: Madam Chair, I think it is best that we not comment on a policy matter of that nature.

Mr HARPER: That is fine. You said before that by simply removing it from the Criminal Code you would still need to direct the workforce through the guideline. Do you have an opinion based on other states and jurisdictions—for example, Victoria and Tasmania—in terms of gestational periods. Is there some discussion around that?

Dr Wakefield: Obviously our job is to respond appropriately to policy positions and legislation passed by the House. I would say, though, that I think it is very clear by the very nature of having a guideline—and you can see from the content of the guideline that this is clearly a tremendously challenging area of clinical practice. It is a tremendously challenging area for women who are faced with difficult decisions. Whatever the policy position from a legislative position that is taken, that will never be anywhere near sufficient to cover the sort of guidance that women and families and our practitioners need to be able to do their job, which is deliver good care which is very focused on person centred care, not just a judgement by a doctor on what is good or not for a woman. Whatever the policy position, whatever the legislation change, I think that we will still need guidance which would be very similar to this. That is the first point.

The second point that I would make is that—this is not an opinion; I think this is fact—because this is currently in the Criminal Code, regardless of doctors understanding the technical detail of the Criminal Code, there is a level of fear that comes with that. The fear that comes with working in this area and potentially being held criminally responsible elicits a fear which may go beyond the actual technical provisions of the law. I would just make that comment that whatever the technical bit of the law, doctors have a difficult job to do. If they are navigating a Criminal Code I think that generates some fear. Would you agree with that?

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Prof. Kimble: Absolutely.

Dr Wakefield: I would leave it there in terms of opinion about policy.

Mr CRAMP: I have an interest around your commentary regarding children, both post and pre 20 weeks, and you said they have a heartbeat and take a gasp of breath, so technically they may be viable. I just want to clarify one thing. Professor Kimble, you state that even in special care nurseries like Mater Mothers, the earliest they have had a viable surviving child is 23 weeks; is that correct? There has been none younger?

Prof. Kimble: That is my understanding from having spoken to my neonatal colleagues, but they are in a better position to answer that.

Mr CRAMP: Could I ask through the chair that we get some information from the department on that and some stats on the youngest surviving children?

Prof. Kimble: Keeping in mind that it is estimated gestation—best estimated gestational age.

Mr CRAMP: I do concede that.

Prof. Kimble: So 23 weeks could be 23 plus four or 22 plus six.

Mr CRAMP: My understanding is that it was younger than that, so I would like to see some statistics around that.

Prof. Kimble: Absolutely. A 22-weeker that might have survived could well have been actually 23 weeks. We do not know.

Mr CRAMP: With regard to that, when a child is born or a foetus comes out—however you like to look at that—and it has a heartbeat, what is Queensland Health's practice with regard to a doctor—we will assume it is a child at this stage as it has a heartbeat and it is a live birth—providing care for that child? If they do not provide any care, what is the procedure with assisting that child through this period where it has a heartbeat and viable life signs? I would be interested to hear that.

Prof. Kimble: Compassionately palliate it, and there is a separate guideline on that as well.

Mr CRAMP: Do you want to break that down into lay terms for everyone who reads the transcript?

Prof. Kimble: The paediatricians, our neonatal colleagues, would be there to provide care and, generally speaking, would provide pain relief for the baby and stay with it. It depends on gestation and whether it is one gasp or whether it is a baby that might demise in 30 minutes. Whatever the situation may be, the neonatologists generally tend to be there to provide what we would call palliative care, and that is reducing pain and suffering for the baby.

Mr CRAMP: That would be some pain relief? It would not be oxygen or anything like that provided to assist the child?

Prof. Kimble: If it is a termination situation then resuscitation is generally not part of it. Then it is pain relief.

Mr CRAMP: Do we have any statistics that we could provide as to how long a child could last in that position and be left in that state?

Prof. Kimble: Once again, it would be best to get the detail of that from my neonatal colleagues. There are neonatal colleagues at the Mater and at the Royal Brisbane who directly deal with that.

Mr CRAMP: If possible, Madam Chair, I would also like to ask that that information be provided in a statistical form to the committee if allowable.

Dr Wakefield: I am not sure that that is collected. I will certainly take that on notice and provide a response.

Mr CRAMP: My last question is in relation to a report that I looked into in regard to four healthy late-term babies being terminated in 2012-13. Two were stillborn and two came out alive. If they are viable and they are very late term, what procedures would be carried out on those children? We are not talking about a foetus at this stage; we are talking about a child that is born very viable, according to this report. The report I am referring to is the Queensland Maternal and Perinatal Quality Council report of 2015, page 106. Are you aware of this report?

Prof. Kimble: Yes, we know of it.

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Mr CRAMP: I just wanted to clarify that for the record. Do you have statistics around the two live births in particular—what medical care and treatment were provided to those two births—and how long those two children survived?

Dr Wakefield: Perhaps I could make comment about that. The quality council provides a report which is de-identified and consistent with the quality assurance committee legislation. I have no access to the individual case data that pertains to anything that is produced by a quality council. The report is public, but the proceedings of that committee are privileged and I do not have access to those, I am sorry.

Mr CRAMP: I have one very quick question with regard to that. Would your practices change in regard to treatment of late-term viable births if this legislation were to come in? Is there an expectation that this situation would increase with the legislation because it would be less restrictive?

Dr Wakefield: Again, perhaps I can answer that and ask Rebecca to comment in addition. The question is: would the proposed changes to the legislation change the number of late-term terminations and, as a consequence of that, would that change how we approach that? Again, whatever the policy or statute changes that occur, we would respond to those. Again, I re-emphasise that the majority of our guidance is about appropriate clinical care; it is not about the legislation per se. The best I could say is that in the light of any policy change we would review that guidance, but most of our guidelines come from clinical evidence, not from a piece of statute.

CHAIR: We also appreciate that you can only provide factual information, not opinion. We do appreciate that.

Dr Wakefield: Would you see that changing our approach, Rebecca?

Prof. Kimble: We then have to look at the whole situation and the family's request for resuscitation or otherwise beyond that viability gestation—what you refer to as late termination—and respect that if the law changes. It is a complex situation. In relation specifically to providing care to that live born baby, it would be the same care. However, the recommendation would be resuscitation by the neonatologist beyond 26 weeks. It is not just a matter of choosing to terminate—

Mr CRAMP: You are clarifying that the neonatologist would actually try to resuscitate that baby and try to keep it alive?

Prof. Kimble: The very strong recommendation from a neonatologist of a newborn baby at 26 weeks would be to resuscitate it.

Mr CRAMP: Would Queensland Health follow those guidelines? Would the doctors attending also follow those guidelines and keep that baby alive?

Prof. Kimble: There is already a guideline on that and it is called care at the threshold of viability. That is quite clear on what is recommended beyond 26 weeks and what is recommended between 23 and 26 weeks.

CHAIR: The time allocated for this briefing has expired. A draft transcript of proceedings will be sent to each of you for any necessary corrections. A number of matters have been taken on notice and the secretariat will contact you to confirm the question taken and when the response is due. Thank you, Dr Burton, Dr Wakefield and Professor Kimble, kindly for your attendance today. The committee appreciates your assistance. I declare the briefing closed.

Dr Wakefield: Thank you, Madam Chair and committee members.

Proceedings suspended from 12.56 pm to 1.33 pm

CHAIR: This afternoon's briefing will focus on psychological issues relevant to termination of pregnancy. I now declare open this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into laws governing termination of pregnancy and the Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016. I acknowledge the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging.

I will reintroduce the committee for those who were not present this morning. My name is Leanne Linard, chair of the committee and the member for Nudgee. The other members of the committee are: Mr Mark McArdle, the deputy chair and member for Caloundra; Mr Joe Kelly, the member for Greenslopes; Mrs Tarnya Smith, the member for Mount Ommaney; Mr Aaron Harper, the member for Thuringowa; and Mr Sid Cramp, the member for Gavin. For the benefit of members of the public, this briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. I remind all those in the public gallery today that these proceedings are similar to parliament to the extent that the public cannot participate. Members of the public may be admitted to, or excluding from, the briefing at the discretion of the committee. Please note that you may be filmed or photographed.

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GRIDLEY, Ms Heather, Australian Psychological Society

HARDY, Dr Fotina, Australian Association of Social Workers, Queensland Branch

WHITE, Dr Lyndall, Royal Australian and New Zealand College of Psychiatrists

WHYBROW, Ms Jacklyn, Australian Association of Social Workers, Queensland Branch

CHAIR: I welcome representatives of the Royal Australian and New Zealand College of Psychiatrists, Australian Association of Social Workers, Queensland Branch and the Australian Psychological Society who have agreed to brief us today. Dr White, can we start with you, please.

Dr White: I am here representing the Royal Australian and New Zealand College of Psychiatrists today. This college is responsible for training, educating and representing psychiatrists in Australia and New Zealand. The college is a fellowship of psychiatrists who work with and for the general community to achieve the best attainable quality of psychiatric care and mental health. The college promotes excellence in healthcare services for patients, their families and carers and cultivates and encourages high principles of practice, ethics and professional integrity. The college has more than 5,500 members, including more than 4,000 fully qualified psychiatrists and around 1,400 members who are training to qualify as psychiatrists.

This briefing note has been drafted in consultation with college members with particular expertise and clinical insight into perinatal mental health. This includes extensive input from the Queensland section of Perinatal and Infant Psychiatry and the Women's Health Expert Reference Group, a group of professionals largely based interstate. For more background on the college's position on these matters, please refer to the discussion paper that that expert committee has put together 'Termination of pregnancy: RANZCP 2011' and the college's submission to the committee on abortion law reform.

While the college has no specific position on lawful or unlawful factors in relation to the termination of a pregnancy, we recommend that a woman's health, wellbeing and autonomy be central to the termination of pregnancy policy. Women accessing termination of pregnancy services may present with particular vulnerabilities and factors which need to be taken into account. Pregnancy can lead to the onset or relapse of mental disorders in some women. This population requires particular support should they access termination of pregnancy services, particularly as these women may be more vulnerable to experiencing an unwarranted or unplanned pregnancy and are more likely to present for assistance later in their pregnancy.

It is essential that women accessing pregnancy termination services have proper access to unbiased counselling and support at every stage along the process, including a routine follow-up. Counselling should be affordable and accessible to all women. Women with particular support needs or risk factors should have good access to affordable counselling services tailored to their circumstances. These include women of Aboriginal and Torres Strait Islander background; those in rural and remote locations; those of culturally and linguistically diverse backgrounds, including refugees; those who undergo terminations for foetal abnormality; those undergoing a late termination; women who have a serious mental illness; and those who are very young. The college recommends that if health providers find they are unable to treat a patient because of their personal views towards abortion, they should exclude themselves from the role but ensure the patient is referred elsewhere for appropriate unbiased care.

In its 2015 report the Queensland Maternal and Perinatal Quality Council expressed its ongoing concern that suicide continues to be the leading cause of death in women during pregnancy and within 365 days of the end of pregnancy. In Queensland, 15.2 per cent of maternal deaths from 2004 to 2013 occurred after a termination of pregnancy, with a portion of these likely to have been suicide. In its 2015 report the Queensland Maternal and Perinatal Quality Council stated that mental health screening of women accessing abortion services is performed almost universally in the public sector but less so in the private sector. The council recommends the use of the Edinburgh Postnatal Depression Scale in the private sector to help identify women who want further follow-up. Likewise, the college is concerned that appropriate mental health support and counselling may not be offered to women in private clinics at a level equal to that of women in public clinics. The college is also concerned that Queensland women who access legal services interstate—for example, Victoria or

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overseas in the United Kingdom or the United States of America—may not receive follow-up mental health support or counselling and so must return to their place of residence and may not disclose what occurred to their local health authorities.

Women with pre-existing psychiatric disorders require appropriate support and care, whether they choose to continue with their pregnancy or terminate it. In its 2015 report the Queensland Maternal and Perinatal Quality Council recommends that a woman with serious mental health illness—for example, schizophrenia, bipolar affective disorder or schizoaffective disorder—should routinely be offered mental health follow-up for at least the first 12 months post-partum. Liaison and collaboration between services will often be required, and families and carers should be involved where appropriate. Psychiatric services should also be available for the assessment and care of women requesting late termination of pregnancy to assist the women negotiate the decision-making process and to resolve ambivalence. Psychiatrists also have a role in follow-up and more ongoing support in the case of adverse psychological outcomes. Obstetricians may also consult with psychiatrists regarding the risks to a woman's mental health if she were to continue with the pregnancy. Under these circumstances the psychiatrist should make recommendations based on the best interests of the patient. Women whose capacity is impaired due to serious mental illness, including involuntary patients, will also require mental health support. The role of the psychiatrist here is to ultimately promote the woman's welfare and autonomy. Psychiatrists should encourage and support the active participation of the woman's family and carer when appropriate, taking confidentiality and cultural factors into account.

There is limited and conflicting evidence as to the psychological effects of abortion on women and the psychological effect on women who are unable to access abortion services. The Queensland Maternity and Neonatal Clinical Guidelines 2013 state that there are significant limitations in the evidence examining the relationships between unwanted pregnancy, termination of pregnancy, birth and mental health. For the majority of mental health outcomes there is no statistically significant association between pregnancy resolution and mental health problems. An unwanted pregnancy may lead to an increased risk of mental health problems, or other factors may lead to both an increased risk of unwanted pregnancy and an increased risk of mental health problems.

When a woman has an unwanted pregnancy, rates of mental health problems will largely be unaffected whether she has a termination or goes on to give birth. Women with a past history of mental health problems are at an increased risk of further problems after an unintended pregnancy. The guidelines also recommend that there should be support and care for all women who request a termination of pregnancy, because the risk of mental health problems increases whatever the pregnancy outcome. The college of psychiatrists considers that, regardless of the limitations of the evidence of the psychological effects of abortion and the inability to obtain an abortion, adverse psychological outcomes are common enough to justify the availability of expert counselling and support services for every woman undergoing a termination of pregnancy if required.

In terms of professional standards and guidelines relevant to counselling of women in relation to abortion, the British College of Obstetricians and Gynaecologists have published an evidence based clinical guideline entitled 'The care of women requesting induced abortion', which includes information which they consider women need to know about abortion beforehand and during follow-up afterwards. The Queensland government's Maternal and Neonatal Clinical Guideline 2013 provides a short table on good practice points for providing information and counselling to women.

The College of Psychiatrists is concerned that not all counselling services are unbiased. Some organisations that offer pregnancy counselling do not aim to discuss all of the pregnancy options in an unbiased way. Some pregnancy options counsellors may advise women against abortions because of their own beliefs. The Royal Women's Hospital in Melbourne recommends women ask questions over the phone before making an appointment for counselling to assess whether the service has any bias. The College of Psychiatrists considers that women in Queensland should have access to unbiased counselling services.

CHAIR: Dr White, you mentioned the importance of unbiased counselling for women and you mentioned an example of perhaps women who may go to a service and they may be encouraged not to have an abortion because of particular views. Have you heard anecdotally of women also getting counselling that did not present all of the options because they may have a particular view in favour of terminations?

Dr White: I personally have not heard of those particular options, although I have seen some women who have been through services where once they were there it seemed as if the process was to be enduring, that once they walked in the door it seemed as if they did not have a lot of choice because they had agreed in some way beforehand. I am not aware, though, of the comprehensive nature of that counselling.

CHAIR: Thank you for that response because it was actually a similar example that was provided to me from a medical professional who mentioned that women who have ambivalence perhaps are at particular risk, and understandably because they are ambivalent, before they go in and may feel—and I do not know if it would be fair to say this—that it is a fait accompli or some sense of pressure of, 'Just do it. Get it done early. Resolve the problem and then you can move away.' I do not know how widely experienced that is. I was just wondering if you had a sense; that is all.

The other thing I was interested in is—and you may have mentioned this in your opening statement—with regard to mental illness you talked about some serious issues around a woman who may have schizophrenia or some different mental health issues. When women who may live with those sorts of conditions consider pregnancy, I would imagine that that is a discussion they have with their treating professional in trying to put some safety around that, for example a woman who may have had postnatal depression with a previous pregnancy.

Dr White: In an ideal situation that would be the case. Unfortunately, many of these women fall from follow-up and care and so they may not have adequate care at the time they conceive. If these girls have ongoing active illness then there may be times when in fact they do not access services until quite late in the pregnancy, and they may not have had good care until that point as well. I guess in an ideal world when a girl is attending a clinic regularly then she will have actually discussed and planned a pregnancy with suitability of medications and proper care, but of course in that situation, too, there are medications to be considered in the context of the pregnancy and the psychosocial supports are very important for those women as well as treating doctors.

CHAIR: Just for my understanding, too, when you are talking about women who present with complex mental health issues—they may be later on in their pregnancy for the reasons that you outlined earlier—is it your experience that the pregnancy was wanted but it has become too great a pressure for the individual or the illness itself has progressed to such a degree that they cannot cope with the pregnancy anymore, or is it more the chicken and egg—that is, the illness itself may have meant that they had impaired judgement or consideration?

Dr White: I certainly have seen both situations and I believe treating psychiatrists in the perinatal field will have seen both situations where girls may have even been unaware that they had conceived for some time because of their illness and certainly were not planning a pregnancy and there would be others with very much wanted babies who need ongoing care and then support to decide whether they are going to continue the pregnancy or not.

Mr McARDLE: Thank you, Dr White, for your opening comments. In your paper you refer to the 15.2 per cent of maternal deaths post 365 days of the termination. You make the comment here that a proportion of these are likely to have been suicide. The figure of 15.2 per cent between 2004 and 2013 would equate to how many women?

Dr White: I would have to confirm that, but I think it would be certainly in single figures. I cannot tell you exactly, but I think in that period—we would have to confirm it—it is in single figures.

Mr McARDLE: It would be less than 10 between 2004 and 2013?

Dr White: I believe that is the case, but I do believe that it is still a significant proportion of maternal deaths.

Mr McARDLE: In that time line, how many women would have died post maternal period?

Dr White: We will have to look into that. Those figures will be contained in that Queensland report from maternal deaths. We have that report with us, so we can confirm those figures. I can certainly supply those figures later for you.

Mr McARDLE: The wording that you use in the paragraph is 'with a proportion of these likely to have been suicide'. That is a very wide statement because you are making a judgement call by saying 'likely to have been suicide'. How do you gauge that sentence to be real against the number of deaths?

Dr White: I do believe that in Australia today the practice of termination of pregnancy is conducted in a relatively safe manner and that deaths from complications physically from terminations of pregnancy would be very rare in comparison to the number of deaths that are reported, so we have to assume that some of those girls then have actually become distressed and taken their own lives.

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Mr McARDLE: There are no statistics or facts you can point to to make that statement; it is an assumption that a number of women may have taken their own life? I want you to be very clear on that.

Dr White: Yes. These are certainly the findings of that Queensland maternal mortality committee, and that is their belief as well. They would have access to many more facts and figures than we do. Unfortunately we cannot do studies or follow-up girls who have terminations because we cannot access them and they do not comply with follow-up in terms of outcomes, so we really do not often know what the outcomes of these girls are. I do know though that for some women in particular this is a very distressing process and if, for instance, they did have a serious mental illness that was undiagnosed or untreated at the time of the termination then some of those women would clearly be at risk just by virtue of the fact that their illness was pursuing and untreated as well as the distress of having possibly undergone a termination. There are so many factors in this area that need to be considered, but I do believe that these girls do not get the opportunity very often to actually have someone to talk to down the line, particularly if they are distressed, and I think those girls are at risk. I have to say there is a significant figure. Those figures are from that Queensland maternal mortality committee and we can certainly tender you that whole report and let you have those figures. I have to say that their very first recommendation for the whole of the Queensland maternal mortality committee—the very first recommendation—is that there should be adequate services for counselling and follow-up for the girls undergoing termination of pregnancy. It is not in relation to more physical care or better follow-up of the process or the techniques of termination of pregnancy. It is ironic that their very first recommendation is that there needs to be more services available for counselling for these girls.

Mr McARDLE: There are many studies across the world in relation to counselling and mental health issues, both pre and post. Would you agree that it is more likely that a termination will trigger an existing condition as opposed to generate a new condition of a mental health concern?

Dr White: I really think that depends on the individual girl. Certainly if a girl has an existing mental health condition she is at risk of an episode and pregnancy itself is a trigger regardless of the outcome of the pregnancy, whether it be termination or birth. For certain mental illnesses such as bipolar effective disorder and major depression for instance, those illnesses do carry their own risks of relapse in pregnancy and at the end of pregnancy regardless of the outcome. Aside from that though, we cannot always predict the girls who present for terminations who are going to be in that class. They may have high risks psychosocially. They may have high risks genetically as well of developing an episode of an acute illness such as postpartum psychosis after a termination. We have no way always of telling or predicting who those girls are.

Mr McARDLE: You would certainly leave open the point that a termination alone, without a pre-existing condition, could trigger a condition in its own right?

Dr White: Yes, I agree because I think it is the whole saga of pregnancy and the outcome. The hormonal profile and cascade that occurs in a pregnancy again may make these girls more at risk by virtue of their vulnerability to that condition, and very often these girls have unwanted pregnancy. They have difficult psychosocial situations and they may also be substance using and have limited support and have other familial risks. I agree that this process then down the track may by virtue of the fact that they have terminated a pregnancy, along with the pregnancy itself, make them more vulnerable.

Mr McARDLE: I pose this question to you: it has been put to me that the younger a woman is the more likely in time that could impact on them and that is determined in their notion of self. With regard to a young woman, say, between 18 and 25 as opposed to an older woman of 25 to 40, is it likely that, irrespective of the age, there is a greater risk of a condition being triggered or does age have a factor in it as well given maturity and given worldly experience?

Dr White: I think it is very hard to predict age being a factor. There are so many other confounding factors in that and I do not think there is any clear evidence that suggests that the younger the girl the more likely she is to have a negative outcome.

Mr McARDLE: Would you agree that, if we agree to do so, the Criminal Code is amended by sections being taken out, but pivotally you would say that counselling and assessment at day one is so important to assist the woman through the pregnancy/termination? In fact, would you recommend counselling be mandated before termination and also a cooling-off period be mandated before the action actually does occur?

Dr White: In an ideal world that would be the very best outcome.

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Mr KELLY: When you say 'mandated', do you mean the mandatory offering of counselling or that a woman seeking a termination would have to go through a counselling process?

Dr White: I believe 'mandate' was Mr McArdle's word, but in response to that I would say that the public girls who undergo termination are all assessed by an allied health professional such as a social worker or a psychologist and in some cases where there are complications, such as late terminations, they are also assessed by psychiatrists—mental health teams.

The private girls, I believe, may be asked if they would like to talk to someone, but there is no mandated, or there is no consistent follow-up. In this situation, the fact is that an unwanted pregnancy is a psychosocial crisis in all women's lives, whatever the circumstance, and she does need the opportunity to be thoughtful about her choices and to be given an understanding of her options—whether she wishes to continue with the pregnancy and parent the child, whether she wishes to continue with the pregnancy and adopt the child, or whether she wishes to terminate.

I think it is very important in the initial stages that girls are given that opportunity to consider their options first of all and then, following the process, I think there have to be adequate pathways to care for all girls who have undergone termination to seek formal ongoing support, counselling and treatment, if necessary, if they develop a serious mental illness.

Mr KELLY: The bill simply removes three sections of the Criminal Code. Would you like to see legislation that requires at least the offering of counselling and creates a uniform approach across the public and the private sector?

Dr White: That would be the ideal situation.

Mr KELLY: I picked up on that number, too—the 15 per cent. Presumably, the suicide is not always but often related to depression. For the 85 per cent, I assume that is potentially postnatal depression as well. Would the removal of these three clauses from the Criminal Code have any significant impact on dealing with that issue?

Dr White: That is very hypothetical insofar as some girls may not travel interstate or have so much difficulty in making choices if they had local counselling available and options for their outcomes, but the college does not have an opinion about the legal process, I would have to say.

Mr KELLY: Right. Are there any longitudinal studies around women who have unwanted pregnancies and the long-term impacts on their mental health and socio-economic situation?

Dr White: Again, they are very difficult to find. It is very difficult to engage these women in any form of follow-up. Again, there are many confounding factors. There would be some material related to the girls who come into our mental health services care, I am sure, but to my knowledge there is no long-term follow-up available at this stage.

Mr KELLY: The numbers that we got this morning were for inpatient terminations in Queensland Health facilities. They were something like 295 versus 10,700, but they could not give us any numbers around terminations that may have been done medically as an outpatient. In your experience, currently, do people who receive terminations as an outpatient get the counselling services that your college thinks they need?

Dr White: I am imagining that most of those women you are referring to as outpatients would be accessing private services. It is my understanding and my personal experience from the girls I have seen who have been through those services that there have not been any significant options offered to them for counselling or follow-up at all.

Mrs SMITH: We had the medical people in this morning and they went through step by step the maternity and neonatal clinical guideline in regard to the termination of a pregnancy. Throughout that document it appears that, as part of the guidelines, there is the opportunity for counselling to happen prior to a termination and then post. Is it your sense that that is not occurring in all cases, or is your concern more the fact that it is not happening or adhered to in the private clinics?

Dr White: The guidelines are best practice. What happens out in the real world sometimes we can only guess, and things are sometimes ticked and flicked. In real terms, there would be pathways and mandatory processes to be followed in the public sector. I think we are unsure what happens, really, in the private sector.

Mrs SMITH: Would you see that there are certain stages of a pregnancy where people require more counselling? This is picking up on questions asked by other committee members. If they are minors, are they requiring it an earlier stage—or somebody who is making the decision to have a termination at a later stage? Do you see that there would be different needs?

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Dr White: Yes, I agree. Certainly with minors, I believe that there is an important role for substitute decision-makers, be they family or whomever, to be involved in the decision. Generally, the outcome from an abortion in an early pregnancy that is unwanted—the figures seem to show that there is not usually a bad outcome, or not often a bad outcome. In terms of the girls who come for late terminations—20 weeks and beyond—very often these pregnancies are much wanted. There is an attachment to the foetus and there may be a foetal abnormality that promotes the choice to terminate, or they feel psychosocially that they do not have adequate support to have a child with a disability. Those areas are very fraught.

Also, in the late stages of pregnancy often there is infanticide involved in the process. The woman has to labour and deliver a dead foetus. That itself is an enormously distressing process. Some of those women certainly go on to not only become distressed but also develop part of an acute stress disorder, which is the acute form of a post-traumatic stress disorder. Not in every case, but in some cases that is a very real risk. Of course, there is still the risk of postnatal depression following the delivery of a dead foetus.

Mr HARPER: I thank all of you for the important role you play in managing these patients. It is a very challenging environment. I have a 25-year history in the Ambulance. I have had some interactions and experiences in managing some of these cases. Certainly, when I reflect on the provision of counselling, I have heard you say many times that in an ideal world it should be mandatory. You have some data about the suicide rates. Do you have any data around postnatal depression and/or anxiety? Has any of that been collated by the college?

Dr White: Not in the termination period, but the risk of postnatal depression following any pregnancy, whatever the outcome, I believe is somewhere between 15 per cent and 20 per cent, and about 30 per cent of postnatal depression commences antenatal in a pregnancy. One in five girls will develop a postnatal illness. Anxiety is probably slightly less, but certainly it is very real and it is very often not found. The symptoms of pregnancy and the symptoms of anxiety and depression in fact often overlap to the point where if a girl is not sleeping and she is tearful and she is agitated she is very often patted on the head and told, 'There, there, dear. You're pregnant,' rather than someone recognising that this girl has a serious depression or a serious anxiety disorder that may need adequate treatment for her then to make an informed decision about how she proceeds.

Mr HARPER: The other point of interest in your recommendations was around the regulation according to the gestational period. You identified that there are complexities in late terminations but that the college has reserved its right to have an opinion in that space. Can you articulate that a little more?

Dr White: Sorry, the college of psychiatrists does not have an opinion on the legality or illegality of the termination of a pregnancy, but we would certainly be supportive of women who have late terminations having the opportunity to have mental health assessments and care as necessary. Earlier terminations I think should be assessed as they arise, unless the girl already has a mental illness or a high risk of it or very difficult psychosocial circumstances such as domestic violence or substance use.

Mr HARPER: Thank you very much.

Mr CRAMP: Members of your college would obviously be involved in our current health system here in Queensland and especially in the public health system.

Dr White: Yes.

Mr CRAMP: What is the counselling process for a patient—if you can tell me, of course—who presents to an ED or a hospital or a public health service to seek an abortion? Is there a standard process of what they must do from a psychiatric point of view if they are diagnosed with an illness? What is the process?

Dr White: I certainly would want to have this confirmed from Queensland Health policies, but my understanding is that, to some degree at least, this depends on the individual services. I know that at some services terminations publicly would be determined based on significant risk just to the mental and physical health of the individual and that those cases would always be seen by a member of a mental health team, such as a consultation liaison psychiatrist. In other services, I believe that they would be certainly seen by our colleagues, the allied health professionals. I cannot tell you. I am sure it depends at least in some part on the availability of the individual's public service, but I would defer to what the criteria are in Queensland public health. I am in private practice, so I do not claim to be an authority on public practice in Queensland.

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Mr CRAMP: Does your college have minimum standards with respect to the amount of counselling for those people? I understand the difference between a psychologist and a psychiatrist, especially in regard to a prediagnosis of a mental health issue. If that is identified at a major public hospital such as the Gold Coast or the Royal Brisbane, would there be a standard practice or a minimum set out by even your college with regard to what is a duty of care?

Dr White: There is a decision paper on the termination of pregnancy by the expert group and I would refer you to that. Again, it really depends on what the invitation to the psychiatrist is. It may be at levels: it may be at a level of ascertaining the woman's fitness to determine whether she should have a termination or not; it may be at her level of competency; it may also be to assess her mental illness status and whether she needs adequate treatment acutely of that condition before she can then proceed to make a formal decision about whether to have a termination.

My understanding is—and I would put this on notice to be confirmed by the college—that there is no formal strategy by the college of psychiatrists that mandates what a psychiatrist should do. It is my understanding that, as experts in the area of mental health, we would all have protocols that we would follow in an assessment of individual cases and then plan for follow-up or treatment accordingly and also assist and inform obstetricians and other medical people involved in her care and the decision-making.

Mr CRAMP: With respect to your previous comments about counselling being available in an ideal world, regardless of whether legislation is brought in, how would the college view an opportunity to provide some minimum standards or at least have some input into minimum standards to Queensland Health? Would you see that as a beneficial outcome to ensure that people with mental illness receive adequate care?

Dr White: I certainly think we would accept the invitation to consider some input. I do not want to underestimate the role of our colleagues in the allied health professions. The clinical psychologists and the social workers are very heavily involved in this area and many opportunities for them to be involved would be all that would be required if a girl just needs that ongoing support and counselling and proper therapy. There are those girls who certainly have a more sinister illness and need to be cared for and we would accept that invitation to have some input into some of those guidelines.

CHAIR: Thank you, Dr White. Can I now invite Ms Gridley to make some opening remarks and then we will open to questions.

Ms Gridley: I wondered if we could go to our social work colleague first because she is from Brisbane and I am from Melbourne and I think it is probably better to hear from her first, if that is okay.

CHAIR: That is fine.

Ms Whybrow: The Australian Association of Social Workers is a professional body representing 10,000 members across Australia. Social work is founded on principles of social justice, human rights and professional integrity. It aims to enhance the quality of life and support and develop the full potential of individuals, groups and the community through ethical, accountable, professional, competent and transparent practice. The profession's values are embodied in the profession's national and international code of ethics, our practice standards and theoretical perspectives that underpin the social work profession and our knowledge base. The AASW seeks to ground the public and policy debate about abortion in solid evidence and a genuine public health approach. We maintain that the termination of a pregnancy is an issue that evokes many wideranging passionate moral values. The issue is one that cannot be divorced from the notions of fundamental human rights and social justice. It is through this lens that the AASW supports the reform of delivering expanded access to Queensland women to exercise their reproductive rights.

The AASW acknowledges that there are many life circumstances that give rise to women and girls of reproductive age seeking to exercise their reproductive rights, including sexual assault or rape, high risk to a woman's or a girl's physical and emotional wellbeing, psychosocial or economic disadvantage, the likelihood of an abnormal foetus or the risk of health complications or the disability of a newborn. We, as with many others who work in this area, are concerned that the existing legislation not only denies women appropriate access to reproductive rights but also particularly disadvantages women who already experience disadvantage. This has been confirmed by organisations that work in this space who report that the most disadvantaged women are currently suffering the most. This includes women who are based in rural and remote areas of the state and those who are experiencing violence in their relationship, just to name a few. Denying access to termination for these women is denying them a fundamental human right to self-determination. The psychological, physical and social consequences of this act can be far-reaching and devastating.

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As a profession it is essential that we highlight the evidence with regard to psychological impacts if a woman is denied access to reproductive rights or if she is unable to express this. I will refer to the evidence based on the Turnaway Study, which was conducted in the USA and is the largest longitudinal study of turnaways completed—that is, women who are turned away or denied access to termination—and is the foundation of a global study of women who are restricted in accessing their reproductive rights. This robust study has been used as a key example in the abortion debate. The Turnaway Study is a prospective longitudinal study examining the effects of unintended pregnancy on women's lives. The major aim of this study is to describe the mental health, physical health and socioeconomic consequences of receiving an abortion compared to carrying an unwanted pregnancy to term.

From 2008 to 2010 the study collaborated with 30 abortion facilities throughout the US and recruited a thousand women who sought abortions. Some received abortions and some were turned away and carried out to term. This study aims to document the effects of unintended pregnancies, abortions and also unintended child-bearing on women and their families. The Turnaway Study was an effort to capture women's stories, understand the role of abortion and child-bearing in their lives and contribute to the ongoing public policy debate on mental health and life course consequences of an abortion and unwanted child-bearing for these families and women.

In reviewing the evidence about adverse mental health and psychological outcomes for women who undergo termination of pregnancy, there are contradictions and inconsistencies which primarily relate to how pre-existing illnesses and conditions have been accounted for. We contend that trying to make a causal link between women having a termination of pregnancy and mental health or substance misuse issues is difficult to achieve because it denies the range of other risk and social factors that are present. The following are some of the key findings from the Turnaway Study that can inform the policy debate here in Queensland.

Having an abortion does not lead women to increase their drug or tobacco use, however some women who carry unwanted pregnancies to term find it difficult to reduce their alcohol and tobacco use. It is of concern that the evidence shows that women in violent relationships being denied the ability of a termination of a pregnancy results in more women staying in these relationships or, at very best, they are still linked to the perpetrator of sexual, physical or emotional violence. These women are then at increased risk of continued exposure to violence.

In terms of anxiety, self-esteem, life satisfaction and emotional outcomes, women who are denied abortions have been found to have worse outcomes. Findings also show that over time there are no major differences in self-esteem, life satisfaction, stress or social support. Women experience a mix of positive and negative emotions after an abortion, however relief is the predominant emotion reported. This supports our argument that termination of pregnancy is not the cause of worsening emotional or mental health outcomes for women. Indeed, it underscores the importance of legalising abortion to ensure better psychological outcomes for women. We contend that doing so would remove some of the inherent perpetuating of disadvantage that occurs for women who are already living in poverty, disadvantage and who experience violence.

The Turnaway Study results show that even when abortion is legal many women are denied access. This denial of care has been found to have a big impact on women in terms of their future, resources and emotional state. As a result of denial or poor treatment, it has been documented that women seek illegal abortion methods outside the formal healthcare system. This is supported by information provided to us by service providers in Queensland that highlight the increased number of women who report that because of the difficulties in accessing safe and professional services they will attempt to induce a self-abortion.

In terms of psychological counselling support, the AASW with others argue that we need to provide professionally robust counselling services to women. However, this needs to be voluntary. Where a woman has made a decision to seek a termination, the decision has been made. Forcing mandatory counselling does not make sense. It denies the individual's right to self-determination and we argue undermines their human rights. Colleagues who work in the field advise us that vast proportions of women do not want to speak with a counsellor once they have made a decision. The Turnaway Study further supports this, arguing that women find counselling less helpful when it is mandated or mandatory to access abortion care. We also argue that counselling services must be transparent in their philosophy. Currently this is not the case and it denies women the right to access non-judgemental and objective counselling services, which is what counselling should be. We argue that the professional counsellor has a recognised degree in social work or psychology in particular because these are bound by rigorous codes of conduct, ethics and standards of practice that ensure quality and transparency. Both of these professions have pathways for unethical behaviour.

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The Queensland branch of the AASW commends the Queensland government for considering the decriminalisation of abortion in Queensland and continues to welcome the focus on implementing the recommendations of the *Not now, not ever* report and the necessity for a whole-of-government approach to preventing violence against women. As a profession we seek consideration for these final points: the AASW encourages policy objectives that ensure access to reproductive rights and demonstrate a commitment to human rights and social justice; the AASW supports and agrees that social workers play a key role in counselling and advocacy during the stages of policy reform and development of therapeutical services; we do not support mandatory counselling for women to access termination of pregnancy in light of the research around poor outcomes for such services; the AASW recommends that policy development in the area of access to therapeutic support services is provided by a social worker who can demonstrate the eligibility to become an accredited member with the association and who has the experience, skills and knowledge appropriate to supporting women to access services. We recommend that this approach is used as it gives a guarantee backed by the AASW trademark that the social worker not only is qualified but also has a commitment to ongoing professional development.

The AASW supports legislative reform that is inclusive of principles of social justice, human rights, collective responsibility and respect for diversity, that the legislative principles for the current reform considers the aspects of the psychosocial needs of our community and that the human need in the current reform is seen in the context of social, political and environmental factors. Finally, it is time to review the evidence in the current reform along with better delivery of women's fundamental rights to access sexual and reproductive health options and equity of access to abortion services. This legislation reform also brings Queensland in alignment with other jurisdictions and evidence from our international platform. Thank you.

CHAIR: Thank you. Ms Whybrow, does the Turnaway Study you referenced have any application to Australia or is it only a study in America?

Ms Whybrow: It is only overseas, in the US.

CHAIR: What information does the association have, if any, which is premised in this country or this state around how many women are turned away in seeking terminations?

Ms Whybrow: We do not have any current evidence around numbers. This is just information that we have sought from our colleagues who provide these services in Queensland.

CHAIR: We heard some figures earlier today from Queensland Health about patients who were admitted. I think there were public and private numbers provided, but the numbers for private terminations were in the order of 10,400 and that did not take into account the accessibility of medical terminations. A comment was also made earlier by the College of General Practitioners about the accessibility of RU486 through online means, whether illegally or legally in this country, so it would seem anecdotally that it is quite accessible. Has that not been your experience or anecdotally your feedback?

Ms Whybrow: I cannot comment on that. The information that we have from our colleagues is that women will report that they would access their own means to have a termination if it is not through an approved healthcare system.

Dr Hardy: If I might just add, in talking with our colleagues who work in this area, there are still a number of women who do not have access to safe terminations, for example women who live in regional remote areas. Some hospitals in those areas, anecdotally, are not able to provide termination services and those women are not able to travel to Brisbane to access those services. Whilst the Turnaway Study is obviously an American study, it is a very rigorous study and our view is that we can draw on the findings in terms of the impacts and the psychological implications of that. That is the reason we decided that we would refer to that particular study. The information that we have certainly been given by colleagues who work in this area is that there are still a number of women who are not able to access termination because they cannot afford it or they cannot access the actual healthcare services because they live in regional or remote places.

CHAIR: I refer to the anecdotal feedback that you are receiving about women who are, perhaps in a rural or regional location, unable to access a termination. Are they terminations that are premised on there being a medical issue for the mother and child or are they terminations that are sought because it is an unwanted pregnancy? I ask that because Queensland Health commented earlier that women who are seeking a termination through the public system because of a medical issue are able to access that in regional and rural locations. I am interested to know about that.

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Ms Whybrow: I think it is a range of unwanted pregnancies, whether it be a medical condition or an unwanted pregnancy.

Ms Gridley: I supervised a student a couple of years ago in Victoria who talked about access to pregnancy services in rural and remote areas of Victoria. One of the things that came up there—and Victoria is much smaller than Queensland, obviously—is that not every country hospital has the capacity to do this. There is not enough demand for the service for somebody to be there all the time. Some hospitals—Catholic hospitals, for instance—were averse to doing it. There were public hospitals that simply could not get the doctors to do it. I do not know if that is the case here. It certainly limited availability in Victoria. Women almost always had to come to Melbourne. There was also the privacy factor.

CHAIR: You made a comment earlier about women who may be in violent situations. Some have certainly raised in submissions that decriminalising would provide some protection or better access for women who are in those situations. Conversely, some have raised in submissions that the current sections of the Criminal Code provide a protection for women who have partners who are likely to force them into a process where they are to terminate a pregnancy if there is not the protection that the Criminal Code affords in relation to abortion. What views do you have, if any, with regard to that statement?

Ms Whybrow: I think our view is that the woman should have a choice to make that decision. It is not really about the perpetrator; it is about them accessing their reproductive right, whether it be to continue the pregnancy or not. Currently they do not have that choice.

CHAIR: The nature of the question is more that women may not be exercising their own choice around their reproductive rights; they may actually be coerced and there would be no protection against that, essentially.

Dr Hardy: That is a really complicated one. They might be coerced either way. It would be interesting to actually know how many woman are protected by the current Criminal Code versus not. We would need to see more research into that to be able to make a judgement. We cannot comment on that. It would be fair to say from the *Not now, not ever* report that the current system does not necessarily protect women who experience all forms of violence exceptionally well, otherwise we would not be going through the reforms that we are. I would make that comment as well.

Mr McARDLE: Ms Whybrow, thank you for your commentary. You have made comment on a couple of occasions that the current law in this state does not allow a woman to exercise her reproductive rights. The current law in this state differs from that of other states in Australia. Does the association have a concept or model in mind as to what the law should be in Queensland to protect the reproductive rights of women or would you simply remove the provisions, as proposed in the bill, from the code and leave it at that?

Ms Whybrow: We support the removal of the provisions in the code to decriminalise access to abortion. With regard to what the model would look like, we have not spoken to our membership about that.

Mr McARDLE: Would you agree to gestation periods being important in relation to a termination? You would not advocate no gestation period or no caveat to ensure that what is going to occur is safe?

Ms Whybrow: Yes.

Mr McARDLE: You mentioned also that you certainly support the principle of counselling.

Ms Whybrow: Yes.

Mr McARDLE: You made the comment that to mandate counselling removes the right of choice of the woman who has made up her mind.

Ms Whybrow: Yes.

Mr McARDLE: Is it not also the case, though, that providing that counselling to a woman, who can reject or accept it, is equally important?

Ms Whybrow: I believe that there are two sides to that. The mandate to actually access the service we do not support, but with regard to the offering of counselling—

Mr McARDLE: That should be mandated?

Ms Whybrow: Do we have a stance on that, Fotina?

Dr Hardy: I do not think we have actually come up with a definitive stance on that, but we would be guided by best practice. As you were saying earlier, best practice would be that all women should have access to counselling—robust professional counselling. As a membership organisation

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we also take on the views of our members, which is why we have gone and spoken to them. The feedback that we have been provided with is that to actually force somebody to go and see a counsellor is not helpful or productive, but it is helpful to have counselling available and each service being obliged to provide counselling—and then the woman can exercise her choice to access that counselling.

Mr McARDLE: Your comment about how you came to the conclusion about it not being mandated I think relies upon you being advised by colleagues about what they believe should happen?

Dr Hardy: We are a membership based organisation. As a professional body we are guided by our members and by the evidence. We have looked at the evidence and we have talked to colleagues who work in this area.

Mr McARDLE: Does that imply that you have done a study of your colleagues on this question? I am not being disrespectful; I am trying to nut out how you have come to the conclusion. Is it a study that has been done by a survey or is it what colleagues have made comments to you about?

Dr Hardy: It is through the consultations that we have had with our colleagues. It has been through the discussions that we have had with our colleagues and through reading the information and research that our colleagues rely on. We have gone to the source of some of that information that our colleagues have looked at, such as the Turnaway Study and some of the other studies.

Mr McARDLE: Have you done a survey of the ladies who come in? Have you asked them?

Dr Hardy: No.

Mr McARDLE: Would they like to have the option or would they see it as beneficial to be mandatory?

Dr Hardy: I guess what we are saying is that we believe that all women should have access to those services. What we are saying is that we would not force a woman to access counselling if she did not choose to.

Mr McARDLE: I accept that, but you have not canvassed the women themselves?

Ms Whybrow: No.

Mr McARDLE: The study you referred to is an American study; is that correct?

Ms Whybrow: Correct.

Mr McARDLE: It looks at the question of women who have an abortion and those who are denied the right to have an abortion, as you see it. There is no correlation to Australia or a study that we can look at here?

Ms Whybrow: No, there is no similar study here.

Mr McARDLE: Would you agree that there are a plethora of studies across many decades in America, Australia, Europe, the UK and the like that come up with different answers not to that question but to the issue of mental health and social work issues and it is very difficult to nut out what I would call the gem or the germ, and we are still looking at this. As psychiatry, social work and psychology continue to develop we will get a better idea, but we are a long way from making a finite determination, so studies need to be looked at fairly closely in relation to other studies that are of the same age and, of course, more recent studies that garner better methods of survey et cetera?

Ms Whybrow: Correct.

Mr McARDLE: Does the association have an idea in its mind as to how the counselling would work? Say a lady comes in and she says, 'Yes, I want the counselling.' How would that progress from pretermination to post-termination? How long would it be? More importantly, who would it involve? It might not just be a social worker; it might be a priest or an ethicist as well. How would that work on the ground?

Ms Whybrow: When we are working from our psychosocial assessments with our women we incorporate all needs—spiritual care requests and what that might mean for working within the system to achieve the best outcome for them. We are always guided by the individuals and families that we work with. Based on trying to reach the best outcomes for them, sessions would be based around that need. I do not think there is ever a set amount of sessions that you would need with a woman to work through these questions or her thought process around accessing a termination. You would always be guided by the presentation at that time.

Mr McARDLE: Can you give the committee some idea of the issues you see as social workers that we would not see as parliamentarians because of our different roles? What are the things that come to your attention that we should be aware of that a social worker sees and needs to deal with on a regular basis?

Ms Whybrow: I think it is really important, as we mentioned in our opening statement, to understand the disadvantage that is already out there—women who are experiencing violence or have been raped through a sexual assault or women who are living in poverty. They are the people who are further disadvantaged or unable to access services under the current legislation. In the future I think we really need to be very aware of diversity and equity of access to services for all Queensland women and not just those who live in metropolitan Brisbane. We also need to be very aware of social justice issues and come back to concepts around human rights.

Mr McARDLE: Which is where you raise the domestic violence issue and the social justice issues?

Ms Whybrow: Yes.

Dr Hardy: Can I just add to that. From a social worker's point of view, what we see when a woman comes in to us to seek support around an unwanted pregnancy, for example, is the context in which that woman is living. It may not be the consequence of a rape or an unwanted assault on her. What we see is that this is a woman who has made a very difficult decision in her life and she is making that decision because she may not be emotionally ready for it or she may have four kids already that she is struggling with. I am thinking about some of the more complex factors here.

Woman make decisions for all sorts of reasons. It may be because they cannot afford to have another child. It may be because they were parented themselves in a way that they have developed lots of trauma because of their own history of child abuse and negligent and they are not ready to be a parent because they do not know how to be a parent and are absolutely scared. We see all of those other things that come with that woman who has come in and said, 'I am pregnant. I do not want to have this child.' We look at all of those things and help that woman unpack all of the different issues and look at the complexity that comes with that decision.

That is what we bring with us as social workers. That is what we look at. When we talk about social justice and human rights we are actually talking about it in very concrete ways—that is, how that disadvantages those women in their day-to-day lives.

Mr KELLY: Thank you for your submissions. With regard to the members of your association, how would you commonly characterise the situations they are working in when they are supporting women who are considering a termination? Are they in the public hospital system? Are they in organisations that support women who are vulnerable—homeless or victims of domestic violence—or are they attached to GP clinics or is it the full range?

Ms Whybrow: It is a full range, and I think that we rely on our relationships with our NGOs and the public health partners to be able to access the services that we need. It is definitely a full range.

Mr KELLY: Your submission, like many submissions, touched on the fact that there are currently access restrictions particularly for vulnerable women and women who are in regional, rural and remote areas. How will the removal of these three pieces from the Criminal Code improve access?

Ms Whybrow: I think it is our hope that it will trigger a policy reform around access and equity of access for women. I think that knowing it is criminalised in Queensland does impact on people even trying to access services. Just having a debate and putting it more in the public health arena allows us to try to promote access for women.

Mr KELLY: If we look at something like conscientious objection, which is dealt with in some other jurisdictions that I am aware of, I think in your opening statement you talked about people having access to a non-biased counsellor, and I think that is important. Do you think it is important that legislation specifies that if someone has a conscientious objection they promote that or advertise that fact and refer people on to another practitioner?

Ms Whybrow: Yes.

Mr KELLY: This current legislation does not achieve that; is that your reading of it?

Ms Whybrow: I think it is not currently out there. People do not have that conscientious objection and put it out there and move people on as they need to, or people just do not seek the services. From our colleagues, pregnancy assisting services, women go thinking that they are going to be non-biased but that is not their experience when they get there.

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Mr KELLY: Thank you very much.

Mrs SMITH: In your submission you refer to the wideranging values based views including within your own membership. How did you canvass your members to come to the view that you supported these reforms, if you have a large number of members? Did you do a survey?

Ms Whybrow: We directly approached a lot of our colleagues that we knew who had expertise in this area but who had also worked in the field for quite some years. We looked at colleagues not just in health but also in non-government agencies that worked for pregnancy support services who advocated for women to access termination. We canvassed a whole range. We did not just target one specific area for our membership base.

Mrs SMITH: What were the varying views? Have you got a sample that could be provided to the committee?

Ms Whybrow: No, we do not have data. The consultation meant that Tina and I literally met with members face to face and talked to them about their views and their experiences. We also had teleconferences and submitted together. There is definitely a gap in research around this in capturing the data and the stats around women's experience and documenting their experiences in Queensland. There is definitely a gap in research.

Dr Hardy: We also looked back at our code of ethics and consulted with our national president, which is the reason Jacklyn in her opening statement talked about the fact that our submission is based on our inherent value which is self-determination. That is the value that underpins our submission, as opposed to social workers who are pro and social workers who are anti. It is about our ethical stance which is around self-determination.

Mrs SMITH: We were referring to the report before because you talked about professional knowledge and evidence based research. Then you referred to a report in America. What was that report called?

Ms Whybrow: Turnaway.

Mrs SMITH: Would you agree that the American health system is vastly different from the Australian health system?

Ms Whybrow: Definitely. We do not have 30 abortion centres. There is definitely a difference, but that is the only longitudinal study available in regard to capturing women's experiences.

Mrs SMITH: But they also have charges. They do not offer a free health system over there. It is a vastly different health system that we operate in—

Ms Whybrow: Correct.

Mrs SMITH:—so it is very difficult to compare apples to apples with that particular report. I turn to where the branches have supported the reforms. They recommend that the three sections be removed from the Criminal Code. We have already said to you that already each year there are approximately 12,000 to 15,000 abortions and there has not been any woman pursued under these current acts. I am not too sure why removing these sections is going to change anything, because people are, as you can see by the figures, already accessing termination of pregnancy. I would like you to expand on why this reform will make such a big impact.

Ms Whybrow: It is more that we need to be moving forward with this legislation for what our community and our women are expressing in terms of their support for their human right to make a choice. Even though they are already accessing services, it does not protect any of our social workers or colleagues who work in this area to support a woman. The opportunity to be prosecuted is still there.

Dr Hardy: The other thing is that we do not know how many women are not accessing terminations. There are obviously that many women who are accessing terminations for whatever reason, but we do not know how many are not. They are the voiceless ones because, as you said, we do not have a turnaway study here in Australia. Again, anecdotally the social workers who work with women who are seeking information about termination report that there is still a number of women who are seeking termination and who are not able to access it. Some really important research needs to be undertaken because it is still unknown, and the anecdotal information that we have from those services is that there is still a number of women who are not able to access termination, and to know that currently accessing termination can be a criminal offence.

Mrs SMITH: Would we be better off getting that information before we go out? If we need that evidence base, would it not be more prudent to get the evidence and the research before we look at changing the laws? I would be interested in your opinion on that.

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Dr Hardy: Whilst we do not have that information here in Queensland, I know that in other states and territories the legislation has been implemented. I think the two could be done together; I really do. On the basis of the information that has been provided to us, we would be arguing for the removal of the illegality of termination and then being able to do some research here in Australia similar to what has happened in the United States.

Mr HARPER: Thank you very much for your submissions. Firstly, with regard to the crossover with the *Not now, not ever* domestic violence report, you highlight some important points. It is really interesting that this goes towards that space. In your submission you talk about robust termination laws to protect the vulnerable. We would like to reduce the threats of people conducting self-terminations. I point to item 4 of the terms of reference in regard to the legislative and regulatory arrangements including regulating terminations based on gestational periods. I want to find out your opinions or viewpoints around that gestational period in regard to the bill before us.

Ms Whybrow: We do not have an opinion on that in regard to the gestational period.

Dr Hardy: I think we would be guided by the best practice and evidence from our medical colleagues around that. We would not be advocating to change that.

Mr HARPER: In regard to conscientious objections, which have been raised by previous members, you have 10,000 members. In terms of those social workers doing their job, if some are deeply opposed to it—and I know you have a code of ethical conduct—what processes would you put in place in terms of respecting everybody's viewpoints? Will there be referrals to another social worker?

Dr Hardy: Our expectation would be that if a social worker in any area has significant value conflicts in the work they are doing they would need to remove themselves. They would need to be very transparent about that. They would need to remove themselves and be very transparent about what their values are that conflict with the person they are working with.

Mr CRAMP: In regard to your commentary on mandatory mental health care and counselling both pre and post termination, I understand that you support mental health counselling but what would take its place? If a woman makes a decision to have a termination regardless of the stage of pregnancy—because currently this legislation does not dictate that—what safeguards would you put in place in your organisation to ensure that their mental health care has been taken into account and that they have made an adequate decision? Perhaps they are prediagnosed with an illness or perhaps it is undiagnosed at this stage and a lack of mental health care would not identify that. Can you see any issues there? What would you put in place to ensure that that person has made an adequate and sound decision based on their current situation, because it has to be a replacement?

Ms Whybrow: We do not have any power in regard to how organisations develop their policies in responding to women, but for our membership we would always make sure that someone has the capacity to make these decisions that is not impaired by pervasive mood disturbance or a significant mental illness. That is a key part of our assessments in working with women to explore history of mental health in medical history and how that might be precipitating on the current presentation that we are seeing. Mental health issues, past trauma and the full psychosocial spectrum of presenting issues we do explore. If we had concerns around a woman's ability to make a decision about accessing termination, we would always refer to our mental health clinicians and tertiary services to be able to support the woman through that process.

Mr CRAMP: With all due respect to your members, wouldn't a psychiatrist or a psychologist be more well placed to decide whether that person required mental health counselling rather than a social worker?

Ms Whybrow: Social workers work within all public and private systems within Queensland. We are employed alongside our colleagues. Yes, a psychiatrist is always the treating first point of accountability but they do draw on their full multidisciplinary team to support them in making capacity assessments and making decisions around a client's mental health and wellbeing. Social workers are very prominent in mental health in Queensland. We are the second largest discipline that is represented through mental health services in Queensland—second to psychiatry nursing. I think we are very well placed within mental health and have a strong evidence base in responding to that.

Mr CRAMP: You were talking about a mental and social capacity to make that decision. From the point of view of an age limit, does your association have any position—you said you spoke to some of your members who are specialised in this area. Is there an age that you look at and it is where you believe they would at least be deemed to have a minimum capacity to make that decision, or are they too young?

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Ms Whybrow: No matter what circumstance it is around capacity to make a decision around health care in general, we always refer to our Gillick competency testing around that. Generally, 14 is where we apply that principle. If we are concerned about someone's ability to make a decision if they are, say, below 14, we would always refer to our child safety or alternative decision-making around that process to make sure that medico-legally we have explored and we support the young person and we have involved their guardian and whoever needs to be involved in that process.

Mr CRAMP: I have a last point of clarification, more so for myself. You were speaking earlier about progressing a woman's right to make that decision. You did make mention that a woman will sometimes make the decision that she may have too many children or it may be a financial decision. I respectfully want to clarify: are you saying that should be a determinant for a termination—finances or number of children?

Dr Hardy: No. That was just an example—no. I would not make that determination on behalf of any woman. What I am saying is that there is a whole range of factors why women would make the decision to terminate. You need to consider all of those social factors. No, we are not espousing that they should be reasons people should have a termination.

Mr CRAMP: You made mention of it. Where do those factors lie within a decision-making process? Do they have some consequence to the overall decision? I am trying to understand that. I come from a single mum with six kids. I am just trying to follow that through and work out where that lies.

Dr Hardy: I guess what I was trying to describe is the kind of complexity in the decision-making that an individual woman would make. Sometimes she is making it on her own; sometimes she is making it with a partner or other people in her life. There is a range of reasons a woman would seek to have a termination of a pregnancy. I do not think that coming up with a list of reasons that are valid or not valid is helpful at all. I was just trying to paint a picture. I guess that is what I was trying to do. There are many women who have many, many children and there are many women who do not. That was not about that.

Mr CRAMP: It is not really going to be a factor that comes into it is what you are saying—a decision based on financial reasons or a number of children?

Dr Hardy: I guess what I was trying to say is that for each individual woman there will be a whole range of factors that impact on their lives and they might be some of the factors that impact on someone's life. It is not for me to judge and it is not for me to make a determination that that woman deserves to have access to a termination or does not deserve to have access to a termination. I think we need to be very respectful. When a woman goes to the point of making such a decision, there are usually a whole bunch of really good reasons they would do that. The good reason for one woman may not be a good reason for you, but it is actually not about you; it is about that woman.

Mr CRAMP: Certainly. I know. I am looking at this from a legislative point of view. Currently, the factors we are looking at are psychological and mental health issues, physical deformities in the child and a physical danger to the mother. When you made those comments it struck me that they were very far afield from what we were looking at, which is my area of inquiry around that. For me, that massively broadens the scope where my preference would be to stay where we are. Are you saying we should broaden that scope right out there because of factors such as that?

Dr Hardy: I think considering psychosocial factors of why a woman may seek a termination—

Mr CRAMP: Your answer is valid. I am certainly not questioning you. I would like to hear from you.

Dr Hardy: I think the consideration of psychosocial factors is important.

CHAIR: I have one final question before we move to Ms Gridley. In your decision and certainly in your opening remarks you spoke quite strongly about these concepts of fundamental human rights and social justice. Of course, these are highly contested concepts in the debate that we are having now. We all appreciate that in this room. You have spoken about, if I am correct, self-determination being one of the key principles underpinning your position. Is there a point in a pregnancy at which the association considers that self-determination is no longer the presiding principle that should be adhered to? This comes back to gestational periods.

Dr Hardy: One of the things that I would say is that we are not debating the current requirements around the gestation periods around termination. We are not debating that. We are not questioning. I think there is best practice around termination and the 20 weeks, later stage and whatever. We are not recommending that termination is available throughout the whole pregnancy. We are not coming into that debate.

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CHAIR: The reason I am asking is that I think I am correct in saying that the current therapeutic guidelines in Queensland are premised on the current law in Queensland, which is obviously the codified law in the Criminal Code, whereas if you look at other Australian jurisdictions they do have very different clinical guidelines such as 14 weeks up to 24 weeks. That is why I am asking you as to what your position is in regard to whether self-determination at some point needs to have additional regulation around it for the broader concepts potentially of what a society considers is social justice and human rights in action.

Ms Whybrow: I can see where you are coming from in asking us that, but we do not have a position.

Dr Hardy: We would need to really think about that. I guess we would again be guided by the best practice that has been developed from our medical professionals as well. We would be guided by that. Does that answer the question?

CHAIR: Not having a position is an answer, which is fine, too. Thank you.

Mr McARDLE: It is sometimes the best position. The Criminal Code and the criminal guidelines are quite distinct in this state. There are no gestational periods contained in the confines of the Criminal Code. Therefore, the code on its own would allow a termination at any period of time. The clinical guidelines dictate the clinical approach that needs to be taken. The chair's point I think is that if we removed the Criminal Code elements and placed them into health legislation, where I think they should exist—not in the code—do you then foresee that there should be gestational periods contained within that new legislation that flows through to most other states with the exception of New South Wales?

Ms Whybrow: From our statements and submissions we do believe that it needs to be in a public health debate rather than in the Criminal Code. I have no opinion around that.

Mrs SMITH: When we talk about the human rights and the ethics part, when is it classed as the child having rights? By 24 weeks children now are surviving, albeit in a neonatal environment but they have gone on then. That is the one thing that I do not know has been covered in there. It has been opened up now to say you support human rights and social justice. When does that kick in for the child?

Ms Whybrow: Correct. Like we said, there are wideranging views and moral debates around that. Especially across our membership there would be many. However, that is not something that we have discussed with them about our position.

Mrs SMITH: I understand you are saying that you do not want to mandate the counselling; you believe that it should be offered but not mandated. What about in the circumstances of 12-, 13- and 14-year-olds—having an age limit? They may not realise that they need the counselling then, but it could have a huge impact. Again, there may be the religious beliefs of a younger girl who is terrified of her parents, for example. I know I could give you a thousand examples. There surely have to be some circumstances where it would need to be mandated, especially if the family of the young girl does not have knowledge that she is pregnant and she is coming in on the sly or whatever.

Ms Whybrow: There are definitely situations that we look at in mental health where young people are accessing services that parents are not aware of and ask us not to disclose to their parents. We always refer to the Gillick competency test around that and we are required by a duty of care and our code of ethics around when we do breach confidentiality or seek assistance from our department of communities and child safety around that. Generally, in terms of making a decision around someone's capacity to make a decision around their health care, we do have means to be able to access psychiatry and a full multidisciplinary team approach about making that assessment for the young person. I think it is a case-by-case situation.

CHAIR: Thank you very much. I invite Ms Gridley now to open with some opening remarks and then we will open for questions.

Ms Gridley: Thank you for rearranging that. I used to be the third speaker in school debates, so I am comfortable going last. I am speaking for the Australian Psychological Society. My role there is as manager of public interest, which means that whatever the APS has to say on everything from refugee policy to climate change to marriage equality to these sorts of issues, the buck sits on my desk. It actually also is a professional practice issue, so I have consulted with our professional practice manager as well. She was not able to be here.

The Australian Psychological Society has 22,000 members. It has nine colleges. Not everyone is in a college, but those who are are spread across counselling, clinical psychology, health psychology. I am a community and counselling psychologist. We also have educational and

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developmental and some others. They would probably be the main ones who would, in different ways, come across women facing these kinds of decision or, in the case of education, younger women, teenagers and such as well. The health psychologists tend to deal with the psychological aspects of physical health and medical procedures, so it is quite relevant to them, too. We have about 40 interest groups of which women and psychology is one and a number of others as well.

About 15,000 of our members are now practising in private practice, which has been a shift since the Better Access Program for mental health services came in. We probably differ a little bit from social work. There is a stereotype and a truth that you find more social workers in the public sector and I think sadly, fewer of them these days and more in private practice. Our members are probably in some ways less likely to come directly into contact with women seeking terminations in the public sector than perhaps the social workers or the nurses are. I am also a member of the APS's ethical guidelines committee, which has been operating since the mid-nineties on developing not the code of ethics itself but the guidelines that elaborate on that. We do have some guidelines which I think we forwarded to you on psychological practice in working with women.

While the APS does not have a formal position on termination, on abortion itself, it is kind of implied in those guidelines by respecting a woman's right to choose and to manage her own body and to respect her capacity for decision-making. Our code of ethics more generally, of course, refers to non-discrimination and human rights. We acknowledge that there are probably two issues where the code of ethics could be read both ways. If you are thinking also of issues around end-of-life choices, you can see do no harm being around right to life at all costs or it can be around not subjecting people to misery and pain and such. These are complex ethical considerations that we have given thought to.

We did not make a submission to this inquiry and I am sorry about that, but we mostly do national inquiries unless state ones are brought to our attention where we think we could usefully say something. If you wanted us to follow up with anything, I am happy to see to that after this. We did make not so much a submission but some representations to the Victorian government when abortion was decriminalised in 2008, and the main focus of that was around mandatory counselling. For similar reasons to the ASW we did not feel that mandatory counselling was appropriate for two reasons. One was that, again, most of the evidence around counselling in general is that it works better when people see it as a need that they have themselves. It is problematic in prisons, for instance, where someone is instructed to see the psychologist but there is not a huge amount of trust involved there. Obviously it does not mean that counselling is ineffective, but it is more difficult. In this area in particular where we are trying to talk about maximising autonomy we would not be in favour of mandatory counselling, but we certainly support the availability of counselling.

I should say, though, and I think this is probably true for psychiatry and social work perhaps, and psychology a little bit more, that because we tend to deal with the clinical end of mental health issues it is easy to assume that that is true for all women. Probably the majority of women who seek a termination do not have a mental disorder and do not necessarily need counselling. We also need to be aware that it can be a delaying tactic. There are certainly some providers who use counselling—particularly some of the volunteer services—to try and stall. Obviously time is of the essence when you are talking about seeking the termination of a pregnancy and that is problematic in some way. That needs to be balanced up—the question of timeliness with the question of how much this person really needs counselling when they may have come to a decision themselves.

The APS was also involved in developing the training around the Medicare item that was brought in I think around 10 years ago. On any pregnancy related concerns someone can receive counselling. My understanding about that as a Medicare item is that it has not been massively taken up by psychologists. A large number of our members need to do I think online training in non-directive counselling in pregnancy related concerns before they can take up that Medicare item, and there is not a huge number who have taken that up. My understanding is that it is mostly used by GPs who are counselling women who come to see them prior to a referral for a service of some kind. While it is available, it is not necessarily used as much as it could be. Maybe people are not aware that it is.

One of the concerns I have about it is that, while people have to do the training, there is no follow-up as to whether they are actually following non-directive counselling. I did a check, because we have a Christianity and psychology interest group as well. Certainly some people who are members of that group have also done that training, and there is nothing wrong with that. In fact, there is a lot of value in a Christian psychologist counselling a Christian person because they will have shared values, but I do not know if we know if those people are doing what they are supposed to do in terms of non-directive counselling, which is to offer all of the options. That is an interesting question

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that, as far as I know, nobody has followed up, but that is available. That is probably as much as I need to say about the APS's position. We have not done as much as you have in terms of surveying our members, but we more have gone by the principles in the code generally.

I also wanted to ask a rhetorical question. When we think about the mental health impacts of something like termination, I was trying to think of a single case, any soap opera. I do not watch *Home and Away* too often, but can anybody think of an example where a woman has become pregnant, has a problem with it, has a termination and lives happily ever after? I cannot think of any example where having a termination is treated as an okay thing to do in the public media. I think it is often a case of, 'No, I'll keep my baby,' or, 'I'll have the termination and I'll feel dreadful afterwards,' but I cannot think of too many where we said, 'No, that was the better thing to do for this person at this time.' I think when we think about mental health impacts we have to take into account the social context in which we present the whole issue. It is still in this day and age pretty loaded. The APS, again, does not have a formal position on decriminalisation, but we are probably uncomfortable with the idea of something being criminalised as a medical procedure when there are lots of other procedures that have emotional consequences—not just for the person but also for family members—that are not part of the Criminal Code. I am sure we would prefer to see it treated as a health issue rather than a criminal issue.

I would like to tell another story out of my own practice which may be illustrative. About 30 years ago I was seeing a family where there were three daughters and a son and the mother was deaf. The father had sexually abused the three daughters over a period of about 10 years, and I did not know this. I was not seeing them for that reason. When the middle girl went to the police and became a whistleblower I became involved in supporting her and her sisters. I could write a book about that case. It was one of the very formative ones in my own career. The family was a very Catholic family. One of the Catholic priests was the one who triggered her going to the police by almost giving her permission in the way he spoke to her class about not needing to accept sexual abuse. Another priest went for the father in the court case. In the middle of the court case the girl, who was 14, became pregnant to her boyfriend. It was a huge issue, as you can imagine. I talked to her, and I was very aware that in her situation it was unlikely that termination was going to be the right solution for her. Already she was carrying a huge amount and she would be even more scapegoated. It is interesting she was being scapegoated and not her father for blowing the whistle on him. I told her about all the options because she still needed to know what they were. I also worked with her and she did chose to have the baby adopted, as it happened. Shortly after that her mother came in to see me and a friend from the church, who rounded on me for daring to mention abortion to this girl. I was a bit shocked because nobody had come in expressing the same outrage about what the father had done for 10 years to those girls, and it really struck me that somehow all the wires got crossed around this issue. I kept in contact with that girl for a few years afterwards, and there are many stories to tell. I eventually lost contact with her. I thought that it is really important to be aware that for somebody one decision like termination is not going to be the right one, but she still needs to know about it and make her own decision. I think that from a counselling point of view it was very important for me to feel like I could say that is what I had done. I was still distressed to be rounded on for even mentioning it.

I suppose in terms of the evidence I know a little bit about the Turnaway Study. I only found out about it in preparing for this so I am not that familiar with it, but a couple of things are worth mentioning about that study in the US. For one thing, they have much more funding to do this sort of research so we never get to do anything as rigorous as they do. It was across 30 states, but the interesting comparisons were around gestational periods because the turnaway was because they passed the gestational period. These might have been women who were 21 weeks when they came rather than 19 weeks, so that is why they did not get the abortion they came for. I think that is correct. They compared women who had had the termination at less than 14 weeks, women who were around the 18 or 19 week mark or whatever the limit was in that particular state, and women who had proceeded with the pregnancy because they could not get access. They found no mental health outcomes that were any different for those groups of women. They found a variation in the emotional responses.

I think just to perhaps pick up your question, you are right that the research is quite confusing. You will have some coming out and saying, 'Yes, there is a lot of loss and grief associated.' You will have some coming out and saying that there is no difference. The American Psychological Association did do a kind of meta review about eight years ago, and they concluded that were there some consistencies. They were around issues like a pre-existing mental health condition and the nature of the choice. Was the person coerced into having the termination or not or were they wanting

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to have one and they were not able to have one? There are all of those kinds of things around coercion. There are things to do with their economic circumstances, their age. There is no one thing you can say about younger is better or worse, but just that is a factor for those women. Certainly socio-economic circumstances—again, with young people you could argue they are more vulnerable but also the outcomes of teenage pregnancy are probably, on the whole, worse than for somebody who gives birth later on. There is not an absolute picture emerging, but there are some trends that I think we can talk about. The other thing that came out of the Turnaway Study—

CHAIR: Ms Gridley, I am sorry to interrupt you, but the committee is limited to the reference before it and that reference does relate to the Australian jurisdiction and the Queensland jurisdiction. I know my colleagues would be appreciative if we opened it up to questions for you. You mentioned evidence from the society that you wanted to present particularly with regard to the domestic jurisdiction.

Ms Gridley: Not particularly, no. I think I was just talking to the only available evidence that we mostly have.

CHAIR: I do appreciate that we do not have a like study here. With regard to accessing psychological services, is it correct to say that women can access a psychologist directly—should they wish to be under a mental health plan and therefore access subsidised services through Medicare—or via a referral from a GP?

Ms Gridley: Aside from the termination issue, yes. To get access via Medicare rebates they need to get a referral by a GP; that is right. You get a mental health plan from the GP.

CHAIR: Purely from an access point of view, is it correct to say that to see a psychiatrist you require a GP referral?

Dr White: Yes. A psychiatrist can also do mental health care plans back to psychologists, and we include that very often as well. We work together in a lot of contexts.

Ms Gridley: Of course a person can see somebody privately without a referral but they have to pay more. There is also access sometimes through drug and alcohol services, community health services, which do not have those requirements. It is only if you want to have it done through Medicare that you need the referral. There is a separate Medicare item specifically around pregnancy related issues which does not require a mental health plan. It is counselling specifically in the context of a pregnancy, and it can be anything to do with termination through to postnatal depression.

CHAIR: Does that item allow services to be subsidised perhaps at the same level that another need under a mental health plan would be and therefore a woman may be left about $25 out of pocket? I am trying to understand access.

Ms Gridley: I think the amount is similar but the session limit may be shorter, but you may know better than I do.

Ms Whybrow: With the Medicare billing you have to meet the criteria of a mental health care plan, so a diagnosed mental health condition or concern could need to be documented for a woman. I am not sure that accessing some psychosocial support or some therapy with regard to the family and their needs is appropriate under a mental health care plan.

CHAIR: Hence the other item that Ms Gridley referred to earlier. If a woman came in to a GP and needed to access counselling services, I am clear on psychiatry and psychology. If you tried to access the services of a social worker privately, where would you sit?

Ms Whybrow: You can access an accredited mental health social worker under the mental health care plan as a bulk-billing or a small fee service, but we also predominantly sit in the hospitals. All maternity wards and all antenatal clinics that are in the public system do have social workers that are there full time.

CHAIR: Would a woman accessing private services be less likely to be referred to a social worker than she would be to a psychologist for matter-of-course counselling?

Ms Whybrow: Most private hospitals do not have a full multidisciplinary team employed on each ward, so on a maternity ward you would not have a social worker available just because they do not fund one.

CHAIR: The reason I ask is that when the member, Rob Pyne, was talking to the bill that he has introduced there was an expectation or a belief that the decision about a termination of pregnancy—putting aside therapeutic terminations and moving to the other category—should be a

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decision between a doctor and a woman and I am just trying to unpick it. I am not really talking about a hospital setting but going to see her GP and they have a discussion such as, 'I'd like to talk to somebody about the implications of this for me.' Where are they referred to? I assumed it would be a psychologist, but then cost could be a factor. Would they refer to a social worker?

Ms Whybrow: Occupational therapists also provide services under a mental health care plan, but it comes down to the GP having knowledge within their own resources and managing the primary health platform. It is a very complicated system. There is no stand-alone service that is identified as a non-judgemental pregnancy support service. Obviously there is Children by Choice in Queensland that I know a majority of our colleagues would use to be able to help a woman navigate the system currently.

Ms Gridley: In Victoria it is probably the Family Planning association as the main one or the Women's Hospital. I would need to check this out, but that separate Medicare item for pregnancy related issues means that you can go to an OT, social worker or psychologist but they have to have done that online training. That is the thing there but, as I say, there is no guarantee that they actually carry it out except that the professions are all regulated and therefore somebody could make a complaint if they were not happy with the service that they got. I am not aware if those complaints have been made and if any that have come in about psychologists but—

CHAIR: It comes down to how well resourced and informed the GP is, and consistency is not present potentially?

Ms Gridley: That is right and no.

CHAIR: Thank you. I have one final question for the panel. A medical procedure requires informed consent. Given the argument that terminations are a health or medical issue rather than a criminal or any other type of issue and can have serious side effects, although rare as I understand, why, then, should counselling not form a part of the mandatory consideration and support provided to a woman when making the medical health decision around termination?

Ms Gridley: I think it probably is for any procedure. Heart surgery carries a lot of psychological consequences too and we do not mandate counselling for it, but my health psychology colleagues would say that everybody should have some health psychology input into preparing for surgery like that—life-changing surgery and such. I think we would all, in an ideal situation, like to see it available. Forcing somebody to get it, though, I think is a different matter. As I say, as far as I understand, that Medicare item is mostly taken up by GPs who would see themselves as doing some of that counselling themselves. Some will do it better than others, but certainly some GPs are very experienced at knowing what the consequences are and talking to somebody about what their choices are and what is available.

Dr White: If I can just add to that, with the perinatal and neonatal council recommendations, to use the Edinburgh Postnatal Depression Scale as the tool, it is very interesting because that particular tool just measures a woman's distress at the time. It is not diagnostic and it is actually not predictive. It measures that girl's distress at that time, and there may be a way therefore, from use of that tool measuring that girl's level of distress, to make significant recommendations that she be followed up and offered ongoing support and care and counselling. This is aside from any notion to do with any pre-existing mental illness. Something like that is a very simple tool to use. There are lots and lots of tools, but it is a universally accepted tool and that may be something that would be more useful in terms of measuring that girl's distress then and there, and the distress may mitigate and settle after the termination in the first 12 months, and there are studies that clearly show that is an option. I do believe that the girls that are excessively distressed at the time certainly are deserving of some opportunity for further assessment and counselling.

Ms Gridley: I guess one of the reasons they do not get follow-up is that termination is a termination and therefore they are not being cared for anymore, whereas somebody who is pregnant continues to be cared for because they are pregnant and so they have more ability to access something. I think you are right that once a person has had the termination we forget about them, but that is probably true of a lot of other procedures as well where they are considered to be finished and they are not necessarily in terms of the psychological effects of them. It would be good in a holistic healthcare system if people understood that there can be consequences for a lot of things and it would be good if they felt able to follow up with them.

Mr McARDLE: Thank you very much for your contributions. The Victorian legislation until 2008 was very similar to the current law here in Queensland. We then had the change in Victoria to remove it as a criminal offence. Has there been an increase in abortion numbers pre and post 2008 commensurate with population growth?

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Ms Gridley: I cannot tell you that. My hunch is not really. My sense is that it is more around the sense of relief amongst both the women and the providers of not having that hanging over their heads. It is possible that it is more available for those reasons that I mentioned, particularly in rural areas. If you think of obstetricians, for instance, or gynaecologists or any medical practitioner who might undertake the procedure, there is an extra insurance factor to be doing something that has criminal overtones, and that was something that did come up in the research that my student did—that is, that people were nervous about this area—but of course when she did it it was in the middle of that reform so it was impossible to make any judgement at that time and I do not know what the circumstances are now.

Mr McARDLE: Is it the case also that taking the step in 2008 alleviated concerns of psychologists, social workers, psychiatrists and doctors as well as we face here in Queensland at this point in time?

Ms Gridley: Correct, yes. I think that is fair enough, yes, and obviously for the women themselves that they were not doing something criminal. In terms of the fear—and I do not know if that is the case here—it probably impacts the sector more at the professional level in terms of hesitancy around it whereas for women they will find some way if they are desperate and they are not thinking so much about whether it is criminal or not as to where and how.

Mr McARDLE: In Victoria you can have a termination post 24 weeks but you need two medical practitioners to certify that that is reasonable in all the circumstances. We have been told here today that one practitioner is enough. Are there reasons around Victoria adopting a two-practitioner model as opposed to just the one practitioner?

Ms Gridley: I am not sure what the reasons were except of course I think people were trying to make sure they dotted their i's and crossed their t's if they felt that the safeguards were there, but I know there are some people who work more closely in the field than I do who do not think it is necessary and I cannot really comment on that. It is not my area. My understanding is that there is a lot of focus on the late period, but actually it is a very small percentage of abortions of course.

Mr McARDLE: You also have non-access zones around the clinics; is that right?

Ms Gridley: Yes. It is a bit of an issue.

Mr McARDLE: Did that come from a particular series of events, because I know the American scenario is much different to Australia in relation to how the public view termination? Did events occur in Victoria to warrant that taking place?

Ms Gridley: There was a guard who was murdered in about 2001, I think it was, outside a fertility control centre. Actually, clinical psychologist Susie Allanson has written a book about that called *Murder on his Mind*. She has been working there in the field, and is much more an expert than I am, for a very long time and she can talk about the distress that happens when people stand outside the clinic and harass people as they go in. I probably have a cousin who does it actually and they are well intentioned, but it is incredibly distressing for people who are already coming in, whether they are ambivalent or with heightened emotion and such, to have people holding up pictures and telling them that they are doomed and things like that or trying to talk them out of it. They have just recently passed a law having exclusion zones and that has been a long fought battle. That murder going back to 2001 was obviously atypical but it is the extreme end of something pretty horrible.

Mr McARDLE: I think you mentioned earlier that you have been in practice for 30-odd years. I am not certain whether you have been involved with termination issues for 30-odd years or not, but would you say that we looking at the issue here in Queensland should look closely at the access zone as well because of the emotional trauma I suppose, if I can use that word, that mums go through when they go through the door? The last thing they want is somebody outside with a placard waving and chanting at them.

Ms Gridley: Sure. You have to balance up the right to protest and free speech with the right to privacy and safety and such. This is not my specialist area, I should say. I was working in community health, so it was a little bit of what you saw in terms of what came in the door at that point. I know some of the people who have worked in this field and I know that it is very distressing and off-putting for them and it has been an ongoing battle. I would certainly hope that you would do the same here and recommend some sort of exclusion zone. I do not know if it is already an issue here around clinics or it may be just a Victorian thing, but it is better to prevent it than wait until it happens.

Mr McARDLE: There is a bill before the parliament now in Victoria, isn't there, the Infant Viability Bill?

Ms Gridley: Yes.

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Mr McARDLE: I only have a synopsis of it here in front of me. Is that reducing the 24-week period in some manner and, if so, how is it doing it?

Ms Gridley: Again, it actually came up just before I went overseas in May, so the APS was not able to put a view. I did come to hear about it and I called my own local member to find out what was going on and it appeared it was the DLP member of parliament who had put forward this legislation and it was the words 'infant viability' to try and repeal some of the 2008 legislation. It did not go through—it did not pass—but it may come up again, but that is what it was about. I do not know the details because I had to go overseas just as it was going through.

Mr McARDLE: Has the bill failed or is it still sitting in the parliament?

Ms Gridley: It failed, yes.

Mr McARDLE: Just going back to 2008 to now and prior to that date, as a psychologist have you seen what trend is developing in relation to termination and attitudes towards termination because of the change of decriminalisation into, I suspect, more of a mental health approach to termination?

Ms Gridley: I think that is right. My understanding is that colleagues are more comfortable talking about it. Again, because I work for the APS now I am not practising in a direct sense so I can only go on hearsay, but I would be interested in fact and this has triggered me to think about doing a follow-up. There was a study done of the take-up of that Medicare item about five years after it first came in, but it is about time we did another look at just what the take-up is and who is using it and how it is being used. It is certainly not the only way people access that service, but it is one that would not be that hard to get the information on.

Mr KELLY: Given that you are from Victoria, it is great to have the benefit of your experience there. Would you, either based on data or anecdotally, suggest that access to termination services has improved for women across-the-board in all socio-economic groups and in all localities around Victoria?

Ms Gridley: Yes, I would like to think so. As I said, the research that I was aware of was going on while that was still in flux, so it was you more heard people saying, 'When the legislation goes through we think we'll get more doctors coming to Ballarat,' or wherever. That was the sort of comment we got. Whether that has actually happened or not I am not sure. I do think that Bendigo Hospital, which was one area that was considered to be a bit of a no-go area, does now provide services. That is one example of change that I am aware of, but I do not know in detail.

Mr KELLY: Just to be clear, are services more widely available in the public health system in Victoria now as a result of the legislative change in 2008?

Ms Gridley: I think they were always there. The Royal Women's Hospital is a stand-out. It is well known as a flagship place where most of the people are referred from country areas or from within Melbourne. The Family Planning association tends to refer people to the Women's, but there are other hospitals that do it. It is generally seen as a better service than most, but not all the private clinics. The Fertility Control Clinic in Wellington Street, which was the old Bertram Wainer clinic, has been going for years and that it is very well regarded, too. I think they try to bulk-bill when they can, but not all private providers do that, yes.

Mr KELLY: Does Victoria have conscientious objection requirements in the legislation?

Ms Gridley: They have the same rule that says that if you have a conscientious objection you have to refer to somebody who does not carry that objection. That is another one that is very hotly debated, yes.

Mr KELLY: Have you had any feedback from your members as to how that is working?

Ms Gridley: Probably the most contact I have had is with Susie Allanson, because she is probably considered the most experienced clinical psychologist in Victoria in this area. She is very strongly in favour of that provision because of that risk of things being used as a delaying tactic. Also, sometimes there is not always a distinction between a professional counsellor and a volunteer counsellor—what they call false providers who talk about being pregnancy support services but they are there to talk you out of a termination, if possible. Again, sometimes they are well meaning. They think that if you have the right support you will not need to get a termination, but they often will not give people the full range of information. I think now the legislation says that they have to. Whether you pay to go to that service or whether it is a volunteer charity service, they still are expected to refer to somebody else if they do not give the information themselves. Whether that is being followed I am not so sure.

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Mr KELLY: Just finally, was your association involved in the Victorian Law Reform Commission review of this area of legislation?

Ms Gridley: Only in relation to the mandatory counselling. We wrote to all of the MPs saying that we did not support mandatory counselling because of the reasons that I said, yes, but we did not make a submission on the decriminalisation. By implication, we would rather see it in the health code than in the Criminal Code, yes.

Mr KELLY: Did you find that process to be one that gave a full gamut of opportunity for people to be involved and consulted in this area of legislation?

Ms Gridley: Within our membership, do you mean?

Mr KELLY: No, the criminal Law Reform Commission process.

Ms Gridley: I think so, yes. It went on for a few years and there was a lot of debate. People were very aware of it, yes.

Mr CRAMP: Thank you, member for Greenslopes, for stealing my thunder in one of his last questions around conscientious objection. I am interested in that area. We spoke about it earlier from a medical point of view. You made mention that you have some groups in your organisation working with Christian groups and counselling. Is that where the conscientious objection is mainly stemming from? Are they related to this issue? Are they trying to work towards a positive outcome?

Ms Gridley: I do not know is the short answer. The interest groups tend to operate a little bit to themselves. We do not want to poke in and say, 'Are you doing the right thing?' One of the issues that has come up recently is around conversion therapy—gay conversion therapy, so-called. The APS came out with a statement a couple of years ago making it clear that we considered that unethical because it does more harm than good, but we have had reports informally that some members still practise that therapy and that some of them were in the Christianity group. We have not done anything about that, unless a client makes a complaint and then goes to the registration board. However, I personally—because as part of my role I had the thought that I would quite like to bring together—

CHAIR: I just bring you back to relevance to the bill.

Ms Gridley: Sorry, I am thinking about this because this is what I would like to do in this case as well—to bring together the groups that have the most interest, bring the women and psychology groups together with the Christianity group and say, 'What is best practice in this area? How do we respect your values with this requirement? If you do not feel able to give that information yourself, you need to let the person know that it is available somewhere else.'

Mr CRAMP: But that is not currently the case?

Ms Gridley: It is expected, yes, but I do not know whether it is happening.

Mr CRAMP: To the best of your organisation's knowledge, have there been any cases—and I open it up to any of the panel here—across this country, because some of you are national organisations, where we have had mental health counselling services that have had conscientious objection in regard to assisting women with abortion and it has possibly become a legal matter or caused a delay that has been documented?

Ms Gridley: We have never had to my knowledge any concerns from our members saying, 'I have a conscientious objection and now they're telling me that I have to refer to somebody else.' I have never heard that happening.

Mr CRAMP: That is all I have, thank you.

Mr HARPER: In the spirit of bipartisanship with the member for Caloundra, if my memory serves me right—I am about a quarter of the way through the thousands of submissions—there is one there that goes to your previous answer. In Victoria since 2008, the reform shows that there has been no increase. I cannot put my finger on the number so I will refer it to our secretariat to find that one. It is interesting that the APS does not have a formal position on the bill before us. However, you have stated today that you support a woman's right to choose. Can I ask you to provide your thoughts on the need to modernise and clarify the law as it stands to decriminalise?

Ms Gridley: It is hard for me to separate my personal views from the organisation's. My views on most things are a bit more radical than the APS's but I have to speak in my role. Certainly, the APS as a whole, I think I can say, would rather see it in the health code than the Criminal Code. The reason they have not made a formal statement is partly that it is not a primary issue for psychologists. We do not work always in the health system. We work with quite a lot of organisations on a whole lot of other things. We are in one sense less directly involved.

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The other is that we know that it is a fraught issue, that it is value laden. We issued a paper on euthanasia a few years ago where we very specifically did not take a stand on that, either. We are possibly moving closer to one. There is a lot more debate about it. We tried to weigh up the ethical issues and the practice issues confronting psychologists in that space. That is the kind of thing that we are more likely to be commenting on here, too. We try not to take a formal position unless we think the majority of our members would agree, although it is pretty hard to canvass 22,000 people.

CHAIR: Thank you.

Mr McARDLE: Ladies, you have made your point about counselling being mandatory. Could I have a minor victory and suggest that the advice of counselling being available be mandatory?

Ms Gridley: I am sure we would not have a problem with that.

Dr Hardy: In fact, we would be supportive of that.

Ms Gridley: I think it probably is in the best practice guidelines. That is the difference between a best practice guideline and a minimum standard guideline. I guess that is where the space is, but I think people should know that it is available without being told, 'You will need this,' because it adds to that notion that I was talking about of the public image of, 'This is always fraught. You should feel really bad,' and, 'What if I didn't feel that bad? Now I have to.' We have to manage that message that has been given, but certainly I would like to see counselling being available to people with a lot of procedures that have life-changing, life-threatening implications.

Dr Hardy: I think having the availability of counselling is absolutely important. Yes, I would agree with that and then it is the woman's choice—and not just to finish at that point where, say, a termination happens or does not happen; it is having access to ongoing counselling as the woman needs it and wants it.

Mr McARDLE: I have always wondered—and I apologise for this—of the American example and their approach to termination. Australia and America are First World countries. We have similar legal systems, similar cultural systems, but the Americans paint the issue of termination to a different level entirely politically, emotionally and in their court structure as well. Why is that the case? What makes it such a volatile issue in America that it becomes question No. 1 for everybody who runs for President in that nation? You have multiple cases of slaughter of people outside abortion clinics.

Ms Gridley: Try to figure out the gun laws, too.

CHAIR: Given we have relevance, I know we will bring that back to a comparative point in the Australian jurisdiction.

Mr McARDLE: Exactly. How does it relate to the Australian jurisdiction?

Ms Gridley: I think we have similar histories. We are similarly influenced by our shared Anglo-Saxon Judeo-Christian heritage. I think in the US for lots of reasons it plays out differently from how it does here. I think you could not become a US President if you said that you were an atheist. We have already had one here a few years ago, so I guess we can manage it.

CHAIR: Thank you. There being no further questions, we will now conclude this briefing. If members require any further information, we will contact you. You will each be provided with a draft transcript of proceedings so that we can ascertain if there are any necessary corrections. I thank each of you in turn for your attendance here today. The committee certainly appreciates your professionalism and the advice that you have provided to our inquiry today. I declare this briefing closed.

Committee adjourned at 3.55 pm

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