

REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON BIRTH TRAUMA

INQUIRY INTO BIRTH TRAUMA

CORRECTED

At Preston Stanley Room, Parliament House, Sydney on Monday 8 April 2024

The Committee met at 9:00.

PRESENT

The Hon. Emma Hurst (Chair)
The Hon. Mark Banasiak
Dr Amanda Cohn
The Hon. Natasha Maclaren-Jones
The Hon. Sarah Mitchell (Deputy Chair)

PRESENT VIA VIDEOCONFERENCE

The Hon. Anthony D'Adam

* Please note:

[inaudible] is used when audio words cannot be deciphered.

[audio malfunction] is used when words are lost due to a technical malfunction.

[disorder] is used when members or witnesses speak over one another.

The CHAIR: Welcome to the sixth hearing of the Committee's inquiry into birth trauma. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders, past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander people joining us today. I ask everyone in the room to turn their mobile phones to silent.

Owing to the nature of this inquiry, I would like to warn those in attendance and listening to this recording that evidence presented today may contain sensitive content or themes. If you feel distressed as a result of the inquiry's sensitive content and themes, please contact one of the resources available on the Committee's website. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures.

Miss CASSIDI-RAE AMOSA, Individual, before the Committee via videoconference, affirmed and examined
Mrs LARISSA PALAMARA, Individual, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our first witnesses. I thank them both for giving evidence today. You are both online but thank you so much for joining us. Before we begin the session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. Miss Amosa, do you have an opening statement you would like to make?

CASSIDI-RAE AMOSA: Yes, I do. In 2019 my life was turned upside down simply because of the negligence of a hospital in New South Wales. It's not every day you hear about a 21-year-old suffering from multiple strokes nine days postpartum. I'm sure you have all read my submission prior to me speaking to you today, so I'll be brief. I do apologise in advance if my emotions get the better of me, but I will try to hold them back. After giving birth to my youngest child, my placenta split and got caught and was unable to pass by itself. Rather than sending me to the theatre, after multiple attempts of pushing out the remains of the placenta by pushing down on my stomach, the doctor decided to perform the most inhumane procedure I've ever heard and, quite frankly, it still gives me nightmares and flashbacks. While I was in the maternity ward, I expressed my concerns about my blood pressure being high. The doctor was adamant that it was going to regulate itself. Did it? No. Did I get a second opinion? I didn't think I'd have to. I think I should trust all doctors, but in this case my trust was broken.

On 5 June I had six strokes—five small strokes and a life-threatening stroke that could have taken my life. At 21 years old, I've had to teach myself how to walk, how to talk. I was dependent on my family and nurses to complete normal daily tasks such as shower, use the toilet, eat or clothe myself. I believe my strokes could have been avoided by many things. I'm very lucky that I'm alive and I appreciate every single day that I have on earth with my babies, but it doesn't stop the trauma and the challenges I still have to face every single day. I am not just a mother of three anymore; I am more than that. I am a victim of medical negligence, I'm a survivor of multiple strokes and I'm a woman with PTSD and severe anxiety. Thank you.

The CHAIR: Thank you, Miss Amosa, for sharing that with us. Mrs Palamara, did you have an opening statement that you would like to give?

LARISSA PALAMARA: Yes, thank you. Since the time I was 19 years of age I have lived with PTSD and suffered ongoing distrust in all things medical following the first pregnancy I have experienced, which resulted in the full-term stillbirth of my daughter when I was 38 weeks and five days pregnant. Added to that, my rights, my dignity and my choices were taken away from me multiple times during my prenatal care and my labour and delivery, and many of the things that I endured I actually didn't know about until some time after when the HCCC supported my investigation. I found out that the medical professionals who treated me on that day decided that they knew best and that, despite knowing my daughter had already died in utero, they subjected me to an unnecessary caesarean section under full general anaesthetic, making the decision for their own comfort that they did not want to deal with me until I was sedated.

I have zero trust in the medical profession. I am now the mother of four surviving children and raising them has been so hard because I do everything that they need medically but I have zero trust. That was stolen. It was absolutely stolen from me by the midwife and the hospital staff that I encountered. The apology I received was that they were sorry I attended their facility on a public holiday. Thank you.

The CHAIR: Thank you both for your bravery in coming today to share your stories. First of all, it's extremely brave of both of you but it's also extremely valuable for the report and the recommendations that we put forward, so thank you so much. I want to start by asking a question to both of you. Both of your birth stories are really shocking, and they show a theme of medical professionals not listening to your concerns or not listening to your pain. I'm wondering if you've felt that being a younger mum influenced the way that you were treated by doctors or other healthcare professionals during your births. I might start with you, Larissa.

LARISSA PALAMARA: Absolutely. I was told directly that my age was the barrier between the rapport with my midwife and the treatment I was receiving, on numerous occasions. When I checked into the public hospital antenatal clinic, I was given no choice in my care that followed. I was told that I was young and healthy and low risk. There was no investigation that proved I was young and healthy and low risk, other than my physical presentation. It was sold to me that I was going to get continuity of care with the same midwife every visit. Unfortunately for me, the midwife that was assigned to provide that care made it very clear to me from the first meeting that her own children were older than me. "They just keep getting younger" was her claim. For me, I was like, "Oh my God, I'm 19. I'm over 18. Yes, I'm young, but I'm certainly not the youngest." And that became the constant theme of any question I asked or concern I raised—that she would link it to my age and state, "I've been

a midwife longer than you've been alive" or "My children are older than you. They would never question me as you do." It was very consistent.

CASSIDI-RAE AMOSA: I was 16 when I had my first child and, yes, I was a baby having a baby. I heard that from all the midwives and doctors, saying that I was quite young. Then when it came to the second child it was the same kind of thing. I was 19 when I had my second child and they treated me as if I was still a child. But I'd also had my first child; it's not my first rodeo. Then when I had my last child, when I did have the stroke, the paramedics pretty much stated that I was so young, there's no chance of me having a stroke. "She must be overdosing" and things like that. Thankfully, my stepdad stood up and said, "No, no, no, she's not on drugs." Until about five to six hours after having the initial stroke, they were putting it down to my age and overdosing and things like that.

The CHAIR: Thank you. Obviously, there are specific challenges that younger mums face when navigating the maternity system and both of you have experienced that. I'm just wondering what sort of additional support you think should be available to other young mums that are in the system?

CASSIDI-RAE AMOSA: I believe all of the information and resources should be given to young mums because they don't know—not unless they've heard it from their family and their mums and things like that. I don't think midwives and doctors tell us exactly what the go is.

LARISSA PALAMARA: I think, personally, one thing that I come back to is that, as a professional sector, I would expect that regardless of age, race or religion we are offered the same experience as any first-time mother or second-time mother. I've now had five pregnancies that have resulted in delivery. I've had a total of 11 pregnancies, so I've endured six losses. I come back to that and I think it doesn't matter which pregnancy it's been; there's been things that have been different about every single one. My trust at every single time has been placed in the medical professional who has been that port of call. I'm reliant on that person to tell me the truth, to support me and to not judge me based on whether or not I'm married and working and looking as though I am socially acceptable, or whether I'm 19 and not meeting the requirements of what they think a mother should be. They had a duty of care regardless of my age. Would it have been fantastic if there was additional support where there was additional training for her as a youth worker? Maybe. I don't know. Social work? I don't know. My experience across the board with the hospital I went to—they failed in multiple aspects. So there's very little trust I hold in the social worker even that attended me.

The CHAIR: I just want to touch on one other aspect from both of your submissions in regard to the experience of PTSD in response to the trauma that you experienced. We're hearing later today from psychologists and psychologist organisations. I just wanted to get an idea from both of you in regard to what sort of support or longer term help could have been made more available to you, or were there avenues that you found that allowed for that support?

CASSIDI-RAE AMOSA: To be honest, when I was diagnosed with PTSD after having my strokes, I didn't want to go to see any doctor. I've got no trust in any kind of doctor at all. I've been in and out of hospitals for five years for panic attacks and things like that, but then it gets to the point where it's like, "They're not helping me; they never did." They would give me some Valium or something like that to calm me down and then they would tell me to go and go see a GP. I've seen GPs and things like that and it's the exact same thing. They're just like, "Well, you'll be fine." So I feel like my mental state has just been dismissed by all doctors—which is kind of good, in my case, because I don't trust any doctors at all. To be honest, it's so hard to find a doctor that's so decent and they'll understand and things like that.

The CHAIR: Larissa, do you have anything to add?

LARISSA PALAMARA: The situation I found myself in as a 19-year-old—I didn't have financial resources for professional assistance, to seek professional support. What I found I encountered was that the public system was linked to the same medical service which caused my PTSD. My attempts to engage in support prior were met with lots of "We can't talk about that", "That's really not what we're here to discuss." That was absolutely what I was there to discuss. That was the help I needed. However, I was met with multiple social workers and even a psychologist through the public sector who stated that they were not prepared to engage with me when my conversation was against their employer.

The Hon. SARAH MITCHELL: Thank you both for appearing today. I have a couple of questions for each of you and I might start, if it's all right, Mrs Palamara, with you. I'm so sorry for the loss of your daughter and your subsequent pregnancy losses. It is never an easy thing to go through and obviously yours was a very traumatic circumstance, so thank you for being brave enough to come and share it. As the Chair said, it does really help the Committee with their deliberations, so thank you for that.

You sort of touched on it a little bit in an answer to Emma's question, but I wanted to ask about, particularly after the loss of your daughter, the subsequent pregnancies and the birth of your four children. Was there any recognition of what you had been through previously? One of the things we've heard throughout the course of the inquiry has been wanting to ensure that staff are aware and providing trauma-informed care, particularly for people who might have been through birth trauma and pregnancy loss. Is there anything in terms of the experience with your other children that was an improvement? Was there an acknowledgement of what had happened? Is there anything you can share about that with us?

LARISSA PALAMARA: Yes. No is the simple answer for me. I was found to have a blood-clotting condition called antiphospholipid antibody syndrome. This young healthy first-time mum that was seen—I was actually a ticking time bomb on the inside. I was experiencing major blood clotting which ended up taking the life of my daughter and, had I not gone into labour when I did, I was told it would have taken my own life as well. The reality for myself was that I ended up having—I've never held private insurance, but for every one of my subsequent four live births I have paid thousands of dollars for obstetric care and private hospital admission under that obstetrician as the public system did not at any time recognise my prior losses, my severe medical condition that occurs during pregnancy.

I have an 18-year-old daughter now. During my pregnancy with her, I was taken to hospital with what I thought may have been preterm labour at 21 weeks gestation. Obviously I was terrified. It was straight back at the same labour and delivery ward which I had been in with her sister. I was met with a midwife that told me there was no point being so upset and that I was only 21 weeks and there was really not much they could do anyway. I broke down; I was devastated. When I attended the same hospital the next day for follow-up ultrasounding and additional monitoring—at that point they found it was a kidney issue—I stated, "I need consistency, I need continuity of care and I need somebody that is medically trained to understand, to read my record to see what I've endured." And I was told, "We don't do that; we don't have time to do that."

The Hon. SARAH MITCHELL: Is that what made you decide to then opt for private health care—that experience?

LARISSA PALAMARA: No. Both of my boys, my first two, had been private health care. By the time my daughter came along, that same system was thousands of dollars more expensive than it had been with them. At that point, that was when I made the decision. I was seated in the antenatal clinic getting the follow-up of this ultrasound here, and I'm begging them for consistency and a doctor that could oversee what I was going through. Instead of providing me with a doctor, they provided me with a social worker who entered the room and asked me questions along the line of "Do you take your boys to the beach? Will you allow your boys to swim in the ocean?" When I asked what these questions had to do with what I was facing, she stated to me that she believed that I was over-protective and that I was panicking over nothing.

I was trying to explain to her that I had a diagnosis of PTSD which was caused by medical trauma, and the fact that I didn't allow my five- and seven-year-old to swim unsupervised in the ocean—to me that was a stupid statement anyway—had absolutely no bearing on what I was facing. She made me feel like she was going to walk out and report me to community services for "not allowing my children to have natural experiences in life", as she put it, and based on my mental health. I felt so unsupported, and that was when I walked out and I said, "You know what, I don't care how many thousands of dollars it's going to cost me. I can't spend another 19 weeks"—or however long I was going to be pregnant—"in this system."

The Hon. SARAH MITCHELL: One of the things we've looked at—and I might know the answer to this already—is whether there should be recommendations around better trauma-informed training or support beyond what is already offered or given to midwives and health staff. I'm assuming you would agree that that's an area that needs improvement from your experience.

LARISSA PALAMARA: Yes, absolutely.

The Hon. SARAH MITCHELL: Yes, thank you. I just have one, if I can, to Ms Amosa. Thank you for appearing today as well. In your submission you talked about not having any follow-up care after you were discharged and before the date that you had the strokes. After you'd obviously been through the experience of the strokes, was there an admission or a conversation about why there wasn't any postpartum care provided? Why was there that gap, and did anyone explain to you why you hadn't had follow-up treatment or care?

CASSIDI-RAE AMOSA: I called them multiple times simply because I knew something was wrong with me, and also my child was—I was breastfeeding, and she wasn't gaining any weight. I had plenty of concerns. It got to the point where I've called pretty much every single day and they've said, "Well, they'll be there, they'll be there." Then it got to the point of, the day that I had the stroke, my mum called them demanding, because my mum also knew something was wrong and she also had concerns on my baby's weight and things like that. They

just said, "We've been so busy", and things like that. It got to the point where it didn't really matter anyway. Once I had the stroke and I was in hospital, my mum took my child to a hospital that I was transferred to in Sydney, and that's when she's explained what's gone on. Then she explained that the previous hospital—they were just not following up with me or my child, and they took my child straight in for follow-ups. They were not really worried about me because I was in ICU anyway, but I didn't think there was any kind of explanation of why they were doing that. The only thing that I do remember is that they were so busy.

The Hon. SARAH MITCHELL: So you had hoped to get a visit from a community health nurse or a home midwife, but it just hadn't happened in the time between when you were discharged and when the stroke occurred?

CASSIDI-RAE AMOSA: Yes. I do remember with my first and second child, because I had high blood pressure and I had pre-eclampsia, they came on the second day and they were also there on the fourth day. Once they realised that I was okay, my medication was okay and my blood pressure was fine, [inaudible] said that I'll go see a GP within the six weeks. I was expecting the exact same thing when I had my last child, and it didn't happen because they were too busy.

The Hon. SARAH MITCHELL: Thank you. I just wanted some clarity.

Dr AMANDA COHN: Thank you so much for sharing your experiences with us today. I had a few questions that have already been asked by other members, but my last one was about the level of information that you would have wanted. You've both got really shocking stories but stories where you've encountered quite serious medical conditions and medical complications. We've heard earlier in this inquiry about the difficulty that health providers find in striking the right balance of giving people enough information so that they feel informed and they feel like they can participate in decisions versus not wanting to worry people. I am interested in your reflections on that in terms of how much you would have wanted to have known about these kinds of complications before they happened to you and how we can do that kind of information provision better.

CASSIDI-RAE AMOSA: Honestly, I didn't know that once you had high blood pressure that you could have a stroke. I mean, most people do but—when I did have the stroke, I actually said to the doctor weeks later, "How did I have a stroke—I'm 21?" I thought having a stroke would be for the elderly. I see so many pamphlets and things like that in the antenatal clinics, but it's not anything about pre-eclampsia or pretty much anything. Mental health is a big thing, of course, and that's always there. And that's great that there is pamphlets and information for mothers who do have mental health. But when it comes to my experience, I would have loved to have some kind of information about what I could do and how I could stop it. I do know that I could have avoided my stroke, but I had no idea that there could have been any way of me having a stroke, if that makes sense.

LARISSA PALAMARA: I think for myself personally, I knew nothing. I wasn't given any information at all about myself; I actually requested testing to find information. I was extremely sick. By the time I was 32 weeks pregnant, I was so sick I didn't really leave the house. As my pregnancy progressed through those final weeks, I was so sick that I had a plastic chair placed in the shower because standing in the shower took more energy than I had left. I was consistently losing weight at every check-up and, instead of being offered testing or having my concerns validated, I was told that it was because I was a teenager who was trying to protect my bikini body. I was begging for something, and on 18 March—which is so clear to me—I went into the family birthing centre, which is where I had been sent as opposed to the doctor-led antenatal clinic. I approached the family birthing centre during lunchbreak when there was a gathering of multiple midwives in the same room. My thought process was "Somebody's going to help me. Somebody will have a different answer."

Unfortunately for me, what occurred that day was that I was actually humiliated in front of all of them. I was described by my primary care midwife as a neurotic first-time mother-to-be, that I was a problematic at every appointment. She singled me out to all of her colleagues and stated that I was a prime example of why teenagers shouldn't get themselves pregnant because they clearly can't cope. She had giggles about that in front of my face with her colleagues. It was only one midwife in that staffroom who presented me with a chart that they called a fetal movement chart and told me to go home, put my feet up, have a cup of tea and count how many times the baby moved. I was told to bring it back in a week.

After my daughter was born and after I found out all of the things that I now know, when a fetal movement chart is given, that should never be given for any more than 24 hours. Then you should be reviewed by primary care to see, "Have you been feeling this baby move? Should it be followed up with a CTG?" I was given none of that. When I called the hospital 24 hours later to say that I couldn't use the chart, my baby—I couldn't feel it moving. I could feel every now and again there was a knee or something protruding from my belly and it was hard, but I couldn't feel the baby get in and out of that position. I was told in front of all of those midwives that day that because I was protecting my "bikini body" and consistently losing weight, my big baby had nowhere to move and I couldn't expect to feel it move.

A week later, when I attended my check-up with that same midwife, there was a student nurse in the room. This is a part of my story that I actually hate has hurt me as much as it did because I have carried the shame of this day for so long. My partner, who very rarely attended any of the visits—he was 18, I was 19; we were young—we were in the room with this very young, attractive student midwife. I was questioning my primary care midwife on the lack of fetal movement and how that fetal movement chart was too hard for me to do, and she was again laughing at me. This time she turned around to the student midwife and stated, "When you get to the time of wanting to have a baby of your own, don't worry about the stretch marks. You're not going to look like her because I'm sure your hygiene will be far better." That was a sentence that I never told anyone. I was so humiliated. I couldn't share it with even my own mother because I was just—I really did believe in that moment that I was what was wrong with this situation. That had been the consistent treatment that I received off that midwife for more than six weeks.

Dr AMANDA COHN: I'm so sorry to both of you that that's what you went through. But, again, I'm really appreciative that you're helping us to make sure that other people have a different and better experience. I just wanted to pick up on something that you both mentioned. You were talking about written information. I think all of us know that a pamphlet can never replace a relationship with a health provider that you actually trust. Cassie, you mentioned pamphlets on various types of conditions; Larissa, you talked about that fetal movement chart. It sounded like in both of those cases, seeing something in writing was something validating, that that condition is real or your concerns are real because it's reflected on a piece of paper. Have I heard that right? Is that something we need to take into account?

LARISSA PALAMARA: Yes, for me it was. I felt like she listened—somebody listened. I just didn't know I wasn't given the correct instructions on how to use it.

CASSIDI-RAE AMOSA: I feel that not just pamphlets but information face to face from midwives and things like that—and to listen to the patients. I had so many concerns on my blood pressure and they were dismissed. I had concerns on my child losing weight and things like that and they didn't listen. But definitely the pamphlet is a big thing. When I say pamphlets, I mean plastered everywhere. Again, in my case, what 21-year-old has a stroke?

The Hon. EMILY SUVAAL: I wanted to start by joining with my colleagues in acknowledging you both for being here today and, certainly, your bravery in sharing your story but also in writing your submission. I was really struck, reading both of your submissions, on the impact that may or may not have had on you both in sharing such really challenging stories. Thank you for writing the submission, which would have been quite a task, and for appearing today. I note you both mentioned at the start that you've suffered significant PTSD since your really awful experiences. I just wondered if you could walk me through what, if anything—and this is completely hypothetical, so the answer may be nothing—would have to change for you to have confidence or regain confidence in any way in our medical system, in that public health system?

CASSIDI-RAE AMOSA: I feel like that it's so hard to find a decent doctor that understands you. It's hard to say, to be honest.

LARISSA PALAMARA: That's a really tricky question; I thank you for asking it. I struggle with this one a lot. I actually left the region I was living in, where my daughter Amber was born, when my children got a little bit older. One of the reasons was because I knew that was my only hospital. That was where we had to go. I remember my son being a 12-year-old child who fell off his pushbike. I had to take him to get an X-ray of his arm. We were in that same hospital and I—for me, finding my voice, I still, when I walk inside that hospital or any hospital, feel like the vulnerable, uneducated 19-year-old who has no right to speak up, whose words are not as valued or validated as the professionals in the room. On this occasion, when they showed me my son's elbow and they said, "He's got four broken bones and we're operating tonight", I found my voice and asked if we could wait till Monday because I wanted the orthopaedic surgeon of my choice, no matter what it cost. They were very upset with me, but I had the right to say that.

We did leave the hospital and went home, with him protected and bandaged. On the Monday I went and got the second opinion I wanted and found out that the diagnosis he was given Friday night of four broken bones was actually the completely normal growth plates of a 12-year-old child, and they were preparing to wire a healthy elbow. I have zero trust in that profession—and that's terrifying for me. I find now, even, as a 46-year-old woman you're approaching an age where you're hearing of all the things that you should be doing on an annual basis to maintain that your own health is in check. I don't want to. I don't want to put myself in that position and that scares me. It scares me for my children that are surviving and how my health may then end up declining, but I know what I have endured previously. I just don't feel confident that it would make any difference if I went in there anyway.

The Hon. EMILY SUVAAL: That's really compelling, Larissa, because it's—correct me if I'm wrong—26, 27 years ago?

LARISSA PALAMARA: It was 27 years two weeks ago.

The Hon. EMILY SUVAAL: Yes.

LARISSA PALAMARA: I still remember every moment of what I went through. I remember waking up in recovery and being alone, and calling for my child and asking what I've had. I remember then being given consistent injections that continued to sedate me. Then I remember waking up and having her right by my bed, and looking at this perfectly sleeping baby and saying out loud, "It was a mistake. She's okay." I can remember it all as clearly as watching a video, and that knowledge of what led to that moment in my life is all stemmed around the medical profession.

The Hon. EMILY SUVAAL: I can't imagine how traumatic that was for you. Thank you, again, for sharing it. In terms of maternity care more generally, we've heard throughout the course of the inquiry that—there have been some consistent themes around maternity care needing to be more respectful. What actions, if any, that you could both describe need to happen to ensure that this occurs? What can we do?

CASSIDI-RAE AMOSA: First off, like I said before, listen, because no nurse or midwife or doctor can tell me my body. If I have concerns, listen to them. Apart from that, just listen, and I will scream that at the top of my lungs. If I had nurses and doctors listening to me and my concerns, I wouldn't be in this situation at all.

LARISSA PALAMARA: I would agree with listening. I would absolutely agree with that. I do think that, when it comes to the public sector, I acknowledge that—and I don't say this from my experience, because my experience was very much a personal relationship. But from what I have seen since, the public system is extremely overwhelmed. I know that the region I was living in at that point in time was, without giving that away, responsible for a very large area—a growing, booming area of families—and the kilometre radius was huge. Yet that was the only antenatal clinic in the region, and you had some people driving 45 minutes to attend that clinic in either direction. So the decision to close down the second antenatal clinic in that area very much overwhelmed the primary care facility in that region.

The Hon. EMILY SUVAAL: Absolutely. If there was a system available in that hospital setting—if you felt your concerns weren't being listened to—for you to, I suppose, escalate your concerns around your immediate healthcare providers, is that something that either of you would have used?

CASSIDI-RAE AMOSA: Absolutely. Absolutely. And that's all I can say.

LARISSA PALAMARA: Yes, absolutely.

The Hon. EMILY SUVAAL: Again, I join my colleagues in apologising that that was the experience you had and that you weren't listened to. We will, as a Committee, do all that we can to ensure that your voices are heard and that these actions aren't repeated. Thank you, both.

The Hon. NATASHA MACLAREN-JONES: I also want to thank you both for coming today and for having the courage to be able to come forward. I would like to ask you about the complaints process. Both of you referred to lodging complaints, and I wanted to understand a little bit more about whether that was through the hospital, first of all, the HCCC and the outcomes of that. As my colleagues have mentioned previously, we are looking to make a number of recommendations. One area is also how that process can be improved and how it was for you, particularly.

CASSIDI-RAE AMOSA: Is that for me or for Larissa?

The Hon. NATASHA MACLAREN-JONES: Both of you.

CASSIDI-RAE AMOSA: I can't answer that right now.

The Hon. NATASHA MACLAREN-JONES: That's fine.

LARISSA PALAMARA: I can talk to that one. From my own personal experience—I'm sorry, I do find myself feeling like I could talk forever on this subject, so I apologise if I talk too much. For myself personally, I was subjected to several other issues that were quite traumatising during my stay in the very same hospital where my son was born. My daughter was born in 1997, in the March. Because I felt like the only thing in the world that was ever going to heal my broken heart was to fall pregnant, I was back in that very same hospital a year later, and I can recall the triggering moment of where I was confronted by the bedroom which I had been allocated and the same familiar white sign that stated, "Do not enter. All correspondence via the nurses station." Knowing I had been in that room with that same sign, I knew what the family inside the room was going through.

I found it so triggering. Then I watched as the wardman came out carrying the tiny brown box that he was swinging and walking down the hallway, like he was on his way to school, and it broke me. I was shattered. I was taken off to the social worker's office, and she said to me, "With all due respect, if any other person had been standing in that corridor, they would never have known what he was carrying." And I said, "Well, with all due respect, I did, and it was me standing there." For me, there was a systemic issue that played throughout every aspect of my care within that hospital, and when I attempted to lodge complaints I was stonewalled so many times along the way.

When I accessed my medical records through freedom of information, I was given partial copies of my medical records. When I went back and complained that I wasn't given the full copies, I was told that was all they could find. Missing from those records were things like the pathology on my daughter's placenta, which was so important to understanding what had happened to me. From the moment I woke up in recovery, the medical staff wanted me to sign paperwork. I was heavily medicated. I couldn't even focus to read, and they kept telling me, "Just sign. Just sign." Even up to day five of my hospital admission, they were still wanting me to sign this paperwork and telling me—they were telling me if I hadn't have signed the paperwork for an autopsy and State burial, then it was going to cost me a lot of money or that it was going to risk the life of any other child I had. The ongoing shame factor in "This is the choice you're making" was consistent.

So when I found out five days later that they knew that on delivery the placenta had been responsible for the death of my daughter, I was stunned because I went home from hospital not knowing that. They did not share that information with me. The only thing I was told was that, by not having the autopsy performed, I had placed all future pregnancies of my own in jeopardy. Going and trying to get those medical records was so important for my own understanding of what I had gone through. It took me four years to find a solicitor that was prepared to work with me. Because of the region I was based in, I had to go out of area.

I did submit my own written complaint to the Health Care Complaints Commission, and to this day I credit the man that was allocated my case with giving me the confidence to continue. He was absolutely worth his weight in gold to me because he rang me and he said to me, "I've never once read a case with such merit and guts." And he said, "Do not stop this fight. They're going to cut you off everywhere you go, but don't stop." From there, I tried getting to work with the hospital; I kept reaching out to the hospital so many times. I had my son in the new millennial—30 December, he was born, 1999. I was in hospital for the New Year's Eve, and I witnessed something truly horrific, and it brought back my own PTSD. After that, I realised, "I can't let this go. I have to continue."

I went back to the hospital and I said, "I need to talk to someone." The nurse unit manager at the time responded by saying, "You know what, midwives are like shopping at David Jones. If you buy a sweater and you don't like the customer service you get, it doesn't mean you never go back to David Jones; it means you just stand in a different queue." I was gobsmacked because I wasn't there to discuss buying a sweater; I was there to discuss the death of my daughter and what I had witnessed that retraumatised me two weeks earlier. I escalated my complaint through the hospital. As a result of that, I actually worked with that hospital CEO for a period of about 12 months where many facets of my care were taken into consideration, including the nursing staff on the ward I was placed and the social work experience I had for myself 24 hours after delivering my daughter.

I was told I could bathe and dress her—that they would get me out of bed after the caesarean and let me bathe and dress her. That opportunity was taken from me by the social worker who said that she couldn't bear that to happen. When that social worker attended my room, she did not want my daughter to come back at all. She stated it would be unhygienic. She stated that it would be prolonging the grief. I had to fight and argue 24 hours after a caesarean section to see my daughter again. When they brought her back in to me, the social worker ended up coming back into my room and asking me if she could hold her, which was so unusual based on how she had been 10 minutes earlier. And being that new mum and going, "Yes, you can hold my new baby", I said yes. And what I didn't expect was for her to sit in the recliner opposite and bring my baby up under her chin and cry more than I did. We ended up needing to press the buzzer and have two nurses, one either side, peel her arms off my baby and get my baby back from the social worker. It took two nurses to lift her up and exit her from the room.

When all of this went through the complaints channel, I was told that they apologised that I went to the hospital on a long weekend. It was Easter weekend and they were operating on insufficiently trained skeleton staff. That particular social worker was interviewed in relation to my care and she stated that she absolutely remembered me. She remembered treating me and stated that she should never have been allocated to a maternity role. However she had accepted the Easter on-call shift and she did not feel she could say no to her employer when she was asked to attend the maternity unit. From that, the hospital questioned—we worked together to talk about what could we do in this. It was deemed that any social worker that was going to be on an on-call basis was going to be subject to training every three months on something that is not their expertise, whether it is organ donation, maternity—something where it's an outlier to what they would normally do—in case they are on call for that that weekend.

The Hon. NATASHA MACLAREN-JONES: Thank you very much for sharing that. I am so sorry for what you went through—not only the challenges you faced in lodging that complaint, but the ordeal that you went through.

The CHAIR: I want to jump back to Ms Amosa in regard to the conversation we were having before about access to psychologists. I know you indicated that you'd lost trust in wanting to actually go in front of a doctor. I want to clarify whether you meant the psychologists themselves or the fact that you actually have to see a GP to get the 10 sessions with a psychologist. Or is it the healthcare profession generally?

CASSIDI-RAE AMOSA: Just in general. I've had so many psychologists and doctors and GPs and things like that, and in my area I've pretty much gone through all of them. It's the fact of they don't understand me and I can't—they don't listen. If they do listen, it's just disregarded and, again, they put it down to my age.

The CHAIR: This Committee will put forward recommendations to the Government about what changes need to be put into place. I would like to hear from both of you about what you would like to see in those recommendations, and also if there is anything else that we haven't asked you today that you want to tell the Committee before we conclude this session. I might start with Miss Amosa.

CASSIDI-RAE AMOSA: For me, it's a consensual thing—some kind of waiver for all mothers, what I went through after giving birth. My midwife said to me that I can say no, and it was disregarded. That's a big thing and that is the most traumatic experience that I've had, apart from having a stroke, of course. But having a waiver and having it in writing that what is going to happen and what the doctor or the midwife is going to do to that person, because I had no idea what the doctor was going to do to me at the time, and it's quite disgusting. Having some kind of waiver and consent form written and some time as well to read it and process it and things like that—that would be absolutely perfect.

The CHAIR: Just before we go to Ms Palamara with the same question, I have a quick follow-up question around consent. I know in your submission you talked about your placenta being ripped out by a doctor, and that doctor didn't even tell you what was going on. Obviously, that would be extremely traumatic. If you feel comfortable, could you share how you felt about that experience and what consent would look like in that particular situation?

CASSIDI-RAE AMOSA: At the time, I was violated. I was absolutely violated, and there's no other word for it. No is no, whether it's "no" or "nah" or "no, thank you". It's non-consensual. It's disgusting. It's literally—I would put it in the same category as rape, to be honest.

The CHAIR: What would you have liked the healthcare professional to have done in that situation? You talked about signing a consent form early on, but I assume, given this is so invasive, it needed some form of consent in the moment. What would that look like? How would that work?

CASSIDI-RAE AMOSA: When my midwife said that she had concerns about the placenta being caught, she said, "If we can't get that by pushing down on the belly, we will send you to theatre to get it surgically removed." So I was pretty much prepared for that. But then, when the doctor came in in such a rush—and she had no empathy or anything. She was just ready to violate. I just—

The CHAIR: I know it's hard to talk about.

CASSIDI-RAE AMOSA: I don't know. I feel like all doctors should listen to the patients. Like I said before, I will scream that at the top of my lungs. If they listened to me, I wouldn't have a tear in my artery and I wouldn't have had a clot in my neck causing strokes. Consent is a big thing. That's all I can say about that. It's a big consensual thing, and it would be good to have some kind of waiver and a doctor to explain what they're about to do to the patient.

The CHAIR: Thank you. Mrs Palamara, if I could go back to that original question about anything else that you wanted to mention and recommendations for this inquiry?

LARISSA PALAMARA: I think, for me, dignity was a huge thing that was missing in my care. I feel that I was stripped of all dignity. I had no ability to be included in my own care. My words were not listened to when I was unwell, and I knew I was unwell. I knew I was very sick. I was shamed. I was humiliated. But I think, for me, the early morning when I did go into hospital—I hope that this is appropriate. I just want to share with you all this photo. This is my little girl. She was perfectly formed, she was ready to be born and I was the only person in the room who didn't know she was already gone, and that was taken from me. They knew, and they've admitted they knew, and they've admitted it was too hard for them to face me until I was sedated. They had no right to do that.

I was drugged against my will, with no knowledge. I don't care how young they were or how new they were to the profession; they held so much power in their hands, and I had none. And from every aspect of my care in that particular hospital—I once had a legal professional describe my situation as a comedy of errors. It's not real funny to me, but there were errors in every single part. And I don't know if all of them were based on my age, but it was made very clear to me that my age was a very significant factor. Even as a 19-year-old—I was the eldest of 15 children—I knew stuff. I was not completely naive. If they had explained to me what was happening, I was of an intellect that would've been able to make informed consent. But they chose not to even explain. Thank you.

The CHAIR: Thank you. Thank you both for coming today and sharing your stories so openly with us. I imagine it has been extremely difficult to do. As the Committee has already said, we're so sorry to hear both of your stories, but they're extremely valuable for this inquiry, for us to be able to make recommendations to the Government. I know that one of the motivations for many of the women who have come forward is to make sure that this doesn't happen to women in the future, so thank you for making yourselves vulnerable on behalf of other women. We really appreciate it. Thank you both so much, again.

LARISSA PALAMARA: Thank you for the invitation.

CASSIDI-RAE AMOSA: Thank you.

(The witnesses withdrew.)

(Short adjournment)

Ms KAREN LOGAN, National President, Childbirth and Parenting Educators of Australia, sworn and examined
Ms ALISON SUMMERVILLE, Engagement Officer, Childbirth and Parenting Educators of Australia, affirmed and examined

The CHAIR: I now welcome our next witnesses. Thank you for joining us today. Do either of you have a short opening statement you would like to make on behalf of the organisation?

KAREN LOGAN: We both will. We would also like to table our national competency standards that we've brought in hard copy today. We'd also like to ask that an amendment be recorded in our submission, that the term "clinical nurse consultant" be replaced by "clinical midwifery consultant"—and we'll email that.

The CHAIR: Absolutely. Thank you.

KAREN LOGAN: I'm the National President of CAPEA, representing Childbirth and Parenting Educators of Australia. I'm a CAPEA-certified educator with 34 years working in the New South Wales public health service and a physiotherapist working clinically in maternity and gynaecology. Thank you for giving us the opportunity to speak on behalf of CAPEA at this inquiry. I would like to acknowledge and thank the women who bravely and generously shared their stories, and thank this Committee for considering the large volume of submissions and recommending the best way forward. CAPEA is a voluntary professional association with a 60-year history of supporting educators from diverse professions as they strive to provide high-quality, accessible and responsive education to women and their families during early pregnancy and early parenting and birth.

Our members include midwives, physiotherapists, independent educators, child and family health nurses, doulas, social workers, psychologists, academics, a lactation consultant, and Calmbirth and hypnobirthing practitioners. Sixty per cent of our members practise in New South Wales. We are reliant on our members volunteering their time and we struggle with volunteer burnout of committee members who are working clinically as midwives, running businesses, as well as presenting education programs. We receive no government support. I would particularly like to acknowledge the work of present and past members, particularly Dr Jane Svensson, our vice-president, who held the only parenting education doctorate in Australia. Sadly, Jane passed away unexpectedly six weeks ago. Her work leading the Further Education Committee developing the competency standards in 2011—the feedback tool and certification process for CAPEA members—has been pivotal for parenting educators to develop their skills and improve professional standards.

There is no registration process or regulation of childbirth and parenting educators in Australia or terms of required training. Anyone with an interest in birth can legally set up their own private business to provide this service. Particularly since COVID, commercialised programs have increased, enabled by social media platforms. Consumers expect a high-quality professional service from qualified educators. The programs vary in cost, curriculum, educator experience and training.

Parenting education programs are an integral part of antenatal care and their role in preparing parents for labour, birth and early parenting is widely acknowledged by consumers and health professionals. Antenatal programs facilitated face to face have been demonstrated to be crucial in their preparation for labour and to build social support networks. Kate Levett, in her research in 2020, the BITTOC study, reviewed the effect of COVID restrictions cancelling face-to-face education. She suggests in her summary that childbirth parenting education be delivered in a coordinated, systemic and integrated manner that allows women to experience social connections, receive high-quality information and gain practical skills for birth and parenting. The national standards are currently under their third review. The 2018 edition, which we provide today, was cited by the 2018 Queensland Clinical Excellence Division *Recommendations for antenatal education*, which stated:

Antenatal education programs should be regularly evaluated and consideration should be given to utilising the Childbirth and Parenting Educators of Australia's (CAPEA) Competency Standards and associated assessment tool

Therefore, the foundations and recommendations have been laid for future practice and could be readily implemented to safely support the profession for the benefit of educators, parents and their families to ensure antenatal education is woman-centred. Similarly, the competency standards align well with goals 5 and 6 of the New South Wales *Connecting, listening and responding: A Blueprint for Action*, dated 2023, and CAPEA were consulted as a stakeholder during the draft process.

We believe implementation of the standards across all programs will assist women and their families to gain better access to the high-quality, responsive, learner-centred education enabling informed choice during their birth. They assist educators in developing their practice development. They provide a nationally consistent approach for educators' competency to be assessed and act as a benchmark for assessing competence to practice in a range of settings by a diverse group of professionals. That can be applied to novice and expert educators, coordinators and managers of childbirth and early parenting education services.

CAPEA also provide a certification process that recognises the skills and knowledge of that educator as a CAPEA-certified educator or trainer. We strongly recommend the implementation of these standards, an agreed national curriculum and the appendix 1 birth parenting education assessment tool as a baseline for all antenatal educators in all settings to provide evidence-based education regarding maternity care options and informed consent. Thank you.

ALISON SUMMERVILLE: I will give a little bit of context around who I am usually. I'm a clinical midwife consultant in parenting education in New South Wales regional and rural health service and have over 25 years experience facilitating and coordinating childbirth and parenting education programs. But today I'm representing the Childbirth and Parenting Educators of Australia, CAPEA. As I said, I'm the national engagement officer. I've been a member of CAPEA for 25 years and I am a CAPEA-certified educator.

Presently there's a variance in the way programs are delivered across the State and by whom. Course content is varied and dependent on the skill of the facilitator, their beliefs and their training. Under-resourcing in training and equipment is reported by our members. Members working at hospital sites tell us resources allocated to the management, administration and support to educators vary greatly. Pay rates for educators working within existing maternity services also vary greatly. There are no national or State awards specifically for birth and parenting educators. They may be employed under a range of award structures or be expected to facilitate programs within an allocated rostered shift, which can be very disruptive for programs.

Without formal data collection across NSW Health on parenting education, it's estimated less than 50 per cent of first-time parents attend formalised antenatal education programs, preferring to seek, sometimes, information from other sources or no information at all. This can lead to inconsistencies between education sourced from other models of care, creating a discord with the local hospital practices they're birthing at or increasing anxiety and mistrust for the woman.

CAPEA support development of evidence-based resources to be used across all health districts. Hospital-based facilitated programs are required to align with The First 2,000 Days Framework and the NSW Health *Connecting, listening and responding: A Blueprint for Action*. Commercialised programs are not required to comply with any of these frameworks. Information needs to be presented across a range of learning preferences and teaching strategies. Specific resources need to be available to meet the needs of all expectant women and families, inclusive of our First Nations people, CALD, LGBTIQI, and parents with special needs, and adaptable to the varying health literacy levels.

We believe that quality, consistent education programs led by an experienced educator in the prenatal setting enable women and their partners to understand common interventions, like caesarean birth, induction, assisted birth, perineal trauma, and applying the BRAIN acronym—this is referred to in *Pregnancy, Birth & Beyond*—to be better able to make informed choices during pregnancy, intra-partum and the postpartum period. The discussion in a group setting with other participants, mediated by a birth professional, allows time to process information from a variety of sources and personal viewpoints, thus developing decision-making skills to give fully informed consent.

Parenting education in 2024 is a specialised area that requires an in-depth knowledge of historical developments and societal changes affecting parenting education in Australia. It is crucial that services have clear governance and are working with partners such as CAPEA and their local health districts, as well as wider government bodies. It is vital we continue to review the current landscape of maternity care and acknowledge that childbirth and parenting education is fundamental to a woman's continuum of care regardless of which model of care they choose.

CAPEA support consistent training and education for all childbirth and parenting educators to ensure woman- and partner-centred care. Having a designated clinical midwife consultant for parenting education would provide leadership, a professional network, consultancy and governance across maternity sites. This is recommended in the Queensland Clinical Excellence Division 2018 paper on page 3, "Suggested actions for Hospital and Health Services". Becoming a parent for the first time is a life-changing event. Our role as healthcare professionals and as educators allows us the capacity to influence two generations of human beings. We have a responsibility to women, families and the community. Thank you.

Dr AMANDA COHN: Thanks so much for being here to share your expertise with us. I read in your written submission with some interest that you mentioned some of the issues with online education. Obviously, for some people that's now a preferred modality so they can do it from the comfort of their own homes. Sometimes that's created a mismatch between the models of care that are talked about in the education that might be quite remote and the models of care actually available to people. What would be the recommendations from your standards of care if there were accredited online resources that could potentially be statewide or national? How do we make sure that that aligns with models of care that are available locally for patients?

ALISON SUMMERVILLE: It's a good point. There are many online resources available. We know with COVID, that changed a lot with online. Some hospitals—and I think it's Levett's study; Karen might correct me here—looked at how the women engaged with antenatal education in COVID. They said some of them were okay online; some of them didn't engage at all. Some hospitals didn't participate in online education because they weren't resourced to do that. I suppose, depending on the modality of the online education—if it's live, that gives the opportunity for women and their partners to ask questions and get them answered; the content of that online, if they're doing modules; and their health literacy—we know that 60 per cent of our population's health literacy level is to about a year 9, so how they comprehend things. In rural and regional areas, that's okay if they're networking their service, their data, their access—do they have mobile devices? What devices are they using? For online learning, yes, it can be helpful, but there has to be a lot of work around the programs. Do you have anything to add to that?

KAREN LOGAN: There have been some programs that are standalone, where the learner progresses at their own rate and watches different videos and can revisit. They might go from early pregnancy right through to postnatal. They can be very useful for a self-directed learner. The problem is that unless they can then talk with an educator who is familiar with their care and fine-tune it to them, it still might be a mismatch. Again, if we have a video about certain services that are being provided and it's not provided in that local area, those women are still feeling that their care is not optimal. It's trying to find that blend. There are some good resources. The Clinical Excellence Commission released a collaborative video package that ran for three minutes that had a lot of the different stakeholders, and that's very useful to show in a program, to start the questions and then discuss.

Dr AMANDA COHN: You mention in both the written submission and one of the opening statements the BRAIN acronym, in passing. Can you talk us through what that is and how it works?

ALISON SUMMERVILLE: BRAIN: B for benefit, R for risks, A for alternatives, I for intuition and N for nothing. When we talk about that, B for benefits—the benefits to you as the pregnant woman, to your partner and to your baby of having this intervention or doing this action and going through that, and making the pregnant woman think about what she wants, because we're all different. We all come from different backgrounds. We've all got different knowledges. We've all got different experiences and different reasons for doing things. So it's what fits right for them. And then they can take that information back to their caregiver so it gives them some tools to be able to discuss. So I say, "Just remember BRAIN."

Dr AMANDA COHN: So it's a framework for someone to think through the information?

ALISON SUMMERVILLE: It's a framework, yes. It's not maternity-made; it's used a lot in businesses, if you're going to ask questions.

Dr AMANDA COHN: This is my last question. We've heard a lot throughout the inquiry, which I'm sure you've been following, about the critical importance of antenatal education and getting it right, so we're really grateful that you're here today. I have forgotten my question! Come back to me. I want to get it right.

The CHAIR: I will throw to the Hon. Sarah Mitchell while Dr Amanda Cohn remembers her question.

The Hon. SARAH MITCHELL: Thank you both for coming today and also for educating us, as committee members. I have to admit, I hadn't thought about the practice of registration for certified educators. In my experience, it was a local midwife who did it, so it didn't occur to me that it wouldn't be a regulated profession, in some respects. I just wanted to ask you a little bit about that—and you did touch on it a bit in your submission. In terms of the different qualifications that educators can have—or perhaps none, as you mentioned in your opening statement—what would some recommendation that the Committee could make around regulation look like? What do you think would be appropriate but not too onerous, and where would that balance lie if we wanted to look at a registration process?

KAREN LOGAN: It's a great question and something we struggle with. It has been a long-term goal for CAPEA to get some oversight of all parenting educators. At the moment, we don't have stats on this, so I would assume that the majority of educators have come from a midwifery training or physiotherapy background. Then other people will still come under the banner of parenting education, because our brief goes from early pregnancy right through to postnatal and child and family health nurses. So it's a very long continuum of care that we're talking about, and we have different skill sets and training for different areas of care.

How would it work? At the moment, when we discuss this with Kellie Wilton, the national midwifery adviser, she suggested we liaise more with ACM and MCAFHNA and see whether they can come up with some good, shared goals. But that doesn't necessarily cover the psychologists or the doulas or any other birth workers. Again, anybody can maybe do a doula course, or they can do standalone facilitation courses, like the hypnobirth; there's a whole lot of different commercial courses. That gives them that accreditation in that system, and they can call themselves a specific Calmbirth, hypnobirth or Lamaze educator, and that covers a little bit of governance,

because they then have to present under that umbrella. But again, there's a huge variation of people who will perhaps say, "Well, I have worked in this area. I have got some skills. I will set up a little business."

The Hon. SARAH MITCHELL: In terms of the concept of a national curriculum, which again is one of your recommendations—it's a very broad question: Where do you see the gaps at the moment in terms of that delivery of education for expectant mothers and families, both before and after birth? Is there anything that you think might be happening in other States that we're not offering here in New South Wales—that there's a bit of a gap?

KAREN LOGAN: Our Further Education Committee, led by Jane, has been looking at what they think should be a national curriculum. They looked at overseas curriculums and Australia-wide, and they have decided that the Queensland recommendations curriculum in that 2018 document is probably the best fit. So we would suggest adopting that. Even if we suggest and adopt a curriculum, how does a body go about making sure that the curriculum is taught? At the moment, different services will teach different parts of the curriculum. They might focus primarily on the birth skills part. They might offer different flavours. It might be a vaginal birth after caesarean. It might be a twin birth program, standalone. Sometimes it's a six-week program that covers parenting education. In the past, in Jane's doctorate thesis asking parents what they wanted, they said they wanted more education about what happens after the baby: how to be a parent.

That's why parenting education changed more from just birth skills to the whole continuum, and then it has now been looking at, "Well, what about if different services offer different combinations?" If you offer those different components and people opt in, people don't know what they don't know, so people can still slip through the system. But if there is online education that is centre-held by the New South Wales maternity system, people can go and look at that, if they choose to. But here are a lot of grey areas. I don't know if Alison wants to speak more to this.

ALISON SUMMERVILLE: I was just thinking, as you were saying it—we're looking at, probably with the online education, white middle-class women that can financially pay for it. We're missing a huge chunk of our community. I do know of individual sites that support Aboriginal women and do their own education with them, but that would be very few. We're also looking at young mums, vulnerable dads groups. There's a lot involved in it. A curriculum would cover all that, but how do you monitor it? How do you govern—

The Hon. SARAH MITCHELL: It might need a local—specific approaches, depending on different communities as well.

ALISON SUMMERVILLE: Yes. That's why having an area health service with, say, a clinical midwife consultant in that area or site-specific—that would probably require some expert and some governance around it, making sure that curriculum was being implemented and also the frameworks. We can say the framework—the connecting, listening and responding documents are there and it has got a lot of stuff about education in it, but how does CAPEA know that's happening? And we've put that in our document.

Dr AMANDA COHN: Thank you for coming back to me. My question was about the evidence base for the education program itself. Throughout your document, you refer to "evidence-based"—I assume in the content of the medical information, which is excellent. It does make intuitive sense for people to feel more informed and more confident to navigate the birthing situation, that that would reduce trauma. But has there been any longer term evaluation that people who go through an accredited program report fewer post-traumatic symptoms six weeks or six months down the track? Has anyone done that length of follow-up?

ALISON SUMMERVILLE: I think there are maybe short studies.

KAREN LOGAN: The studies are dependent on where they're being funded by and who they're being administered by. You might have different stakeholders within that whole birth area doing different studies. It's great to get collaboration, like the clinical excellence committee, on bringing in all those stakeholders and their individual research to find what is the best way of sharing the information at the appropriate level.

Dr AMANDA COHN: Thank you. That sounds like something the State Government could be facilitating.

The Hon. EMILY SUVAAL: Thanks to you both for appearing today and for your submission and the additional document. I'm really sorry to hear about the loss of your colleague. It's really sad news.

KAREN LOGAN: She would've been here.

ALISON SUMMERVILLE: Yes, she would've been sitting here.

The Hon. EMILY SUVAAL: A real loss. My condolences. Obviously there is a need to improve the information that is available and provided for women in the antenatal and postnatal care period. What method is the best way? What are your thoughts on that—online, websites, classes?

KAREN LOGAN: All of the above, because there are so many different ways people choose to learn and engage. For example, some programs have continued on with online—a hybrid with face-to-face—and for some people that's very convenient. If they're a FIFO worker, have difficulty travelling, that can be a really great way of learning. Other people prefer the face-to-face. Other people prefer face-to-face with a very specific brief of mainly the birth. Again, I think the learners need to choose, but I think we need a balance of evidence in those supporting documents and for that to be available for women to review.

The Hon. EMILY SUVAAL: We heard earlier this morning about written publications, around information. What are your thoughts around that—fact sheets and all of that sort of thing?

ALISON SUMMERVILLE: Look, there are so many fact sheets out there and a part of it, with health literacy and consumer engagement—I think much to do with that but with national standards too—is reviewing all those and reviewing them on a three-yearly basis and making them consumer friendly. There's a lot of work around that for each site. I do think they have a place because some people do like hand sheets, fact sheets. But standardising them—and that's actually one of the points in the Connecting, Listening and Responding document: standardising antenatal information sheets. Again, that's left up to each site or health district. I do think they have a place. QR codes have become very popular—scan on the QR code. And probably a part of people wanting the—they're sick of QR codes. And, again, what device do they have? Can they read it? Are they going to read it? "Oh, this is too much information", so, yes, there's a good spot for fact sheets.

Again, as Karen said, the Clinical Excellence Commission has produced some beautiful films. That may be one way people learn. The adult learning series are quite vast. It's a part of having that educator but selling that from the initial antenatal appointment: the value and the worth for you to do some more education in your pregnancy. That's important. I don't know how CAPEA does that at the coal front. How do you get the midwife or the medical officer seeing that woman for the first time to sell the value of birth and parenting classes? And giving the woman the options, too, I think.

KAREN LOGAN: I think if quality education is on offer and it's reasonably connected with the provider, then women will take it up. There's a lot of social media chat about different programs. Women are learning a lot through social media. There are also great resources federally that are easy to access. Pregnancy, Birth and Baby, I think—

ALISON SUMMERVILLE: Pregnancy, Birth and Baby. It's a national site.

KAREN LOGAN: And instead of having to read the information, you can click on it and it reads it to you. There are great resources out there, but as a skilled facilitator you have to be aware of all of these little fragments of information and then pull them in and weave them together at the appropriate time and level in that program with the learners that are sitting in front of you. And the learners in front of you can be ranging from people with a planned caesarean to people who are planning a homebirth, to people who are having complications, and their goals are changing quite quickly in the six weeks or two nights that you might see them.

The Hon. EMILY SUVAAL: If we were to recommend a standardised antenatal education program in New South Wales, what topics would that cover and how should it be facilitated?

KAREN LOGAN: Great question.

ALISON SUMMERVILLE: Yes, it's quite vast.

The Hon. EMILY SUVAAL: Sorry.

ALISON SUMMERVILLE: That's okay. Does antenatal education begin right from early, early pregnancy? It could look at early pregnancy programs. Then you're looking at pregnancy itself, you're looking at birth—so what's happening in pregnancy, changes that are happening. Maybe touch on our maternal health initiatives like smoking, alcohol drinking and gestational weight gain. All those things can be covered early in pregnancy, and then your birth and parenting programs would cover the actual pregnancy, birth and immediate postpartum period: who can you connect to in the community after you've had your baby and the resources out there in the community.

I think there is a niche for dads' programs, probably without a woman facilitating or without their partner with them. And also, with our Aboriginal women, having Aboriginal maternal health workers involved with the program. The curriculum may follow the same, but their actual lesson plans and how they implement that curriculum will be vastly different for each group. I think it goes right through to baby and parenting relationships.

Our programs have changed a lot in the 25 years. We do a lot more on relationships and trust with your partner—what does that look like in pregnancy and what does that look around birth, and then afterwards. That's probably a big change in parenting education. Karen said earlier we've changed from birthing classes or antenatal classes to add parenting on to the end of that—so the importance.

The Hon. EMILY SUVAAL: It sounds like there are two different sets. There is the early pregnancy but then also this sort of continuum and the need for that birthing education also. Would it be two separate groups?

ALISON SUMMERVILLE: I think early pregnancy you wouldn't need to do many hours, and birth and parenting—most birth and parenting programs would run for 10 or 12 hours. In that time, especially if you're face to face, you develop a community with the people in the group, and then that is so powerful. They've got that community. They've got someone else that's experiencing what they are going through.

The Hon. EMILY SUVAAL: How do you strike a balance between too much information and not enough? That is obviously key: sharing enough so that people are informed and prepared but also not providing unwanted or unnecessary information, if you like.

KAREN LOGAN: I think in a face-to-face situation a skilled facilitator can gauge by the body behaviour, the attention, the questioning, the interaction between the group discussion. If it's a facilitator who is using a whole lot of different group discussion-type activities, there's a lot of time for parents to learn from each other. As an educator, you're pointing them to further resources for them to continue their learning journey, of their interest. And some people are not going to want to know more about certain parts, and that's their choice as well. It's trying to find that right balance when you've got a mixed group in your program—whereas if you know that all of the people here are planning a caesarean birth and want skills to support their partner in a caesarean birth, that's a completely different brief.

ALISON SUMMERVILLE: The other thing along with that is being aware if someone looks upset in your group or walks out of the room in the middle of the—knowing what to do with that.

The Hon. EMILY SUVAAL: It sounds like ideally it's a clinician, someone that has experience, but also an educator that is trained in the skills of adult learning.

ALISON SUMMERVILLE: Extra training, yes.

KAREN LOGAN: It's no longer didactic—that you've got the expert and you're the learner. It's a shared journey.

The CHAIR: I think that's a question that has come up a lot: How much education is the right amount of education? Your position is that having the right educator, a qualified educator who is part of this system, actually is the answer to that. It's sort of how long is a piece of string, because it's going to be completely different. The only way to navigate this is really to have a proper system in place that makes sure that that educator is aware of this and is able to change their process depending on who they're working with.

KAREN LOGAN: And I think women after they've birthed might say that they wish they had known more about specific things, but at the time that they were doing their programs they weren't ready to hear that information. Australasian Birth Trauma Association has been great at putting out programs to educate women as consumers, but also people working in the birth space. So, again, it's having enough resources to start the conversation and then letting the learner and their partner decide what parts of that they want to explore further. But having good, balanced education, even online as fact sheets that they can go to and hear extra information, statistics—I think statistics can be used really well but, again, they have to be suited to the area people are birthing in. Statewide stats aren't necessarily reflective of local practice.

The CHAIR: Absolutely. My colleague asked before about the BRAIN acronym. Just following on from that, can you talk through how that acronym can be used in regards to informed consent, because that's something we've talked a lot about in this inquiry, and how that helps make sure that somebody who is going through the birthing process understands informed consent and can advocate on behalf of themselves?

KAREN LOGAN: I think it's really important that the woman and her partner do have a birth plan. Some units do have as part of the woman's notes that she and her partner have gone away and written their birth plan, and then that is discussed at various times of the journey before it actually gets to birthing. Sorry, I have forgotten the question.

The CHAIR: It was just around the BRAIN acronym in regards to informed consent.

KAREN LOGAN: In teaching the BRAIN acronym in a program, everything is very calm, it's all quite academic. They're at a stage of, maybe, 32 weeks. If they've got those basic understandings of their rights and responsibilities as an engager of the service, so they could make an informed consent that they either do or don't

want certain procedures at that point, that can then be discussed with their caregiver on the way to the birth in terms of—way before the birth. Then, at the birth itself, that can be in their notes and it can be another point of discussion at the beginning of the labour, and that can then change. I think more training on informed consent for us as educators, because we're informing people of what the system is doing, and for the people—clinicians—working in the system and marrying that together would be great.

ALISON SUMMERVILLE: It's a decision-making tool, so then the decision-making tool at the time—it could be even used if it's an emergency: "Oh, BRAIN. Do we need to do this? Why am I doing this?" even though it's got to be quick.

KAREN LOGAN: That's where the N comes in. In that situation, is there time to do nothing? What is the time frame that a decision has to be made? And are they prepared—plan A, plan B and plan C—with the risks and reasons for them, personally, birthing? That's very tailored to the individual.

The CHAIR: Absolutely. Thank you. The other question I wanted to ask is with regard to your curriculum. Does it cover the rights of women in childbirth, including that idea of declining interventions or how to make a complaint? These are things that we're constantly hearing from individuals who have come forward to this Committee, about being lost in the complaints process but also not feeling they know how to decline interventions.

KAREN LOGAN: I think that training is happening as we speak. This is a very new topic in the birth space and I think it would be something that would be great to be part of the curriculum, and very sensitively handled. So I think that's a work in progress, not just for the curriculum as dictated by Queensland and perhaps to be adopted by us but something that we need to consider, and all the other training that needs to go around that for educators.

The CHAIR: I also wanted to ask about the different availability of antenatal education around regional, rural and remote areas as compared to Sydney. Could you talk us through that? I know we talked a little bit about online courses but, of course, different modalities will suit people differently. What are we looking at when we're looking at regional and remote areas of New South Wales and what do we need to be doing particularly to make sure we're supporting women there?

ALISON SUMMERVILLE: I'm happy to talk to that. It is hard because of the remoteness and also there are a lot of hospitals that don't have maternity anymore. There are only 13 maternity sites in New South Wales, and some of those have very limited maternity care; it might be only antenatal care. So it is difficult and, yes, online learning, whether that's a live program and maybe from the hospital that they're going to be birthing at so they get a bit familiar with the person on the other end—I don't know how this would work, thinking about it, but maybe even the educator from the hospital they're birthing at going to them.

I know some of the women in regional areas are in the car, driving 40 minutes for care or an hour for care. That's for their care, but if maybe the educator could go to them, making sure that there are venues and equipment and all the rest of the logistics behind it, that would be a lot easier than having a cohort of women having to drive an hour—one person. So that may be—I don't know about the really remote areas. That's not practical, probably, but that's where online education and making sure live online resources are there and they are funded.

The CHAIR: Definitely. Thank you.

The Hon. MARK BANASIAK: CAPEA has endorsed courses and endorsed providers. Are you, on notice, able to provide to the Committee a list or the number of those endorsed courses and providers, and perhaps the geographical spread within New South Wales? Are you able to do that for us?

KAREN LOGAN: Yes.

The Hon. MARK BANASIAK: Thank you. If we move towards this national curriculum model that you support and are involved in, where do you see CAPEA's role in that once we get a national curriculum? Would you want to be the quality assurance checker of that or would you palm that off to someone like ASQA who already does that work in a national space?

KAREN LOGAN: Are you talking actually going out and assessing hospitals?

The Hon. MARK BANASIAK: Yes, that's what ASQA would do. They would assess a training provider and the trainer. Is that what you would—

KAREN LOGAN: We're not an RTO. As a voluntary organisation, we can collaborate and we can make recommendations but we don't actually have the physical capability of going out and—

The Hon. MARK BANASIAK: In a situation where ASQA is involved, it's not the RTO that goes out and does the assessing; it's ASQA that goes out and does the external assessment.

KAREN LOGAN: Okay. That could be a good collaboration.

The Hon. MARK BANASIAK: So you would like to see ASQA do that, not yourselves? Even though you've developed these national competency standards, you've obviously carried this process all this way—I'm just wondering—are you happy to then hand it over to someone like ASQA and say, "You now deal with it"?

KAREN LOGAN: We would have to think about that and do more research. That's a new concept for us.

ALISON SUMMERVILLE: Yes.

The Hon. MARK BANASIAK: Okay. Thank you.

The CHAIR: Thank you both for coming today and providing your evidence. It's been extremely useful and beneficial for the Committee, so thank you both. There were some questions taken on notice, which the Committee will be in contact with you about, and if the Committee has further questions we'll be in contact with you about them as well. Did you have something you wanted to add?

KAREN LOGAN: Just with the notice question, is it providers as in organisations providing a package or are we talking about certified educators that you would like a list of?

The Hon. MARK BANASIAK: Whatever you've got. Whatever is easiest in terms of the format you've got, that would be great. Thank you.

KAREN LOGAN: Thank you.

The CHAIR: Thank you so much.

(The witnesses withdrew.)

Dr NAMIRA WILLIAMS, Chief Executive Officer and Educator, disAbility Maternity Care, before the Committee via videoconference, sworn and examined

The CHAIR: I now welcome our next witness, who is joining us online. Dr Williams, did you want to start with a short opening statement?

NAMIRA WILLIAMS: Yes, I do have an opening statement. It probably is a little bit longer but I hope you will bear with me. Thank you, firstly, for the opportunity to present evidence to this Committee on birth trauma. To begin with, I would like to acknowledge the Biripi peoples, the traditional custodians of the land that I'm on today, and pay my respects to Elders past, present and emerging. I extend that respect to all Aboriginal and Torres Strait Islander people here today. I would also like to acknowledge, value and appreciate the contributions of those with lived experience of disability. Their voices, together with those of carers and families, is crucial to creating an inclusive society.

As CEO of disAbility Maternity Care I also bring lived experience, with people in my family living with disability. I must specify that my evidence will be within my professional role. To give you some context, disAbility Maternity Care is a not-for-profit organisation and was founded by me in response to a need identified through both my findings of my doctoral research, as well as my professional experience as a midwife and personal lived experience. DisAbility Maternity Care aims for parents with disabilities to be equal and empowered citizens. This is underpinned by our philosophy that all people with a disability have the right to have relationships, consensual sex and to become parents, if they so choose, and that parenting is a learned skill.

Our organisation primarily provides education to a range of health, disability and other community organisation providers to increase their knowledge about disability-inclusive maternity care. We also support parents through raising awareness of issues, providing feedback and guidance on relevant documents, undertaking projects and working closely with our sister organisation, DMC Support, to connect women to the NDIS and support them during pregnancy and into parenting.

Australian research shows that women with a disability contribute to approximately 10 per cent of birthing women—that is, one in 10 women giving birth in a hospital. Women with disabilities, and especially those with intellectual disability, have increased vulnerabilities. They experience higher rates of domestic violence, sexual abuse and a history of trauma within their lives than many of their non-disabled peers. They also have increased rates of perinatal mental health challenges, pre-pregnancy comorbidities, caesarean section rates, stillbirth, and removal of their children from their care. For example, approximately 40 to 60 per cent of women with intellectual disability will experience having a child removed at some point in their lives, either straight after the birth or during early childhood.

Despite these statistics, women with disability are marginalised. Many of these mothers experience trauma from the beginning of their pregnancies. They may often be pressured into terminating their pregnancy by providers or family. A lack of appropriate maternity programs to support them creates an environment where women often feel judged, unwelcome and unsupported. We have five recommendations for improving the experiences of maternity care and reducing trauma for women with disabilities. These are, firstly, for appropriate models of care to be developed and implemented, supported by long-term funding that meets the needs of women with disabilities. This particular group of mothers are often actively excluded from continuity of care midwifery programs. This results in them not having an environment where they can develop meaningful and trusting relationships with their maternity providers.

In turn, when providers don't know women, it increases their perceptions of the woman's risk. Women also have to retell their story again and again to new maternity staff or choose not to disclose their story again, leading to lack of appropriate supports being implemented or reasonable adjustments made to accommodate their disability. Having to retell your story means revisiting the trauma experience. Women are notified to child protection services. Continuity programs would allow for greater transparency by both mother and child protection care providers.

Our second recommendation is that training programs on disability-inclusive maternity care be implemented in all government and non-government organisations. Such training should be co-designed to inform professional knowledge and practice skills. Many women experience negative attitudes from care providers that they interact with, many of whom have limited understanding of disability or making reasonable adjustments within the maternity care. Despite their vulnerabilities, they're often invisible within maternity care policies.

Our third recommendation is that maternity risk assessment tools be developed specific to the needs of mothers with disabilities and include reasonable adjustments; the development or adoption of existing tools that enable providers to provide a safe space to ask and allow women to disclose their disability. Unless women feel

safe to disclose, they will often hide their disability. As stated previously, research says about 10 per cent of women, but these statistics are likely to be higher as women may choose not to disclose their disability. Data collection in this area is poor, which means outcomes for this group of mothers is not highlighted nor funded appropriately.

Recommendation four is that appropriate long-term funding be allocated and quarantined to co-design pilot projects that will trial appropriate models of care to meet these mothers' needs. Such projects include participation from women with disabilities through all phases of the project, from inception to evaluation. Like other vulnerable groups, such as First Nations women and women from culturally diverse backgrounds, women with disability need long-term funding committed. This is especially important where women have babies or children removed from their care.

Our fifth recommendation is the inclusion of women with disabilities in working parties to review existing maternity policies and the development of future disability-inclusive maternity care policies. Failure to include this group of mothers leads to further trauma, as it devalues the opportunity to contribute to agency within their lives. With the implementation of these recommendations and the outcomes for mothers and babies, the trauma experienced would be significantly reduced. Thank you.

The Hon. NATASHA MACLAREN-JONES: I just wanted to ask if you could provide a copy of that statement you gave?

NAMIRA WILLIAMS: Yes, I have already.

The Hon. NATASHA MACLAREN-JONES: Thank you. You mentioned that you refer some of the people who come to you to NDIS if they don't have plans in place. I was wondering if you had any stats, whether it's on a yearly basis or shorter, about the number of people that you have needed to refer and some of the reasons why they're not accessing a plan to date?

NAMIRA WILLIAMS: I don't have any statistics on that. Our sister organisation is still fairly new. But yes, we do have referrals. The reason we get referrals, often, is because mothers may be managing without an NDIS plan. They can manage quite well, particularly if their disability is invisible or if they have an intellectual disability and it's mild. They can often manage to get by in their life by themselves, but once you add pregnancy and a baby into the mix and are looking at supports for them, that becomes quite a challenge. The referrals that DMC Support has had have often been around identifying a woman's disability, for a start—the providers have picked up that something's a little bit different, or they may have a mental health disorder that they're not coping with that's been exacerbated during pregnancy. They're the sorts of reasons that women are referred for access to NDIS services.

There are women, particularly those with intellectual disability, who feel that when they actually access services that they are often stigmatised by doing so or that they feel that their risk perception increases. If they actually ask for support, then the perception of providers is that they won't be able to cope with their baby, and the sequence of events or the cascade of intervention, with child protection, can often occur then.

The Hon. NATASHA MACLAREN-JONES: That leads to the next area in which I'm interested. You mentioned there is concern or the mother feels that there is risk with child protection. What interaction do you have with DCJ when a client comes to you to provide that wraparound support, or do you have any involvement with DCJ now to work with mothers that come to you?

NAMIRA WILLIAMS: Under the DMC support, I do. I also work for them part-time as a support coordinator. Yes, I do work with DCJ for particular mothers, and I have a couple of mothers at the moment that I'm working with. So we work quite closely together.

The Hon. NATASHA MACLAREN-JONES: Do you find that there is, I suppose, a concern or that some mothers might be reluctant to come forward to see you because of that concern that child protection may become involved?

NAMIRA WILLIAMS: I think there is that from mothers that I haven't been involved with or that our organisation hasn't been involved with. Our organisation states up-front that we're mandatory notifiers but that we will always discuss any concerns or risks in their behaviour that we have with them first before that notification so that we are very transparent as an organisation around our work with mothers.

The Hon. NATASHA MACLAREN-JONES: Are there any recommendations for this Committee about how we can engage with mothers with disability to increase their awareness about the supports that are available to reduce that fear of coming forward and seeking support?

NAMIRA WILLIAMS: I think it's about child protection services being very transparent and working with mothers to meet their needs, whatever those needs may be. Sometimes it's actually about stepping outside, perhaps, some of the work roles, I should say. It's not transgressing the boundaries of your work role, but it's actually going that extra mile to support the mother that actually develops that relationship with a mother, because a lot of these women are really quite untrusting of many services—not just child protection, but maternity services. That's why one of the recommendations around continuity of care programs is vital, because it actually allows that mother to then develop a relationship with a primary care provider—usually a midwife—who can then actually get to understand what's going on in that woman's life.

The Hon. NATASHA MACLAREN-JONES: That brings me to my next question, which is also my final one, in regard to your involvement with NSW Health now and what improvements need to be made, because they do have their maternity plan, but it doesn't specify disability. I'm interested to know what recommendations you have to increase care and support through NSW Health.

NAMIRA WILLIAMS: I'm a member of the NSW Health maternity networking group. Another hat that I have is actually my chair hat on the ACI Intellectual Disability Network, as a co-chair for the carers advisory group, so working really quite closely with the ACI in that space. Even though it's wearing a carer's hat, I do try to contribute in terms of changes in the maternity space.

The Hon. NATASHA MACLAREN-JONES: Is there anything specific that you think NSW Health could be doing better?

NAMIRA WILLIAMS: I think there are a lot of things that NSW Health could be doing better. I think the first step is developing a committee to actually look at developing disability inclusive policies and practices, and that needs to be co-designed with women with disabilities, which is crucial.

The CHAIR: Before I throw to Dr Amanda Cohn, the Committee has received a document from you, Dr Williams, *Working with women who have a disability*. Did you want to table that document with the Committee?

NAMIRA WILLIAMS: Yes.

The CHAIR: Wonderful. Thank you. Dr Amanda Cohn.

Dr AMANDA COHN: I'm just picking up on the line of questioning around hospitals. It was reported in the ABC that a quarter of public maternity hospitals in Australia report adequate services for women with disabilities, so we can read into that it's three-quarters that don't. Could you perhaps speak to some of those specific services that are commonly missing? In your work advocating for improvement, what are some of the barriers you've seen to implementing those services more widely?

NAMIRA WILLIAMS: In looking at maternity services, I guess you're looking at three to four critical areas: pregnancy care; birthing care and postnatal services; and also high-risk services—so when women are identified with high-risk medical concerns. I think, particularly in pregnancy, women with a disability are not well identified within maternity services at this point in time. As I said, at the moment the research from the study in Victoria shows that approximately 10 per cent of women—and I think in the UK approximately 13 per cent of women—have been identified with a disability.

Certainly improving data collection services, but in order to ask about disability, maternity services need to provide a safe space for women to disclose their disability. They need to feel that they're not going to be judged about their disability or that they're not going to increase their risk, particularly of child removal, around the disability. Having programs, particularly continuity-of-care midwifery programs, for women with disabilities, regardless of type of disability, and having accessible maternity units so that women, regardless of their particular disability—I mean, how often do we see information provided in adjusted formats? We're just starting to see some easy English formats around information for women with learning or intellectual disabilities, but it's quite difficult, I think, for maternity services to contact hearing interpreters or to provide information about pregnancy, birth and postnatally for women with vision impairments.

It's also having rooms that are actually accessible for women with a physical disability and to be supported in that way. Do the midwives understand the importance of pressure area care for women who have a spinal cord injury? Are there options for women with chronic disabilities or disabilities that encompass pain? How is that managed through the birthing process? What options are there for women when they actually go home with their baby to then be followed up for some intensive parenting support? And to work closely with NDIS providers.

Dr AMANDA COHN: Thank you. That was an extremely comprehensive answer to the first part of my question. That's all right. I'll just jog your memory. The second half was: In advocating for the things you've just listed, what are some of the common barriers you come across from public maternity services?

NAMIRA WILLIAMS: I think a lack of knowledge by staff about how to make reasonable adjustments for the woman's disability. I must say, recently, in my role as support coordinator, I've had one hospital where a clinical midwife specialist has contacted me for an NDIS participant who's currently pregnant and said, "What can we do to help?" So we had a very long conversation around how to actually meet this particular mother's needs—being aware of this particular mother with autism and setting up the environment so that when she comes in to give birth to her baby, how the midwives can accommodate her needs and reduce sensory input, because of her autism. That's just one example, but I think that is an example of where it has worked well. The care provider has contacted the NDIS support service as well and said, "Okay, what can we do together to put things in place for this particular mother so that we're setting her up to succeed, both for her birth and for when she goes home?"

Dr AMANDA COHN: That's a great example of that system working well. For all of the other parents who haven't had that kind of experience, is it that the health providers just don't know that your service exists or ring? Is it that they don't have enough resources or that you don't have enough resources? What's preventing that from happening every time?

NAMIRA WILLIAMS: I think it's partly that some services don't know that we exist, particularly those rural and remote services. Others are about providers not potentially wanting to go the extra mile, or having their own values or attitudes affecting their ability to work. That's one of the things that I found, actually, in my research. There were comments made by staff that were really quite stigmatising, particularly to women with intellectual disability.

The Hon. SARAH MITCHELL: Thank you very much, Dr Williams, for being here today. I was having a look on your website prior to today, and there's a section where you talk about the trauma—I think you call it disenfranchised grief—of women with intellectual disability who come home without their baby in the interest of having that child cared for by someone else. I thought that was an important concept. We have spoken a lot about birth trauma, but that hasn't been something that the Committee has considered. Do you think there are sufficient supports in place for women and families when that does occur? Are there recommendations the Committee could make for better support for families in those circumstances, in your experience?

NAMIRA WILLIAMS: I think there is a lack of services in supporting women through that process. I think it's important to try to put supports in place during pregnancy, so that in situations where a mother or a father are unable to care for their baby full-time, they're aware of that prior to it happening. So often what I hear from providers is that child protection services will not—that the parents don't know prior to the birth, and then after the birth, child protection services step in and the baby is assumed for care. Of course there's a lot of grief around that. But the disenfranchised grief occurs because then there's a perception by staff within the maternity unit that that mother or parent doesn't deserve to grieve because she wasn't able to look after her baby first. I think, because of that, it increases the trauma that women experience as opposed to, if everybody is transparent, women understand up-front what is going to happen.

For example—I'm just going to put my midwife hat on for now—this is probably one of my really early experiences around caring for women with disabilities. I was asked to care for a woman who came in to accident and emergency who was 26 weeks pregnant who was having a psychotic episode with schizophrenia. She was admitted to the mental health unit. She was actually retained as an inpatient until she gave birth, but I was involved because I was the lead clinical specialist in antenatal care for our particular hospital, providing her midwifery check-ups but also liaising around what would happen when her baby was born. She'd had two previous children—this was her third—and her two other children were in the care of her partner. They had subsequently split up quite some time ago. They were older, her other children. But there was a very clear plan for her.

She realised that she would not be able to safely look after that child and she actually wanted to adopt the baby out. But child protection services suggested that rather than adopting the baby, which wouldn't have allowed her to have the baby back in her care at some point if she became well again, the baby go into foster care. There was a very clear plan for when she gave birth in terms of even just holding the baby, being in the maternity unit, whether she decided to breastfeed or not for a day or two. That was all planned during the pregnancy. So, when she actually had her baby, it worked really well. Even though she didn't get to take her baby home and experienced that grief, everybody was on the same page and she had an understanding before she gave birth that this is the process and what would happen.

The Hon. SARAH MITCHELL: That's useful information, thank you.

The Hon. EMILY SUVAAL: Thank you so much for appearing today and for your submission. Can you advise the Committee what we could do to ensure that the information and care that is provided, certainly by NSW Health, is inclusive and supports the needs of pregnant women with disabilities?

NAMIRA WILLIAMS: I think the primary way to do that is to actually include women with disabilities as key stakeholders in developing any programs. That is whether it's a continuity of care program, whether it's looking at resources and developing appropriate resources—whatever you're doing needs to include women with disability as key people in making the decisions around that.

The Hon. EMILY SUVAAL: You mentioned earlier that a committee should be set up. Is that what you would anticipate had that lived experience aspect, if you like?

NAMIRA WILLIAMS: Definitely. That's right.

The CHAIR: Earlier, when you were speaking with Dr Amanda Cohn, you gave an example of a unique experience of a woman with autism giving birth in the hospital. I assume you speak with a lot of people with disabilities who are giving birth through the system. I don't know if it's appropriate to give examples or not, but are there some examples that you're able to give of where you've heard things go wrong, so that we can better understand the unique experiences of these women? And then maybe some more examples of where it has gone right? I think that would be really beneficial for us to understand this in context.

NAMIRA WILLIAMS: To give an example of a comment made by one woman with a physical disability who had a planned caesarean birth, one of the things that she commented on after her birth was the fact that nobody had talked to her about the fact that having a caesarean would bring all her previous hospital trauma to the surface again. While she was actually lying on the operating theatre table, she experienced a lot of the trauma that she had felt previously. She had actually had multiple surgeries as a child for her disability. The caesarean had caused a lot of that anxiety to resurface. But nobody had actually talked about that with her at all, prior to the caesarean birth, as part of the planning for caesarean birth. I guess that's one instance where maternity services could improve. In terms of positive experiences, I gave you the experience there of a mother with autism. I think, unfortunately, the positive experiences for many women with disabilities are just not there.

The CHAIR: My next question was whether there any disability-friendly maternity wards, or wards that are doing the right thing—but it almost sounds like it just hasn't become part of the conversation yet.

NAMIRA WILLIAMS: I think there are champions of change within maternity units. We connect with a lot of those because they are providers who are wanting to change the way things are provided for women with disabilities in maternity care. I think there are maternity units who are doing a little bit here and a little bit there, but there is no overall unit that I think is doing extremely well across all areas.

The CHAIR: What are those maternity wards that you would describe as the champions of change doing? Is it just that they're reaching out and keen to learn what they need to put into place or is there more than that being implemented?

NAMIRA WILLIAMS: No, I think it's often individuals who are champions of change rather than necessarily maternity units per se.

The CHAIR: Can you also talk us through the different risk factors or concerns? We've talked a lot about intellectual disabilities and also physical disabilities. Can you talk a little bit about the difference between those concerns and risk factors for women who have an intellectual disability compared to, say, a physical disability?

NAMIRA WILLIAMS: I think people often feel more comfortable with—well, I should say, providers to some degree feel more comfortable with women with a physical disability or a hearing or visual impairment disability rather than intellectual disability. I think a lot of that comes from our history where people with intellectual disability and mental health disorders were often incarcerated. It's within the living memory of providers still and so I think, because of that, that's one of the differences. Providers may feel uncomfortable talking about intellectual disability, so they may not necessarily know how to have a conversation about an intellectual disability. If they think that there's something a little bit different about that particular mother, they don't know how to lead into having a conversation, as opposed to where you have an obvious disability, then you can actually have a conversation about it because it's a lot more apparent to the provider when that woman comes into the room—whether she's walking with a walking stick or a walking frame, or is in a wheelchair, if she needs guidance if she's visually impaired. I'm not sure if that sufficiently answers your question, sorry.

The CHAIR: No, that's alright. It's still very useful, thank you. It's interesting, hearing your answers today, you're talking about a lot of the same things that we've heard throughout this inquiry: trauma-informed care, informed consent, education. How do we make sure that these recommendations also specifically address the unique concerns of individuals with disability who are giving birth in these systems? How do we make sure that these quite broad recommendations are also tailored?

NAMIRA WILLIAMS: I think it's quite a challenge. It will be quite a challenge for NSW Health to ensure that all of the recommendations that are made are implemented. I think the key issues to look at, really, are

around education of providers, the people who actually interact with women, around skilling them up and also ensuring that maternity units actually do provide disability-inclusive care from the perspective of when they're going through that journey of maternity. So I think the first step, really, is undertaking an audit of maternity services, looking at how maternity services can be classed as disability inclusive or disability friendly. Having a specific group of parents with disabilities steering that is crucial.

The CHAIR: Thank you. We do have a few more minutes if any of the Committee members have further questions. You're all good? I might finish with one last question regarding the recommendations that this Committee will make. There are two parts to it. First, is there anything you wanted to address today that you haven't been asked by the Committee? I invite you to make those comments now. Second, I know that in your opening statement you talked about some of your key recommendations, but are there any recommendations that you would really like to highlight and to see in the Committee's report to the Government?

NAMIRA WILLIAMS: Thank you. Perhaps I could go back to the terms of reference for the Committee. It would be wonderful under paragraph 1 (d) for women with disability to actually be included in that. You've listed a whole range of other vulnerable groups of women, so I think that would be really important. In terms of other recommendations, I think the five recommendations that I have suggested today are really key to changing maternity services. I think the commitment to long-term funding is really important for any programs that are developed for women with a disability. So often, programs are funded for only a couple of years and then, depending on whether the program actually shows a positive outcome from the data, it either continues to be funded or that funding gets pulled back. I think for women with disabilities that it's crucial to have long-term funding.

The CHAIR: Absolutely. Thank you so much for your evidence today. I'm not sure if there were any questions taken on notice, but the Committee might have further questions, in which case the Committee secretariat will be in contact with you about those. Thank you again so much for your evidence and for your time today, and for all the work that you're doing. Thank you, as well, for the information that you've tabled with us today.

NAMIRA WILLIAMS: Thank you for the opportunity.

(The witness withdrew.)

Ms ALYSHA-LEIGH FAMELI, Registered Psychologist, and PhD Candidate, University of Sydney, affirmed and examined

Ms SAHRA BEHARDIEN O'DOHERTY, President, Australian Association of Psychologists Inc., affirmed and examined

Ms PIETA SHAKES, Executive Director, Through the Unexpected, affirmed and examined

The CHAIR: I now welcome our next witnesses. Ms Shakes, do you have a short opening statement that you'd like to give?

PIETA SHAKES: No.

The CHAIR: Ms Fameli, do you have a short opening statement?

ALYSHA-LEIGH FAMELI: Yes. Thank you to the Committee for inviting me to participate today, and thank you to the mothers who have participated in this birth trauma inquiry in the thankless labour that is recalling your difficult and at-times horrific birth experiences. I hope that the outcomes of this inquiry will be worth your emotional labour. Birth trauma has a ripple effect, as emphatically stated for 20 years by pioneering birth trauma researcher Cheryl Beck. Traumatic births profoundly impact mothers, infants, the mother-baby dyad as a unit, partners, and the healthcare professionals who bear witness to—and at times, often due to systemic pressures, are complicit in—traumatic births.

Maternal psychopathology is one of the biggest predictors of child social and emotional outcomes. Maternal morbidity data—that is, any death, medical or otherwise, during pregnancy, labour, birth and 42 days postpartum—is recorded in Australia. From 2012 to 2021, the fourth leading cause of maternal death was suicide. Birth trauma is a social, political and public health issue. Adverse childbirth experiences impact not only mothers but their babies and can be considered one of the earliest adverse experiences of childhood, through not only the experience itself but the rippling impact on the mother's wellbeing and her capacity to attune to and bond with her infant.

In Australia, women can access 10 Medicare-subsidised psychology sessions per year, as can the general population. The Medicare rebate for registered psychologists was subject to a freeze in rebate increases for several years. In the last decade it has only increased by approximately \$5 per session for registered psychologists. For this reason, women currently often incur substantial out-of-pocket costs to access mental health care. Not only this, but 10 sessions are vastly insufficient for the treatment of trauma. Given that the mother-baby dyad is inextricably linked at this time, often psychologists have two clients—the mother and the infant—to consider.

I urge the Committee to consider making midwifery continuity of care models the gold standard and the primary model of care. I urge the Committee to consider raising the rebate for all psychologists to at least \$150 per session and abolishing the two-tier system. I urge you to consider extending the number of Medicare psychology sessions available to mothers to 40 per year, in line with current practices for other sensitive mental health concerns, such as eating disorders. I urge you to consider reinstating the 20 sessions per year available during COVID so that birth partners and healthcare professionals can seek psychological care that is in line with best practice. No trauma therapy is remotely possible in 10 sessions per calendar year. It is in fact negligent, at times, to embark on this work without being able to ensure it can continue.

It is also crucial that psychologists, who have extensive training and experience working with trauma, are included in the development of trauma-informed care principles as well as in the implementation of training for maternity providers. I urge you to consider developing legislation around the process of gaining truly informed and non-coercive consent in the maternity context and legislation to mitigate obstetric violence. Finally, I urge the Committee to consider the need for culturally sensitive birth practices. When birth is emotionally, culturally and physically safe for our First Nations women, who experience maternal morbidity rates at three times higher than non-Indigenous women, we will all be better off. Thank you.

The CHAIR: Ms O'Doherty, did you have a short opening statement you'd like to make?

SAHRA BEHARDIEN O'DOHERTY: Yes. Thank you all for inviting the Australian Association of Psychologists to speak about the pressing issue that has touched the lives of many, yet which often remains shrouded in silence: the trauma experienced during birth. Traumatic events can range from instances of obstetric violence, insufficient communication, to the physical and mental health complications encountered during, before and after birth. The repercussions of these traumatic experiences are profound, leaving lasting psychological impacts on women, their children and their families, necessitating high levels of care and support.

Approximately 3 to 5 per cent of women have reported experiencing physical and emotional distress due to poor treatment during childbirth, a figure that is alarmingly high. This trauma is not confined to the immediate aftermath but can extend far into the future, affecting their mental health and familial bonds. The urgency of addressing this issue cannot be overstated, as the availability of and systemic barriers to trauma-informed care remain a significant concern. These barriers are particularly pronounced for those in regional, rural and remote areas, for First Nations People, culturally and linguistic diverse groups, LGBTQIA+ individuals, young parents, and people with disabilities, who all face unique challenges in accessing timely, comprehensive and culturally sensitive maternity care.

The physical, emotional, psychological and economic impacts of birth trauma are far-reaching. In the short-term, physical injuries can impede the postnatal recovery process, while the emotional toll can hinder the vital bond between a mother and their newborn. Long-term effects such as PTSD, anxiety and depression can severely impact one's quality of life, placing an additional financial burden on families and the healthcare system. Moreover, the stress and burnout experienced by healthcare professionals involved in traumatic births underscore the pressing need for improved support and resources within our healthcare infrastructure.

To address the complexities of birth trauma, AAPi underscores the necessity of a multifaceted approach. This includes reversing cuts to Medicare-subsidised psychology sessions and advocating for the inclusion of provisional psychologists in providing Medicare-rebated services. Additionally, AAPi recommends ending the two-tier Medicare rebate system for psychologists, thereby ensuring that all individuals, regardless of their geographical location or socio-economic status, have access to the mental health support they critically need. Furthermore, incentivising mental health practitioners to serve in rural and regional areas is crucial in mitigating the current demand and enhancing the overall quality of care.

In conclusion, the journey towards healing and prevention requires our collective commitment to implement legislative policy and practical reforms. By embracing trauma-informed care, respecting the diverse needs of birthing individuals and ensuring equitable access to mental health services, we can forge a path towards a future where birth trauma is no longer an issue. Together, we can safeguard the mental health and wellbeing of individuals and families across New South Wales, transforming their experiences of birth into ones of empowerment, safety and respect. Thank you.

The CHAIR: I will start with a couple of questions. Ms O'Doherty and Ms Fameli, you both talk about collapsing the two-tier system within Medicare. Is my understanding of it correct, that clinical psychologists are getting one rebate and then other class of psychologists are getting—so if it's a counselling psychologist or a health psychologist, it would be different. Are you suggesting that, say, health psychologists would then go up to what clinical psych is currently rebated as? So those other classes are going up to where clinical is—is that how you're proposing it?

SAHRA BEHARDIEN O'DOHERTY: I'm happy to answer this question. The proposal that AAPi is suggesting is one where there is a singular rebate across all psychologists, because what we see in the training of all psychologists is that not all psychologists will have experience working in the perinatal mental health space. However, there are so many psychologists who do have experience and training in this space, whether they are registered psychologists, clinical psychologists, health psychologists, educational and developmental psychologists et cetera. What the AAPi is advocating for is one single rebate that actually exceeds the current rebated amount that clinical psychologists are currently able to provide. We're advocating for \$150 rebate per session across the board for all psychologists who are qualified to provide services in this space.

The CHAIR: What is it currently? What is it for clinical psychs currently and for other registered psychs?

SAHRA BEHARDIEN O'DOHERTY: For clinical psychologists, it's roughly \$136 per rebated session. For registered psychologists—that includes all other endorsement areas and all of the other psychologists, so that's about 65 per cent of all psychologists—the rebate is roughly \$93. There's about a \$40 gap between that. I also just want to call attention to the perinatal or pregnancy counselling rebates that Medicare allows. Only three Medicare rebated sessions are able to be provided under that service, and that could be in addition to the mental healthcare plan of 10 sessions. However, the rebate for this is substantially lower—it's only \$63 per session.

The CHAIR: That also takes me to the 10 sessions. Ms Fameli, I know you also mentioned that in your opening statement. I think we can understand why it's grossly insufficient. For the benefit of the Committee and also for the report and the information that we put together, can you talk a little bit more about why 10 sessions is not enough? For somebody that has never seen a psychologist or done any psych training, what does it mean to start 10 sessions and then stop?

ALYSHA-LEIGH FAMELI: Firstly, the reason it's vastly insufficient is that when you are engaging in psychology, you are needing to build a safe relationship with the person that you are working with. That is crucial.

It underpins all clinical outcomes, the rapport that you have with your clinician. It is unfeasible to expect that someone is going to come in and they're going to go, "Here are all the things that have happened to me in my life and how they might be contributing to where I am now," and be able to wrap that up neatly in 10 sessions. Often after 10 sessions—firstly, mental healthcare plans were meant to only be used for mild to moderate mental health conditions. That is not who we see.

If we're using markers like the DASS—the Depression Anxiety Stress Scale—that doctors get people to fill out and they come to us with, people are coming to us with severe and extremely severe symptoms that are drastically impacting their capacity to function. For mothers, it's impacting their capacity to support their babies and to care for their babies in an attuned way. Firstly, they shouldn't even be coming under a mental healthcare plan. They don't meet criteria, but there is no other way. In terms of trauma therapy, trauma therapy often involves more intensive approach. If we were doing best practice, sometimes things like EMDR therapy, we would be looking at two sessions a week for blocks of time—so two sessions a week. Once you've built rapport in 10 sessions, you are done within three weeks. It's not practical for anyone really, unless you were potentially coming in with a very, very mild anxiety or something like that, which you could probably benefit from other programs for.

The CHAIR: Thank you.

ALYSHA-LEIGH FAMELI: Can I also just add one thing. The other thing that I think is really of concern is that, as psychologists working with mothers in the perinatal space, we are working with mothers and often their infants, partly because mums often have to bring their babies with them but also because mothers are coming in with concerns about their capacity to meet their baby's needs, due to their level of distress. We essentially have two clients that we're caring for. We're monitoring the babies. When you are a perinatal psychologist, you are monitoring the baby. You're looking at them. You're looking at how they engage. So we're looking at them. They are not an official client of ours, but we have to consider their needs, maybe first and foremost, and then we have the mother to consider. Mental healthcare plans are not given to infants, primarily because an infant needs a mental health diagnosis to be given a mental healthcare plan so GPs aren't saying, "This baby has got adjustment disorder." Even if maybe clinically, as a psychologist, we would say that that would be reasonable to expect—if a baby is struggling to settle, struggling to feed or struggling to sleep, we might say this baby is struggling to adjust and would benefit from that, but it's just not done.

PIETA SHAKES: I will tap onto that. We did mention the non-directive pregnancy counselling. I guess, in my space, I am advocating for the psychosocial needs for parents who receive a prenatal diagnosis—so unexpected news about the development, health or genetics of their baby. At the moment, they need to then go and be diagnosed with a condition to be able to go and see people because the non-directive pregnancy counselling sessions are only three. They're hard to get into. GPs don't even necessarily think about prenatal diagnosis and referring people on. The rebate is limited. Just thinking of some of the people that I have provided peer support to during their diagnostic period, one was over eight weeks of fetal MRI and genetic tests, secondary consults. Sheer and utter distress during that time, and then a really traumatic termination of pregnancy where they weren't able to be contained and supported in the way that they needed to be at that time where everything just went really poorly. They're expected to cope with all that with three sessions.

The CHAIR: Wow.

ALYSHA-LEIGH FAMELI: It's per calendar year too. If you come in in January, you've got 10 sessions until January next year—

The CHAIR: You have a big gap there.

ALYSHA-LEIGH FAMELI: —which is a huge gap. Particularly, we're talking about families on maternity leave, often. They've often lost an income; they're on really reduced income. They just can't afford it.

The CHAIR: Absolutely. My next question is for all of you. We've heard a lot in this inquiry about trauma-informed care. I just wanted to hear from psychologists as to what trauma-informed care would mean, what it looks like and why it's so important.

ALYSHA-LEIGH FAMELI: I came prepared for this one. There are lots of studies about what trauma-informed care should actually be and how those principles can be used in healthcare settings. To my knowledge, there aren't studies about it specifically in the maternity sector, but we can apply other things like paediatric oncology, those kinds of principles. Essentially, there are six core principles of trauma-informed care. Number one is safety. That encompasses physical but also emotional safety as being equally important and valid principles. Trustworthiness—that's how much can this individual trust their care provider and the collaborativeness of that relationship.

There is choice. A lot of advocates will call this voice and choice. Does this participant have the ability to speak to their healthcare provider? Are they getting balanced information about their choices and options? We use statistics often in health care. Are statistics being explained to people who don't understand research? If someone says to you, "You have a 12 per cent chance of this happening," are they then telling you that you have an 88 per cent chance of it not happening? Because 12 per cent chance of something bad happening to your baby sounds very scary, whereas the inverse of that—88 per cent of it not happening—is a really different picture and might allow you to actually balance your options.

Collaboration: Is maternity care happening alongside the woman or is it happening to her? Often, in my practice—in my research as well, I've interviewed over 100 women about their traumatic birth experiences in clinical interview format. What I often hear is that it felt like things were happening to them. Not just in the moments where it's down to the wire, but from the beginning in pregnancy, it felt like things—they were just being dragged through a system. Empowerment: Do people feel like they have an opportunity to have a voice, that they have a say? Do they feel empowered to make choices? And then also respect for diversity—so cultural, historical and gender-based issues, just to name a few, that might actually come into play. There is a really great paper that has been released by an Australian colleague, Lucy Frankham. She looks at the Power Threat Meaning Framework applied to maternity care. That looks at what happened to you, how did you make sense of that, how did it impact you. That's a really valid and useful principle to be applying to maternity care that coincides with trauma-informed practices.

The CHAIR: Thank you. Ms O'Doherty?

SAHRA BEHARDIEN O'DOHERTY: Just in terms of adding to what Ms Fameli has already spoken about, the main thing that I want to emphasise here is communication. That's about having supported and additional communication for not just the birthing parent, but for the partner or other relatives or any support people who also may be involved. One of the things that I've come across a lot in my own practice has been the increase of birth trauma experiences from women during the COVID lockdown periods. During that period where their partners weren't allowed into the room, where they weren't able to clearly think through and discuss different sorts of issues that were happening during their labouring and delivery process, and that situation where they weren't able to gain additional support or have time, where the medical model insists that they need to be moving quickly through procedures—those probably were a lot of the issues that I saw in my practice. I think we need to be aware of not just verbal communication but written communication. Having translator support, as well, is another really big challenge for a lot of people that I work with.

The CHAIR: Thank you. Ms Shakes?

PIETA SHAKES: Thank you. If I can add, my PhD research focuses on parents who receive a particular prenatal diagnosis. Through that, we identified that often when a mother receives the diagnosis—this was focused on mothers, but I appreciate that there are more than just mothers in the room. When they receive the news, many mothers actually experience quite a disassociation at that time. We are expected, as mothers—and I was a mother who received a prenatal diagnosis, so I will say "we" in there—to understand the information being offered at that time and potentially make a decision to continue or end your pregnancy in one appointment.

Some of the people in my PhD drove from a regional area to the city fetal medicine clinic, sat down—they didn't know why they were there. They didn't know any of the news. They were given the news, left in the room for 10 minutes, came back—at 32 weeks pregnant, "Would you like to continue or terminate the pregnancy?" That was their one fetal medicine specialist appointment. We don't recognise the trauma in this, as it is. While we might have clinicians that are doing their best to be really empathetic in their communication and to slow down processes and things, there's no training about the psychosocial aspects of prenatal diagnosis.

We're working on that slowly but, without funding, it's very difficult. This has been an area that has been hidden everywhere. Thank you for even inviting us today, because it has been missed out of many other inquiries and reports. We don't have enough training and structure to even realise that there's this trauma in there. Studies say that 30 per cent to 50 per cent of mothers who receive a prenatal diagnosis and continue pregnancy meet full diagnostic criteria for PTSD down the line. We have a higher incidence of suicidal ideation. We have all of this stuff, and we are not aware of the trauma in that space. We don't have the systems set up to be able to navigate that trauma.

Trauma-informed care in this space is not just about—well, all of those other important things that are lost even while at screening when it's routinised and people don't even know what they're attending for. But it's recognising and slowing down the process and meeting the people where they're at, and being able to provide the individualised care, which is going to be different for different people who bring in different histories, different perspectives of the world, different perspectives of disability, different perspectives of their family. Trauma-informed care is coming back and meeting them where they are.

Dr AMANDA COHN: My first question is for the psychologists. Thank you so much for being here. We've had lots of discussions through this inquiry about the need to better identify people who have had previous trauma as they come into maternity care. I think in your submission, Ms Fameli, you mentioned the City Birth Trauma Scale. Could you speak to that a little bit? Is it a validated screening tool? How useful would it be to apply in that context?

ALYSHA-LEIGH FAMELI: Well, here is one I validated earlier, because this is actually one of the cruxes of my PhD. Sorry, I'm not supposed to make jokes in things like this. The City Birth Trauma Scale is a measure of childbirth-related PTSD. It was validated by Susan Ayres and her colleagues in the UK, and it actually maps onto the DSM-5 criteria for PTSD. It's in line with current diagnostic criteria, but it's modified for the perinatal period. My research looked at validating it with a big sample of Australian women. We had 705 women participate in that part of the research. We found that it is psychometrically valid. It does map onto the DSM-5 criteria for PTSD. International studies have found the same thing.

Eighty-eight per cent of women in my research said that they would be happy to fill out that as a routine part of screening during pregnancy and in the antenatal period. I think the tricky thing is that's a really great, valid measure. It's easy to administer. I have some concerns about who is administering it and what happens with it, because with any routine screening we then need to have a pathway and we also need to have someone interpreting that screening who understands mental health concerns and is able to understand the nuances of the presentation of PTSD. PTSD is a heterogenous mental health concern in that you can have five people with PTSD and they can have different presentations across the category groups. We also then have to tailor treatment to those people. In part, we need to be able to have trained mental health care professionals who can deliver that screening but then also who can provide wraparound continuity of care.

And this is where, I think, having continuity of care as a baseline is really critical, because if we do have midwives who are trained in screening and then have allied health professionals that they can refer to, then we actually have a system that works. If we're doing lots of routine screening and then we're not doing anything with it, then—well, that's what is happening. That's what we're doing right now. The City Birth Trauma Scale is great for looking at PTSD. It can be used for things like fetal anomaly. However, it is very aimed at—it uses the word "birth", so I would suggest that something different should be used there. Or that may be another area for research—would be actually adjusting a scale like this to look at things that can occur during pregnancy that can result in birth trauma.

Dr AMANDA COHN: Presenting the Committee with a validated screening tool is extremely useful, so thank you. I think you touched on this in your response, but I want to probe further. Applying that broadly when we haven't necessarily got the tools to actually follow people up appropriately, is there a risk that we could actually make things worse or retraumatise people by asking them those questions and then not doing anything with the answer?

ALYSHA-LEIGH FAMELI: That's an interesting question. I think that you risk more by not applying tools like this because then we never have the numbers, we don't know how many people are suffering, we don't know to what extent. In terms of questionnaires like this, often with informed consent we can actually help people to figure out themselves whether they would be okay to fill out questionnaires like this. If we say to someone, "You might actually start thinking about your birth and it could be tricky. Would you like to continue or not?" then they have an opportunity to say, "Actually, no. I don't want to." Definitely we shouldn't be willy-nilly handing out any screening for mental health, because any mental health screening can be very triggering. Many of the routine things we use, like the Edinburgh Postnatal Depression Scale, ask about suicidality and things that can be really distressing. I think the risk is actually in not screening for childbirth-related PTSD.

Dr AMANDA COHN: I have a question for Through the Unexpected. In your written submission you mentioned the PEARLS clinic for continuity of care post prenatal diagnosis. Can you explain how that clinic works and what it does?

PIETA SHAKES: I actually can't explain much about the clinic itself. I read about the clinic through one of the general articles that was sort of talking about it.

Dr AMANDA COHN: On notice, could you provide us with that journal article?

PIETA SHAKES: Yes, I could, actually. From the journal article, I understand it to be a clinic that looks at a specific anomaly group in a specific area. They do provide that continuity of care in that model, but it's time limited. The article did talk about significant gaps in care and trauma—funnily enough—before and after that care period as well, because it isn't continuous post-birth and obviously there's a lot of stuff that happens before getting into a clinic like that.

Dr AMANDA COHN: I was also really interested in the discussion in your submission of the experiences of rural and regional parents. Obviously, maternal-fetal medicine is extremely sub-specialised—typically only available in the city. But I think you've raised real scope for improvement in the wraparound support that we provide for parents and families so that that's not just a one-off appointment. I'm interested in your perspective on access to terminations as well, particularly in rural and regional areas. Is that something that we also need to improve so that people can access that closer to home?

PIETA SHAKES: Yes, and so that the links and those networks are formed that—providers tend to know other providers in their local area as well, so that becomes a way to access follow-up. Because if you come to a city clinic and have a procedure, then you go home to no-one—to no links, to no services. Even in terms of actually navigating that or who else is staying in the area, there's more costs, there's more disruption to work, there's more happening for people. But the access isn't just about the rural as well, because if you receive a prenatal diagnosis at a religious hospital they might have an objection to that. Then you need to sometimes find your own clinics and go down that path as well.

The Hon. EMILY SUVAAL: Thank you, all, for appearing today. I might start off with a couple of questions for you, Ms Shakes, in your role. I wondered if you could let us know how the Committee could better ensure that the information and care that is provided by NSW Health, for example, is inclusive and supports the needs of women and their families when they receive an unexpected diagnosis through their pregnancy.

PIETA SHAKES: The first thing is acknowledging that it exists. It has been overlooked in so many inquiries. It's a really complex space because it is so individual and two families that receive the same diagnosis can have vastly different experiences; they can have different experiences personally, different experiences with their networks, with their hospital. It's really complex. We have, at the moment, external systems really driving what happens in appointments, because we have genetic screening, which is advancing. But often that focuses on the tests. So even when we look at mass applications, they're always about funding the test, but there's no support that is also funded in that package. There's no focus on making sure that the providers who are referring people to screening tests have adequate education. It's just all hidden; it just happens. At the moment we have external forces impacting on the care that's provided in the clinics.

There's some research that we're doing at the moment with health and allied health professionals who support parents in the perinatal period. They have identified that they have been learning on the job because there's no specific training about this, as I said. So it means that these continually advancing tests are changing what's happening in appointments, but the structures actually in those appointments aren't changing to allow more time, to allow more processing, to allow more holistic support. It's quite different to years ago when there may have been different expectations of consumers in terms of the power dynamics and things, and maybe different expectations—or maybe it was just completely overlooked even. What's worse is where there was an assumption that if you receive a diagnosis you will have a termination: You'll get it done; it's a medical event. We move on, don't talk about it again—you're lucky you fell pregnant. That's historically, because screening was brought out for that purpose.

But now we have families who have really considered their options beforehand and considered what may happen. They're coming to their appointments and receiving unexpected news, and the delivery of news can be against—our national pregnancy care guidelines use a particular language of high "chance" rather than "risk". But they're getting stigmatised discussions and communication. They're getting urged to terminate; they're told that their families are going to break apart if they continue their pregnancy. It's a very different space now and the biggest thing we can do is actually acknowledge that this is a huge thing and it's been boiling and sitting under, and we have been harming families because we have not been paying attention to it.

The families don't necessarily come back and speak up about it because some that have gone down the termination path have been advised to tell their friends and then it works that they had a stillbirth, because of the stigma. So then they sit with that with shame, and they sit with that in silence. For other people, like myself, that was the very first thing when there was a diagnosis: "Oh, you can have a termination at the hospital and tell people you had a stillborn." I had to advocate for further tests and had to advocate for more information. Sorry, I'm going on a rampage now because I'm just excited that this is even mentioned, because it's a really complex thing.

We have some amazing clinicians doing what they can in really limited systems where they just don't have the training, the time, the continuity of care. If you're in a midwifery clinic and you have a fetal anomaly, that's it—your whole birth plan, everything that you hoped for is gone. You're now with a different clinic. Then if you decide to continue, you might get referred to this clinic or you might get referred to that clinic. You're repeating your story over and over again. You're seeing different people along the way who, again, haven't been trained, necessarily. You finally decide or you continue—if I go from my own example, for four weeks between 32 weeks and 36 weeks pregnant I had to decide, "Do I deliver my baby into the world and she's potentially going to have

this hard life that doctors are painting, or do I put a needle into her heart and terminate my pregnancy", when I had a hospital bag packed and had a nursery painted. It was a very traumatic time and I continued my pregnancy.

Then, after birth, I reached out for mental health support. I'm a mental health nurse, by the way, a credentialled mental health nurse, and I couldn't navigate the system. I reached out for support but I actually was refused support because my daughter had an anomaly, so I couldn't go to a mother baby unit because that introduced risks to their thing. There's this big systemic hush. We don't talk about it. It's not out in society. We need to talk about it. That's probably, on my big tangent, the biggest thing: Put it in the reports. Make it heard. Let's get some communication about this. Let's try and—I don't have the answers about how we can address this. This is a thing bigger than me; it's bigger than Through the Unexpected. It's collaborative. It's bringing people on board to do it the right way.

The Hon. EMILY SUVAAL: Thank you for that. It's really informative and helpful. I wondered if you could perhaps walk me through something that you said about the external forces that were sort of impacting on the delivery and that appointment or the care that's provided, and the advances in technology and how that's impacting. Do you have a practical example of that, just for my brain, that can help us to understand how that's happening?

PIETA SHAKES: Previously we have the nuchal screening that you would have. So NIPT—or NIPS, however you want to call it—is a screening test that looks at more, or it can look at different parts of the genome, really, and different parts of the genes. But this test, at the moment—so people are paying privately for it. There's a bit of information and you have your positive predictive values and all of these different things to communicate to parents as well about what the results may mean either way. But that test itself can now be an expanded panel where we can see much more of the DNA. We can look at much more and we can provide much more information, but that, necessarily, doesn't come with any actual—what it means to the family. So you can find something on a baby's DNA and they can actually say, "We've seen this. We don't know what it is" or "We don't know how it's going to affect your baby."

We're expecting, firstly, people to be able to understand those tests to be able to consent to them. When you said trauma-informed care, there was this element of consent and awareness of what's going on. But often that first appointment with a pregnant woman is "Here you go. Here's all your blood tests; here's everything. If you want screening, great—here you go." So the tests are expanding but without the time to actually unpack what that means and without the time to come back and—there's so many conditions now that can be picked up that some of the information probably needs to come to more of a value base: What do you want to know and what will be helpful for you, and how will you cope with uncertain information for the rest of your pregnancy and how will you cope with these sorts of things? Because the amount of things we can screen for is rapidly changing.

Now there's carrier screening as well, which is aimed at pre-conception but it will be used by a lot of people in early pregnancy. Again, that was a Medicare-funded test—that's just come out—but there's no more funded support. We're increasing the complexity of the tests, we're increasing the complexity of the information and we are not increasing the time that people have to talk about this. We are not changing the system of things.

The Hon. EMILY SUVAAL: Thank you. That's helpful. Just a final question, if I can, about when a diagnosis is received. What mode of care would you suggest is the best to ensure that women and their families are properly supported through that process?

PIETA SHAKES: That's a big question. The best care is going to be care that is able to meet the needs of that person and that family, because that person and that family are going to be different to the next person and the next family. I would say that there's things like continuity of care. The literature is really quite limited still in this space of what is the best care, because we haven't even talked about the fact that there's all these issues, let alone to look and fund progress towards getting interventions in here. But what is the best care? It's going to be care that meets parents where they are, that is focused around their values and what they bring in. That means clinicians who can adapt their language, who can adapt their world views and who can step outside of their own assumptions and biases. Biases aren't necessarily a bad thing. We all have biases because the world is complex. So we structure things and we learn and we assume; we make assumptions to cut through all the complexity in the world.

In the medical space we've learned "this is normal" and "this is abnormal". But that kind of language when you're talking, perhaps, about a baby with a disability, and if you're talking with a family who have accepted the baby with a disability, and disability as a difference and just a part of the diversity of human life, and you're calling this baby abnormal and you're saying you need to terminate it, or terminate the pregnancy and not even associating the baby—my research has also found that the diagnosis can overshadow the baby in a continuing pregnancy. Pregnancy becomes a medical event, and mothers often miss out on the pregnancy-related care because it becomes about medical. That can impact attachment, bonding—all of those things that you would typically have in a typical

pregnancy. Preparing for birth and all of that really important transitional period can be lost because the diagnosis has overshadowed the baby. Care needs to be flexible; it needs to be able to slow down. Equally, it needs to be able to be responsive to those people who do know what they want immediately. We need to actually sit with lots of people and lots of key players in here and come up with what that care looks like.

The CHAIR: I think Ms O'Doherty has something to contribute as well.

SAHRA BEHARDIEN O'DOHERTY: Yes, thank you. I just wanted to expand on that point because AAPi is in the process of recommending a number of different changes to the Federal Government. One of the things that we are recommending is having something similar to the referrals that are currently available for people experiencing eating disorders, which is a packet of up to 40 sessions per calendar year where we are able to self-refer. So the patient, the birthing mother, the pregnant person is able to self-refer to a psychologist of their choice. This might be on the advice of a genetic counsellor—potentially at a hospital—or an obstetrician, or they're able to find a perinatal or trauma-informed psychologist who is able to support them even during their pregnancy, and around that delivery and then postnatal period. Being able to self-refer for these services, I believe, is absolutely crucial. So that is something that we would like to also propose in terms of that continuity of care.

The Hon. EMILY SUVAAL: I have more questions for the psychologist but I am mindful of the time I've taken up, so perhaps I'll put them on notice.

The Hon. SARAH MITCHELL: Thank you all for being here today. My first question is probably more directed to the two witnesses here in the room, and then I've got one for all three of you after that. Firstly, thank you for sharing your personal experiences. It's very powerful to hear that, both here today and also in the written submission, which I know that you did, Ms Fameli, so thank you for that. One common theme that I noticed between both of your submissions was particularly around the lack of research into birth trauma and the lack of data. Ms Shakes, in yours you talk about not really having any concrete data around things like the psychosocial impacts when there are those diagnoses of fetal anomalies. This is a really simple question: Do you think the Government needs to be putting money into more research in this space? Who do you think would be best placed to oversee that and conduct that research? I'm happy for all of you to answer if you'd like to, because I suspect that Ms O'Doherty might want to answer that as well.

ALYSHA-LEIGH FAMELI: I think we would all agree that, yes, it would be great for the Government to fund this research. I think that a lot of birth trauma research has come from women who have experienced birth trauma, and I think you'd find the same in fetal anomaly research. A lot of that research is unfunded. I am four years deep into an unfunded PhD and I have two small children myself. There is actually a lot of research around birth trauma. A lot of it has focused on what causes it. We've looked at lots of things to try and prevent it, which is really crucial and important. I know you've heard a lot of stuff about that. In terms of who would be best placed to do it, I think that universities have really high standards of research output—so, specific PhD placements at universities, funding research through universities, and then also organisations who have a vested interest in the outcomes pairing with those universities so that we have good strong research design, really making sure that the research is ethical because that is something that is so crucial in this.

We are talking to people who have had traumatic experiences. We need to make sure that we are being mindful of the outcomes on them for potentially participating in this research, and then even making sure that we potentially provide funding to remunerate participants because this is free labour that women are engaging in. For the women who've participated in my study, and I think there's been over 1,000 now cumulatively, it's free emotional labour and time labour, and they've participated because they want there to be change. So that's my two cents on that.

The Hon. SARAH MITCHELL: Did you want to add anything?

PIETA SHAKES: I will add that internationally there's a lot of literature about the psychosocial aspects of prenatal diagnosis. In fact, that's why Through the Unexpected came about—because we've got 20 years of other literature sitting there. What we don't track is what actually happens here in Australia. We don't track it well with our mental health screening at the moment anyway: the siloed care, parents getting lost in the systems, all of these things, the screening tools. If you actually do the Edinburgh and it asks you if you've had any—what's the specific word? It's about feeling these feelings without any real reason to. If you've received a prenatal diagnosis, you're not going to tick that because there's a real reason why you might be distressed.

We're actually not even capturing any of that. Even clinical indicators in Australia, if you do continue pregnancy—I'm not sure about our clinical indicators in that space. But if your baby has a congenital anomaly, that's it—you're not included in any of the actual outcome information either. You are actually just excluded from things. In terms of research, I do think we need to track what's happening here in Australia. I do know that there's some teams that are trying to get that, but they're competing against all of the other things. They're competing in

a space where we're not talking about prenatal diagnosis. It doesn't come up on people's agendas, which is why some targeted funding of that research would be amazing. If people don't know how important this is, it's not going to rank highly compared to the things that are out there being discussed at the moment. And, yes, I would say the same thing. It does need to be done well. It needs to be done properly to be meaningful and it needs to be done ethically. We also need to come back and co-design all of this stuff because, in this prenatal diagnosis space, we have a discordance between health professionals and parents who have received a prenatal diagnosis. There are two different stories and two different things happening in here. We need to bring everyone to the table.

ALYSHA-LEIGH FAMELI: In regard to fetal anomaly, often that becomes an exclusion criteria for birth trauma research because there is an expectation of, "Of course that's traumatic." And then those participants and people who have stillbirths are excluded from birth trauma research. I think it's an important thing to note that we take it for granted.

PIETA SHAKES: Yes, absolutely.

The Hon. SARAH MITCHELL: The other question I had—and, Ms O'Doherty, feel free to kick-off with this one, if you're happy to, and feel free to add something on the earlier question too—is around the role that you see partners playing. You have been speaking about psychological support and the number of sessions and I think you indicated, Ms Fameli, how you often treat both the mother and the baby. In terms of support people and partners, where do you think a gap is there? We've had some really powerful evidence come through from partners telling their experiences of watching their wife or girlfriend or partner go and they don't know what is happening and they experience trauma in a different way. How do you think that process could be improved and does there need to be some specific support for partners who have also been involved in a traumatic birth experience, in your view?

ALYSHA-LEIGH FAMELI: I definitely think that there does. The City Birth Trauma Scale has been validated for use with partners—internationally, not in Australia, but with similar population groups. We can be screening; we don't. I think what's really critical is that, when you have a woman who is traumatised by her birth, she is often turning to her partner or her co-parent for support. If that person is equally traumatised, then we have a whole system of trauma. We have a baby who is likely responding to a mother and a partner. If we were to offer tailored support to partners, we are essentially impacting the mother's and the infant's outcome. There is substantial data that exists that, if you have a mother with psychopathology, whether it be depression, anxiety or PTSD, and you have a partner who is well and able to provide attuned responding to the infant, the outcomes for the whole system are better—infant outcomes are better and maternal outcomes are better.

I think what's really important too is that it's only really in the last few decades that we started bringing male partners into the birth space. In terms of education around childbirth, I think it's really important that we talk to partners about the things that they might see and what it might feel like to be a bystander. Vicarious trauma can be as visceral as experiencing it yourself. Often one of the things I see is that birth partners come into treatment to support their wives or their partners and their responses are so visceral and so intense that they're actually part of the system that's retraumatising their wife, particularly if they go to have another baby. So you have a really fearful partner who has nearly watched his or her partner die, and they are part of the system saying, "Don't do that. That feels really scary." If we had more holistic care for everyone—ultimately, families are systems. They are units. It's not like one person exists on their own. If we were to take that approach, everyone would be better off.

The Hon. SARAH MITCHELL: Ms Doherty, did you want to add anything to that?

SAHRA BEHARDIEN O'DOHERTY: Yes, please. To go back to the previous question in regard to research, I would like to emphasise the fact that a lot of research that's conducted in English speaking western countries is often not inclusive of marginalised communities, of people of colour, of First Nations and Indigenous people and of LGBTQIA+ and also neurodiverse communities as well. I think we need to be really making sure that we are capturing a lot of this because standardisation of treatment and informed continuity of care needs to be inclusive of each individual and each group of community experiences and diverse needs. That was my first point.

My second point is just in regard to partners and support for partners. One of the definitions of trauma is witnessing threats to bodily integrity. If we have male partners and other partners who are in the birthing room with the birthing parent and they are witnessing either distress of the birthing parent or distress of the baby or they are witnessing any kind of surgical or medical intervention, this could absolutely form a traumatic response in the non-birthing parent. So it's about making sure that there is a trauma informed response treatment and continuity of care for partners as well.

When we're talking about partners, we're often talking about things like vicarious trauma, as Ms Fameli was talking about, and helplessness and a lack of control. When the birthing parent is experiencing a lack of control and helplessness, there is even less control and even more of a sense of helplessness with a witnessing or bystander parent or any kind of support person. We need to make sure that there is communication of supports and communication of what is actually happening during these processes to the partner or to any supports and then, afterwards, engaging that parent or support partner into things like, as Ms Fameli was talking about, family therapy and family support for that whole family unit.

The Hon. SARAH MITCHELL: You don't have to, Ms Shakes, but do you want to add anything?

PIETA SHAKES: In this context, the partner is the father and there is not support at the moment for fathers. I know where the father has been involved in a very traumatic birth, with termination of pregnancy late. There's a sense that some places will have a bereavement midwife but, if you labour when a bereavement midwife isn't there, then the care may not be someone who chooses to be in that space. There can be challenges in that for the midwife as well and whoever is then thrown into that space, where they might feel unprepared.

But also in the context of coming back, even at the point of news and discussions, we assume that we can give parents the information and that they will work out what their values are and that they'll make the decision that's right for them and that they'll be okay because of that. We see that there's this element of choice, but parents can want different things. This can completely throw turmoil into a relationship and into a partnership. They can be isolated, even together. They can also then carry whatever that is down the line as well. So it's not just down the line. We need to be supporting people right back there and then.

I will flag as well that we run a risk if we look at this from a mental health lens, specifically because a lot of parents during their high distress and periods of disassociation and acute distress may not actually—they might be offered mental health support but they don't connect with that because, "It's not postnatal anxiety. It's not these things." I want to throw in that caution as well because we need to be really mindful about how we do this and how we normalise the fact that there can be distress in here. Not everyone is going to be distressed, but there can be. We need to create these links that don't necessarily mean, "Go and get a diagnosis of a mental health condition." And for both partners, absolutely.

The Hon. NATASHA MACLAREN-JONES: I've got a question about Medicare that's probably more for Ms O'Doherty, although it's touched on by other submissions. Obviously, psychologists are all funded through Medicare. Have you had any conversations at a Commonwealth level about rebates or any work that's been done across other jurisdictions to put a coordinated approach to the Commonwealth on it?

SAHRA BEHARDIEN O'DOHERTY: Yes. We are in constant communication with the health Minister and his team and also the associate mental health Minister as well. There are lots of ongoing conversations; however, they have not as yet been successful. We have been advocating for the reinstatement of the additional 10 sessions that were lost post-COVID. We've been tirelessly advocating for an increase in the mental health Medicare rebates to be \$150 per session for all psychologists. This is something that at the moment the Government does not yet seem interested in reinstating. However, we are going to continue to talk to them.

The Hon. NATASHA MACLAREN-JONES: As I said, we know it's at a Commonwealth level and I don't want to allow them to get out of one of their responsibilities. Having said that, is there anything from a NSW Health perspective that could be done whilst you are campaigning to try to get the Commonwealth to commit?

SAHRA BEHARDIEN O'DOHERTY: We can absolutely look at different levels of funding. I'd probably like to take that question on notice so I could have a think about it and provide you with more options.

The Hon. NATASHA MACLAREN-JONES: That would be great. Thank you very much.

The CHAIR: I have a quick follow-up question. Ms Doherty, in your opening statement and your submission you mentioned provisional psychologists being able to provide services under Medicare. Is that because there is a limit on the number of psychologists available? And do you see that falling into another two-tier system in regard to rebate, because obviously there is a difference between provisional psychologists and fully registered psychologists? What would their title be to differentiate them so that people understood who they were getting that health care from?

SAHRA BEHARDIEN O'DOHERTY: Absolutely. First of all, in terms of provisional psychologists, there is a workforce shortage at the moment. Since 2010 there have been so many course closures in psychology across Australia. That has really put a massive bottleneck in terms of how many provisionals are coming into psychology. To clarify, a provisional psychologist is someone who has undergone their formal academic training and they are now in their supervised practice training, so the last one to two years before they are a fully registered

psychologist. In that period they are receiving extensive supervision. It's usually one to two hours of supervision per week. If there are provisional psychologists who are working in a perinatal space, they're already getting this on the ground experience and receiving on the ground supervision from more experienced psychologists. What we are looking for in terms of a Medicare rebate for provisionals is about employment opportunities. Provisional psychologists are often underemployed or they are not being adequately funded for their positions. If we did have access to a Medicare rebate for provisional psychologists, then more employers would be able to take them onboard in order to provide the Medicare-rebated services.

In regard to your question about two-tier Medicare systems, currently the two-tier Medicare system is essentially a false two tier where only about 30 per cent of psychologists are on this higher rebate, when many other psychologists have equivalent experience, training, academic qualifications et cetera. When we're looking at a unified single tier for all registered psychologists, that is the kind of rebate that we are pushing. Yes, it would potentially create another two-tier system if provisional psychologists were able to enter the Medicare system. However, as provisionals they are student psychologists or intern psychologists. They are not yet fully registered. There is a very clear distinction there between the current two-tier system and the proposition that AAPi is putting forward.

The CHAIR: Do you have a proposed Medicare rebate for provisional psychologists?

SAHRA BEHARDIEN O'DOHERTY: We would love it to be as high as possible. Currently, the rebates for all registered psychologists are woefully low. We are not in a position to really put forward what that dollar amount would look like. However, it would be absolutely necessary for any kind of additional funding for provisional psychologists so they are adequately paid for the work that they are doing.

The CHAIR: Thank you. I think that does bring us to time. Sorry, did you have something to add?

PIETA SHAKES: I was just going to add that there is a workforce outside psychology as well who don't get access to a lot of the different rebates. I'm a credentialed mental health nurse, masters, another postgrad in child and adolescent mental health, worked in mental health services for 20 years, worked in the perinatal team and things, and I can't go and get a rebate. So then I looked at different career paths and now I'm an academic. We lose other professions because of the way that the payments are structured. But even in the space of prenatal diagnosis, genetic counsellors have been trying to get some Medicare rebates as well. That might open up this potential for informed decision-making and things that we're talking about as well. There are other workforces as well—just flying the flag for everybody else.

ALYSHA-LEIGH FAMELI: And clinical nurses as well, in terms of birth trauma processing. One of the things that I often do when I'm working with someone with birth trauma is refer them to midwives within my local area who I know do birth trauma debriefing, because they can take the clinical physiological side of birth and step them through those elements as well. I think there is a need to really consider multidisciplinary teams and the fact that birth is a neuropsychosocial event; it is not a medical event, strictly.

SAHRA BEHARDIEN O'DOHERTY: Absolutely. Sorry, just to add to that a little a bit more, mental health social workers and other social workers who are able to provide care in that perinatal period work with a very holistic family-oriented systems focus, and that is absolutely the kind of additional discipline that we need in the space.

The CHAIR: Thank you all for coming in and giving your time for this inquiry. There were a couple of questions taken on notice. I also believe that a few of us had more questions. The Committee secretariat will be in contact with you about those questions to provide them on notice. Thank you again for your time and the valuable information that you provided. The Committee will now break for lunch and return at 1.30 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

Ms AMY TYSON, Doula, Breastfeeding Advocacy Australia, affirmed and examined

Dr SUSAN TAWIA, Breastfeeding Researcher and Health Professional Educator, Australian Breastfeeding Association, before the Committee via videoconference, affirmed and examined

The CHAIR: I now welcome our next witnesses and thank them for attending today. Ms Tyson, do you have a short opening statement that you'd like to make?

AMY TYSON: Yes, I do. Breastfeeding Advocacy Australia would like to acknowledge the traditional custodians of the land on which we meet today, the Gadigal people of the Eora nation. We pay our respects to the Elders past, present and emerging. We also pay our respect to the First Nations mothers and aunties, who have birthed, nursed, nourished and cared for their babies on this land for millennia. Volunteers for Breastfeeding Advocacy Australia work to support, promote and protect breastfeeding. We aim to create awareness and provide education about the critical barriers to achieving physiological breastfeeding and the role that physiological breastfeeding plays as the single most important public health measure for our country as a whole.

Successful physiological breastfeeding is placed at critical risk when women begin their mothering journey physically, psychologically or spiritually wounded by their caregivers. The mother and baby are a dyad; they are one. What is done to one is done to the other. The effects of birth trauma reach far into the future for mother-baby dyads. With between one-third and one-quarter of women emerging from their baby's birth traumatised, we must consider the urgency with which we need to tend to this epidemic. The mother-baby dyad is vulnerable and we are all responsible for their care and protection.

Breastfeeding Advocacy Australia has been collecting data on women's experiences in breastfeeding since our inception. For the purposes of being called as a witness in this inquiry, we wish to table a report of a recent survey we conducted, which was specifically aimed to look at the relationship between women's experiences with birth trauma and establishing breastfeeding. Women deserve kindness, care, respect, dignity, autonomy and nurturing throughout their motherhood journey. This would enable women to come into motherhood feeling capable and worthy, and for their babies to come into the world feeling safe and valued. The positive effects this would have on health and wellbeing for our entire country would be significant. This is something that deserves our immediate attention as a society. Breastfeeding Advocacy Australia wishes to acknowledge the courage of all the women who've made submissions to this inquiry or who have or will give evidence to the members of this Committee. We implore you to hear and heed their words.

The CHAIR: Dr Tawia, did you have an opening statement that you'd like to give?

SUSAN TAWIA: Yes, thank you—on behalf of the Australian Breastfeeding Association, the ABA, which is a not-for-profit organisation. ABA is Australia's peak body that provides breastfeeding support, information, education and advocacy. A major way, but not the only way, that ABA supports mothers to breastfeed is through its helpline service. Through ABA's free, 24/7 national Breastfeeding Helpline, staffed by certificate IV-trained ABA volunteer breastfeeding counsellors, ABA supports more than 50,000 mothers, parents and their families each year. That's 1,000 calls a week. ABA volunteers make a real difference to those who call the helpline. Contacting ABA's helpline has immediate and measurable outcomes. When surveyed within four weeks of their call in 2023, most callers stated that after the call they felt reassured, less stressed, less worried, and were more confident and knowledgeable about breastfeeding and more determined to continue breastfeeding. They agreed that the support they received helped them to resolve their issues and encouraged them to continue breastfeeding.

Breastfeeding protects the physical and mental health of mothers and babies. Breastfeeding reduces the risk of SIDS, sudden infant death syndrome, and is included in the safe sleep messaging from Red Nose. Breastfeeding reduces the risks of babies and young children getting respiratory, gastrointestinal and ear infections, which means fewer visits to the doctor and fewer hospital admissions for respiratory infections and diarrhoea. Breastfeeding reduces the risk of breast and ovarian cancers and cardiovascular disease and diabetes in mothers. Breastfeeding can improve the mental health of mothers. Breastfeeding is associated with fewer mental health symptoms, including postnatal depression. However, when breastfeeding challenges and low breastfeeding self-confidence are present, there is an association with increased mental health symptoms. Breastfeeding, and breastfeeding after birth trauma, is very personal and individual. Mothers must be supported by well-informed and suitably trained health professionals and peer supporters.

Specifically in relation to breastfeeding and birth trauma, to quote Dr Kathy Kendall-Tackett from the US, who specialises in women's health research—including breastfeeding, depression, trauma and health psychology—birth trauma and breastfeeding intersect in some key ways. Birth trauma can negatively impact breastfeeding, and breastfeeding can be a source of healing following a difficult birth. Research into the effect of birth trauma on breastfeeding—and breastfeeding on birth trauma—is uncommon, but what has been done

provides valuable insights. When researchers focused on and recorded the breastfeeding experience of mothers who have experienced birth trauma, they found:

The impact of birth trauma on mothers' breast-feeding experiences can lead women down two strikingly different paths. One path can compel women into persevering in breast-feeding but the other path can lead to distressing impediments that curtail women's breast-feeding attempts.

The CHAIR: Thank you so much to both of you for coming here today. I'll throw to the Committee for questions. Dr Amanda Cohn?

Dr AMANDA COHN: I'm happy to go first. I've got a very niche question, so apologies. We're going to go very niche, very quickly. The Australian Breastfeeding Association wrote a report on the Black Summer bushfires, particularly the needs of pregnant people and carers of young children in disasters, which I thought was very interesting and something this inquiry hasn't looked at, at all. Certainly, disasters are going to be more frequent with climate change and are a different type of traumatic experience. I was hoping you could speak to that report and what some of those needs of pregnant people and carers of young children are.

SUSAN TAWIA: Yes, luckily I was partly involved with that report. They did a survey of carers of children, as well as first responders and people who were involved in places and spaces where mothers and babies were. What they found is that these people looking after babies and young children often are pregnant as well. Often they are on their own. Their partners are often dealing with the property or out fighting fires or something, so they're on their own. They're often very vulnerable, as you can imagine, when they come to a place or a space where they're meant to be safe from the fires. In those places and spaces, they almost need priority care. They need private spaces and protected spaces for themselves and their babies where there's supervision. They need to be separate from other people. Often the mums were women we encountered that had a bed or a cot in a public space and couldn't leave their children. They need to be prioritised for food and water, and for care, and preferably have separate spaces where they can feed their babies or look after their children, but also have people who understand their needs and helping them with what they need. They shouldn't be standing in queues for a long time with children running around and things like that. They have very particular and specific needs, and that report does talk to those needs.

Dr AMANDA COHN: I appreciate that this one may need to be taken on notice, but are you aware of any examples where that was done well? Did you have any survey respondents say that they actually felt well supported?

SUSAN TAWIA: I'm not sure about Australia, but I know in the report—and we could perhaps share the report with the Committee—they do talk about places overseas where there are models of care that could be useful. That's another thing they did: They sort of did a global survey.

Dr AMANDA COHN: I've got a second, more general question for both of you. Certainly in my own clinical experience as a GP, before I was in Parliament, a lot of people became aware of your organisations when they were having trouble. They often came to my attention because, for example, babies weren't putting on weight. You then realised there was trouble with breastfeeding or attachment and all the various reasons for that. What opportunities are there for us to take a far more preventive approach and give people that support before it has actually become a crisis?

AMY TYSON: Good question. The whole premise of this Committee is how to address the issue of birth trauma. We know that women who experience birth trauma are put at risk for experiencing difficulty establishing breastfeeding, which are the problems that you're talking about. When a baby and a mother have been through trauma, it is an extra hurdle for them to get over and establish breastfeeding well. Obviously, if we can address the issue of birth trauma affecting one-third to one-quarter of women in Australia, we could eliminate some of that issue.

But obviously if that has happened, the woman and the baby do need support establishing breastfeeding—access to some form of peer-to-peer support, whether that be an actual breastfeeding counsellor or other women who are experienced in breastfeeding. Access to community groups—BAA, Breastfeeding Advocacy Australia, runs a group called Nurturing Mothers, which is such a group, where women can actually access other women who have expertise and understanding of breastfeeding. That access to other women in their own community is shown to really improve breastfeeding outcomes and breastfeeding rates.

SUSAN TAWIA: Similarly, ABA's Breastfeeding Helpline gets calls from mothers when they're having problems. They come to us, but it might be a week. Sometimes it's a few days, but it might be a week or two weeks or a month, and they're having breastfeeding problems. We need the people who are caring for them immediately postpartum to be knowledgeable about breastfeeding and how to support all mums, including those who've experienced birth trauma. The midwives, the nurses, the GPs, the people who they would be looking to,

the maternal child health nurses—those people all need to be well educated, well informed and trained to support these mums to breastfeed.

The Hon. NATASHA MACLAREN-JONES: I have a couple of questions for Ms Tyson in relation to your submission. One of the things that you've suggested is bundled maternity funding. Could you talk us through how that would operate?

AMY TYSON: Similarly, you could think of it kind of like the NDIS and how that was rolled out for persons living with disabilities, where they are given an amount of funding allocated to them to spend to increase their capacity and their quality of life. Pregnant women could be given an amount of funding, which could be different based on whether they are rural or in the city, or maybe it could be based on what is the main kind of maternity care they want to actually go ahead with, and then they would have funds available to them that they are able to spend on the things that they feel are important and the things that they feel are supportive to them. There are a lot of people talking about that in Australia, and how that could help women to be making more informed decisions and decisions that are based on their own values and their own beliefs, and that that could help reduce birth trauma.

The Hon. NATASHA MACLAREN-JONES: Have any costings been done around—

AMY TYSON: Not that I know of, but I'm not entirely sure about that.

The Hon. NATASHA MACLAREN-JONES: Was the survey that you put together Australia wide or just in New South Wales?

AMY TYSON: Breastfeeding Advocacy Australia is national, so I don't actually know where all of those responses came from but I would presume national.

The Hon. NATASHA MACLAREN-JONES: If you are able to take that on notice, because I noticed 33 people responded, so I'm interested to know the time frame of when that survey was conducted and how many participants came from New South Wales.

AMY TYSON: We can take that question on notice.

The Hon. NATASHA MACLAREN-JONES: Also, if there's a breakdown, how many were regional and how many were metro from that?

AMY TYSON: Sure, absolutely. Yes, there is one question about whether or not the woman answering the question is rural, but we could be a bit more comprehensive with that answer for you if you like.

The Hon. NATASHA MACLAREN-JONES: I noticed that they came from Queensland, so that's why I was interested to know how many from New South Wales participated.

AMY TYSON: Sure.

The Hon. EMILY SUVAAL: Thanks to you to you both for appearing today and to Ms Tyson for your submission. My first question is to you. In your submission, one of the specific solutions that you mentioned is about health professionals being trained in informed consent and what constitutes informed consent. Can you expand on that statement and explain what exactly you're recommending with that?

AMY TYSON: Yes, sure. BAA as a group did expand on the recommendations that we made in the submission to a more comprehensive list, so I might speak to that because it does go into a little bit more detail, especially about the mandatory education and training for health workers to understand and prioritise supporting the physiological processes of birth and breastfeeding. When delivering care to pregnant and breastfeeding women, health workers must understand women's human rights in childbirth and postnatal care; how to offer maternity care and counsel women respectfully, with all the information they need for them to make informed decisions, i.e., informed consent; that women are capable of and responsible for making their own decisions about their care; and the long-lasting impacts of birth trauma on women, babies, families, the wider community, the environment, our health system and economic costs.

The informed consent means health workers understanding what they actually need to be doing to achieve that with women. Women need to understand fully the risks of whatever is being offered to them as an intervention in their birth and for them to be able to make that decision free from coercion, because lots of women report that that is where their birth trauma stems from: that they didn't feel honoured in their true wishes, and they didn't feel that they were respected as a person who was capable of making a decision on their own.

The Hon. EMILY SUVAAL: Thanks for clarifying that for us. Feel free to both answer this one, as it relates more generally to breastfeeding and breastfeeding education. If we were to provide more information or education to women about breastfeeding, what method of delivery would be best—online classes, face to face?

SUSAN TAWIA: I'm happy to start with that one.

The Hon. EMILY SUVAAL: Sure, noting what you said about clinicians earlier.

SUSAN TAWIA: Yes. Most women actually understand the importance of breastfeeding, and they nearly all—90 per cent or 95 per cent—start breastfeeding. They are, overall, at least knowledgeable up about the importance of breastfeeding. There are opportunities for antenatal education around breastfeeding. Hospitals have done in the past; I'm not quite sure how good they are at doing them now, especially since COVID, but breastfeeding should always be part of that antenatal education in hospitals.

There are childbirth education providers separately from hospitals, private practices. ABA has online and face-to-face breastfeeding education classes for women before they have their babies. At the moment, whether there's a preference between the two isn't clear, whether it's online or face-to-face. I think it's a personal preference and we're happy to keep offering both styles. But what women need is their health professionals to have a similar level of education about it and, like Amy was saying, they should be respected for the choices that they want to make and supported in the choices that they want to make around breastfeeding.

The Hon. EMILY SUVAAL: Thank you. Did you have something to add?

AMY TYSON: I just would quickly like to add the Australian National Breastfeeding Strategy, which is a plan to increase breastfeeding rates, includes a priority for education around breastfeeding. As Susan was saying there are many ways for women to access that at the moment. But we know that a lot of women are not accessing that sort of information. As Susan was saying, I think it's every point that a woman makes contact with a health professional in her pregnancy, that person could be delivering some breastfeeding education, but the reality is that most people working in that sector actually don't know very much about breastfeeding and can actually be giving damaging information rather than supportive information. There's a lot of work to be done there. Access to peer-to-peer groups is very important as well. The information needs to not just come from what we consider a medical professional but from other mothers, so peer-to-peer groups provide that kind of support.

The Hon. EMILY SUVAAL: I might direct this one firstly to you, Dr Tawia, and then, if you've got anything to add, obviously, Ms Tyson as well. Through your work that you've done through the ABA and the BAA, what are things that you have found women and their families most benefit from? What has been most beneficial for women in their journey?

SUSAN TAWIA: In terms of good breastfeeding outcomes?

The Hon. EMILY SUVAAL: Yes.

SUSAN TAWIA: It will be a range of things, but probably the very early interactions that a mum has with her baby. Amy was talking about something called physiological breastfeeding. This is encouraging the natural interactions between mothers and babies. The very first thing—and it's a bit of a lesson in breastfeeding physiology—is to not separate the mother and baby. Policies and practices in hospitals would be really important. Mothers and babies should be skin to skin straightaway. That encourages a whole lot of physiological things. It encourages breastfeeding and all the hormones that are required to get that all going; then mothers and babies staying together; the health professionals working with them understanding how important that is; and then good community support as well and community support in relation to their maternal child health nurses understanding about breastfeeding, or their midwives that are taking them into the community after giving birth. They need community support. As Amy said, at every point that mums encounter information or support from the minute their baby is born—even before—but when their baby is born, to every health professional understanding how to support these mums.

The Hon. EMILY SUVAAL: Thank you. Do you have anything to add?

AMY TYSON: I would just add that this inquiry is about birth trauma and, as Susan was saying, that critical time right after a baby is born, when there are so many physiological processes going on—some of which we understand, a lot of which we don't yet understand of what is actually happening between the mother and the baby at that point. If we can support almost all women to have a physiological birth where they come through that birth process to feel powerful and to feel capable as a mother, they can then trust their instincts and have that time with their baby and that will protect breastfeeding.

The Hon. SARAH MITCHELL: Thank you both for being here. I wanted to ask a question about how we can prepare women for some of the challenges that come with breastfeeding, because I note particularly in your survey you talk a bit about how women who've been through birth trauma often experience difficulties—and, you know, it's a personal experience I had myself. I want to thank the ABA because I was one of the women who called your service because it can be quite hard, particularly as a first-time mother, not talking away from the importance of it. But do you think there is a place in terms of that prenatal education component where, for

instance, it is made clear to women that if you do have trouble, you should reach out to these organisations or lactation consultants? Do you think that's part of maybe what's missing in some of the antenatal education as well, in terms of that continuity of breastfeeding for those who maybe don't find it as easy as some?

AMY TYSON: Yes, absolutely. A lot of antenatal education does focus on the birth, and for good reason—because that is a major event in a woman's life and it's obviously the first major event in a baby's life to be born and it's very important how that is approached. But some time spent on preparing mothers on what to expect with breastfeeding, what is normal baby behaviour, the support that they should maybe be starting to gather around themselves, familiarising themselves with supportive health professionals and other supportive peers, groups that provide breastfeeding counselling—all of those things could be very useful in preparing them.

The Hon. SARAH MITCHELL: Do you want to add anything, Dr Tawia?

SUSAN TAWIA: Yes. Just to add to that, ABA's working with hospitals now to let their staff understand—particularly, there's something called the Baby Friendly Health Initiative, where hospitals are breastfeeding supportive and accredited to be that. They then refer on to support in the community. It used to be very specifically peer support groups, but it's not so much. But we're working with them to educate their staff to understand the work that ABA does so they can give a very informed referral to the mum and say, "If you call ABA—if you need support, contact ABA. Here's their helpline number", but not just that. They understand what they can tell the mums about what ABA actually does and so how we can help them. That's not generally everywhere, but we've certainly got some places and spaces where we're doing that work so that there's that very informed referral on to community support and peer support.

The Hon. SARAH MITCHELL: Just following from that, obviously from the evidence that you've both given, there would appear to be linkages between a traumatic birth experience and that bonding period, potentially, with your child, and then potentially breastfeeding issues stemming from that as well. Do you think there needs to be more explicit advice given to women who have been through birth trauma around those breastfeeding supports? To me, it seems very clear that that could be a direct correlation, yet when women are in that lived experience maybe they don't see that in that weird time when you first have a baby, which is challenging for everybody, let alone when you've been through what some of the women who've appeared before our Committee have. Is there a gap there, do you think, in terms of that specific, almost trauma-informed breastfeeding support?

AMY TYSON: Absolutely. Those women are particularly vulnerable.

The Hon. SARAH MITCHELL: Yes.

AMY TYSON: All mothers and babies are vulnerable. It's a very new space for women, even if it's not their first baby. It's their first time with that baby, so it is a vulnerable position. If there is trauma on top of that, it is an extra thing that that woman needs support around. So, yes, we should be recognising when birth trauma has occurred and have a plan for extra supports for that woman to help her understand that it may take a little bit longer to establish breastfeeding but that she will be able to access the support that she will need to do that.

SUSAN TAWIA: Again I would argue that the health professionals supporting that mother should be providing trauma-informed care as well. They should be recognising it and appreciating from the instant that the baby's born that she's going to be needing extra support.

The Hon. SARAH MITCHELL: Thank you. That was all I had.

The CHAIR: The Hon. Mark Banasiak, did you have questions for this session?

The Hon. MARK BANASIAK: No.

The CHAIR: I've got a question for both of you in regard to some of the evidence that we have heard during this inquiry. One story that we heard was a positive story about a woman who—unfortunately the baby had been rushed off to ICU. She was with a midwife, so she was talking about continuity of care with a known midwife. The midwife stayed with her and said, "Okay, we need to start to prepare you for breastfeeding because your baby is not here." She talked about how that was really beneficial because not only did it mean that she was able to breastfeed the baby when she was able to make contact with that baby but also, in that moment of feeling completely powerless to do something, she had someone guiding her through things. I wanted to hear from you both in regard to having a known healthcare provider with women straight after birth and also working with them around breastfeeding, and that continuity of care context and what that means in the spotlight of breastfeeding.

AMY TYSON: Yes, good question. The second proposed solution that BAA has for the Committee today is to significantly expand access to models of care that provide continuity of carer with a known midwife, as currently only 10 per cent of women in Australia have access to that model of care. That model of care can mean everything to a woman, especially if she experiences something like what you're talking about. If there is a

complication, if there is a need for her baby to be separated from her, then that known care provider knows that woman. They have built a relationship. The woman trusts her. The midwife can read that woman's body language and can build an even deeper rapport when something like that happens. That level of support can mean the world of difference for that woman to be able to keep working and be able to successfully breastfeed, because that is a lot of work in that situation and it requires adequate support.

The CHAIR: Dr Tawia, did you have anything to add?

SUSAN TAWIA: I agree with Amy.

The CHAIR: We've also heard that a lot of women have received conflicting information, either from a midwife or other hospital staff, about breastfeeding and what they should or shouldn't be doing. I'm wondering if you hear that as well and why there's such a variance in the advice that's being given?

AMY TYSON: That's because midwives and doctors receive very little training around breastfeeding. I have a certificate IV in breastfeeding education, and that is a much higher level of education than midwives and doctors receive on breastfeeding. That's dismal. It's not really good enough. Those health professionals are in touch with women who've literally just had babies, or are about to have babies, throughout their whole career, every day. It's so important that they have the right information and that they know how to counsel women, not stand over them and direct them with what to do with their body and their baby but to counsel them with information to empower that woman to make decisions for herself and for her baby to help her successfully breastfeed, if that's what she wants to do.

The CHAIR: Doctor, do you have anything to add?

SUSAN TAWIA: Again, I agree with Amy. Our ABA breastfeeding counsellors are all certificate IV trained in breastfeeding education and counselling. It's a minimum 12- to 18-month qualification. They're much better trained than most of the health professionals that mothers will encounter. As Amy said too, the Australian National Breastfeeding Strategy states that all health professionals that meet mums should be trained in breastfeeding education. As far as I know, the only ones that have a requirement specifically are midwives. That's a little bit hit and miss, depending on their undergraduate course or the midwives that they're working with. Babies should be breastfed, but we know that 30 per cent of babies are being given formula in hospital. That's exactly a way to undermine a mother's confidence in breastfeeding. They're not giving good information. It could be that somebody was trained 20 years ago and the information changes over time. It could be too that what you will tell a mum around a day-two baby compared to a week-two baby or a two-month-old baby could be very different. So people need to be aware of the information that they're giving mums, but it's a lack of training.

The CHAIR: You mentioned just then that only midwives are specifically required to have any kind of training. What other healthcare professionals would you advocate should potentially be required specifically to have a minimum level of training in this space?

SUSAN TAWIA: Maternal child health nurses and general practitioners. The kinds of people—health professionals that mums would immediately, quickly go to if they were worried about their baby. But, truthfully, all of them should have, because they might see a physio or they might see a dietician if they're worried that something they're eating is upsetting their baby, or whatever. So there's a broad range of health professionals who mums should have confidence that they understand about breastfeeding and support them to breastfeed and not make a suggestion that maybe other things, like introducing some formula, might be a solution to their problem, or whatever. It's that immediate circle around the mum that would be the most important, but we would advocate for all of them to have undergraduate training.

The CHAIR: In regards to that, you mentioned dieticians. Are you finding that there are a lot of dieticians that are giving advice and information without having done any sort of training around breastfeeding and in regard to, "Am I eating something that's affecting the baby?" and potentially recommending that they take them onto formula?

SUSAN TAWIA: I can't answer that question, except that I know that sometimes dieticians, especially in hospitals, know what's in formula. They have a nice ingredients nutritional panel and you can't always know what's in breastmilk. We know that formula is inferior to breastmilk, but we don't have that nice nutritional panel. Sometimes it can make it seem a bit easier if they want a certain protein level or something. The other beautiful thing about breastmilk is it changes over time, even over the day. So what is in it is appropriate for that baby at that time. So you're never going to nail exactly what's in breastmilk.

The CHAIR: Today the Committee also heard from CAPEA in regard to education and information for mothers as well. I didn't actually ask them if breastfeeding was part of that, but do you feel like it's important that any kind of—we've talked a lot about the healthcare professionals and the fact that they need that level of

information and education. Do you think that there also needs to be a lot more information going to the women themselves? That's for either of you.

AMY TYSON: Of course. We were talking about antenatal education. Is that what your question is about?

The CHAIR: Yes.

AMY TYSON: Absolutely.

The CHAIR: If there was some kind of approved education program, making sure that that was a very specific part of that.

AMY TYSON: Yes, absolutely. There's no reason why NSW Health couldn't be providing a program like that and developing it together with organisations who are already doing that education and that advocacy and providing it for free to all women. Breastfeeding should be one of the top priorities for health promotion and protection in Australia, and it could start there; it could start with education.

The CHAIR: You both have talked about interconnections between breastfeeding and birth trauma, that the trauma can lead to some women unable to breastfeed and that some women can experience further trauma if they're unable to breastfeed when they wanted to, either because of physical trauma or inadequate support or some other reason. I just want you to talk a little bit more about this and the recommendations for change that you hope to see within the inquiry report in this particular space.

AMY TYSON: Did you want to go, Susan?

SUSAN TAWIA: What quite were you—

The CHAIR: Sorry, I know it's a very broad question. I think I'm trying to nut down some of those interconnections between breastfeeding and birth trauma. Because it's complicated, I'm just trying to understand what other key recommendations that we should be looking into in regard to untangling that interconnection, how we make sure that the services are aware of that interconnectedness and also making sure that there are recommendations in the report that are targeted towards helping remove that additional form of trauma.

SUSAN TAWIA: I think it's going to be very difficult. From a second research project that I've been reading by a woman called Northrup in Canada, in 2020, she said that they're inextricably linked. As soon as someone is talking about their breastfeeding problems or their experiences after birth trauma, they always speak about their birth. They're always going to be linked. In terms of a recommendation, this will be thinking on my feet—

The CHAIR: It's a big question. I'm happy for you to take it on notice, if you need some time.

SUSAN TAWIA: Yes, we could do that. I've got a feeling that what we need to do is—the health professionals working directly with the mother need to recognise that she is traumatised. Actually, I will tell you—and I might take it on notice but also talk about Kathy Kendall-Tackett, who I was talking about in my opening statement. She has done a lot more of this work in the US, and she has some recommendations around trauma-informed care for people like lactation consultants. There may be something in that that might be useful.

AMY TYSON: I would also suggest the Australian National Breastfeeding Strategy as a resource for looking at recommendations in regard to that. To go even a step further to say that birth and breastfeeding are linked, I would actually say they're the same thing. It's literally a continuum—you are pregnant, you birth, you breastfeed. It all happens one after the other. It's a huge hormonal event for women, and you can't take one away from the other. All of it is part of the same experience.

The CHAIR: Absolutely.

The Hon. EMILY SUVAAL: I wonder if you could—Susan, starting with you—recommend the ways that we can support breastfeeding women and families more generally or what we could look to in terms of recommendations to improve support.

SUSAN TAWIA: Good question. They need to be aware of all the services that are available. I know this is very broad picture, but they need to be confident in themselves and their bodies and breast milk. There's a lot of advertising of alternatives to breast milk that undermines women's confidence in their bodies and their capability to look after their babies. So there's that. There's also societal support. Women cannot do it on their own. They need everybody, including governments, supporting them and supporting them to breastfeed—things like maternity protections, breastfeeding when they return to work, "breastfeeding welcome here" accreditation of workplaces. It comes from working with the mother as a simple person or a dyad with her baby, right through to big societal supports. It's not just one thing; there are lots of things. I could probably create a more comprehensive list; maybe I will take that on notice. It's more than just working one-on-one with the mum; it's a

whole lot of things. It's community support, peer support—everybody understanding the importance of breastfeeding.

The CHAIR: Did you have something to add, Ms Tyson?

AMY TYSON: Yes, I might quickly add. The first proposed solution from BAA for this inquiry is to fund and implement the Australian National Breastfeeding Strategy, which is a plan to increase breastfeeding rates. The ANBS includes the Global Strategy for Infant and Young Child Feeding, which states the 10 steps to successful breastfeeding, from UNICEF. Those 10 steps for successful breastfeeding from UNICEF could be implemented by every hospital in Australia tomorrow if they were told to do so, in addition then to peer support and support from individual health professionals and support from families, reducing birth trauma so that women aren't going into their mothering journey wounded. The funding and the implementing of that strategy could be instrumental to improving breastfeeding rates.

SUSAN TAWIA: Can I just second what Amy said and just also state that the ANBS was published in 2019.

AMY TYSON: Yes.

SUSAN TAWIA: Many breastfeeding advocates worked with the Federal department of health to create that blueprint for how to support mothers to breastfeed. Your recommendations could come from that. But that has just sat doing pretty well nothing. There's no implementation plan, and there's very little funding for it. ABA is actually funded to do its helpline through that, but we were funded for that from years before that. They do see that as an important service. If you look at the Australian National Breastfeeding Strategy 2019 and beyond, there would be a lot in there that would be very useful for your recommendations.

The CHAIR: Thank you both for your time today and for coming to give evidence. We really appreciate all the work that you're doing and also your submissions. It's so wonderful. I think there were some questions taken on notice, and the Committee might have further questions, which the secretariat will be in contact with you both about. Thank you again.

(The witnesses withdrew.)

Dr REBEKAH HOFFMAN, NSW and ACT Faculty Chair, The Royal Australian College of General Practitioners, affirmed and examined

Dr ISABELLA SUKKAR, General Practitioner, sworn and examined

The CHAIR: I now welcome our next witnesses. Thank you both for coming along today. Do either of you have a short opening statement you would like to make?

REBEKAH HOFFMAN: I do, thank you. The RACGP is Australia's largest professional general practice organisation. We represent over 4,000 members working in or towards a specialty career in general practice. In New South Wales and the ACT, the faculty actively supports and advocates for more than 13,000 GPs working across New South Wales, with a commitment to ensuring equitable access to health care for all. General practice plays a really vital role in pregnancy and birth-related care, with GPs providing a number of important functions into and relating to pregnancy and postnatal care. The role of a GP is integral to providing holistic and collaborative care during all phases of the antenatal and postnatal periods. GPs are in a unique position to identify and provide supportive, collaborative care to vulnerable patients and their families. We would like to thank the Committee for the opportunity to provide this evidence at this hearing.

The CHAIR: Did you have anything further to add with an opening statement, Dr Sukkar?

ISABELLA SUKKAR: No, that's fine.

Dr AMANDA COHN: For the record, I should declare that I'm a member and a fellow of the RACGP. We've heard a lot of evidence throughout the inquiry about the importance for patients of continuity of care with a known provider. A lot of that evidence has focused on midwives, and I understand that is the preference for a lot of people. Could you speak to some of the opportunities for GPs as providers of continuous care and perhaps also some of the barriers to that care being provided as well as it could be?

REBEKAH HOFFMAN: I think that GP, or general practice, is the only specialty where we can provide pre-conception care, antenatal care and post-conception care. We know patients' families, we know their mums, we know their brothers and we know their kids. We often care for all of them. The opportunity to have diagnosed illnesses before falling pregnant, as well as then to look after them after the pregnancy is completed, is a really unique position to be in. As a GP that's where we flourish, that's what we love and that's the care that we really enjoy; it's that whole-of-life care. I think that's a really lovely, unique position for this specialty to be in.

Dr AMANDA COHN: I'm also interested in some of the barriers. We've heard some quite shocking and distressing evidence from people about not getting the level of care that we would've hoped or expected from GPs. There's been some recent media attention on issues impacting the sector—for example, financial disincentives to providing longer consultations. I was hoping you could speak to what some of those barriers are and the things we might be able to address.

REBEKAH HOFFMAN: Absolutely. I'm happy to start with that one, talking about financial disincentives. There's not been a review on the rebates for general practice for the last 10 years. Specifically, when comparing antenatal care to physical care, the antenatal rebate for a patient is less than what it would be for a physical consult. If a patient comes to see me and I spend 15 minutes with them, their rebate for the time spent with their GP is less for being pregnant than if they'd come with a cold or flu. More than that, the recent tripling of the incentive payments, which meant that most GPs can now bulk-bill vulnerable populations, isn't tied to antenatal numbers. So you can't use those incentives on an antenatal number, the same as you can't use them on a mental health number.

If they come in with trauma post-partum and you're wanting to then bill a mental health item number as well, there's still no bulk-billing incentive and the rebate is less than if they had a cold or a flu. There is a significant cost disparity between GPs wanting to do what is often really complex antenatal care and being remunerated appropriately for it. What that means is often there's a gap. It means the cost of seeing a GP is increasing, with the AMA suggesting that a standard item level or a standard antenatal consult should be about \$102 for the cost to see a GP but the rebate that is provided for that is actually less than \$40. That means the patient has to cover that additional out-of-pocket cost or the GP has to reduce their fees to what it costs less than to cover those fees. There's quite a big gap in the payment that's there, and it's only increasing year on year.

Dr AMANDA COHN: I wanted to explore briefly the situation in rural and regional areas where historically—and, in some areas, still—there's a really important role for GP obstetricians who are providing medical support for deliveries in most cases. The number of GP obstetricians in New South Wales is really on the decline. What are some of the reasons for that and what can we do about it?

REBEKAH HOFFMAN: There was quite a disincentive for GPs being VMOs in the hospital, where GPs weren't recognised for all of their skills in the same way as non-GP specialists were, and there was a bit of a funding issue. The RACGP specifically is now funding a rural generalist program. We are now funding more GP obstetricians, particularly in those regional and rural areas. We've also started to train more FSP positions. That means that specialists who have another degree from a different country come to Australia now have a shorter training time and are required to train in regional and remote areas. There is a pathway for us to try to increase those numbers. But, yes, for the last decade there has been a significant decline in GP obs.

Dr AMANDA COHN: We've heard evidence to this inquiry about the gatekeeping role that GPs can play. Pregnant people who have chosen a different model of care often still need to see their GP first and get preliminary investigations and referral to some other kinds of service. Some people have said that their GP didn't have all the information they needed and that they weren't told about other local services that are available. What can NSW Health do to support you in your role so that GPs can give patients the best quality information to make an informed choice?

REBEKAH HOFFMAN: The GP is usually the first place that patients go to. They fall pregnant, they pee on a stick, their periods are late and they go to see their GP. That's a hugely rewarding visit for all of us. There are a number of places that GPs can go to to get information. One of those is what's called HealthPathways. HealthPathways are locally PHN-run. It is an online system that is regionally edited and each region is then responsible for updating that pathway. If a GP goes, "I've just moved to this area. I'm a brand-new locum. I don't know what's available," they can log into HealthPathways and say, "There's a great midwifery group program", "There are no local obstetricians", or maybe, "There are five local private obstetricians", with direct links to all of them as well.

The CHAIR: I might jump in with a couple of questions based on some of the information that we've heard during this inquiry. I know that a lot of women who have reported an experience of birth trauma go to their GP after the fact of the birth trauma and that you would be the first port of call for that. I'm wondering what resources and support should be included in addition so that GPs have access or have certain services that they can refer patients to who go to GPs explaining that they have had a very traumatic experience.

REBEKAH HOFFMAN: There's a number which we use. This morning I had a similar patient and we were able to use a mental healthcare plan program to enable her to see a psychologist that I know specialises in this field, and she could then have subsidised visits to see the mental health specialist. We've just heard from the ABA. They're fabulous; we use them all the time. We're also lucky enough to work with an IBCLC—a GP who's also a lactation consultant. But the tricky question that was asked before was what media do we use for which type. And it's different for all mums. There's not going to be one thing that works for all GPs or one thing that works for all mums, because, invariably, the mum comes and sees you after they were up at 2.00 a.m. looking on Google and going down a rabbit hole. A lot of what they've looked up isn't relevant or isn't in Australia. The GP needs to rationalise that, work with them and then work out what's right for them. That will be different for all of your patients.

The CHAIR: Absolutely. We've heard from psychologists this morning who think that the 10 Medicare rebate for psychological services should be increased to 40. We've heard as well from physiotherapists that there's still a limit in regard to how much women can have access to them. Do you support their calls to expand those services so that as these women come to GPs, you're able to refer them on to make sure that they're able to fully access these services? Can you talk a little more about what it means for GPs, in practice, if you were to provide—and you just gave an example where you were able to make sure they were given those 10 sessions with a psychologist. I'm assuming some of those patients may come back to the GP and say, "Now what?" I'm wanting to hear a little bit more about what pressure that puts on GPs and what we really need to recommend and put into place.

REBEKAH HOFFMAN: Absolutely. Keeping in mind there was 20 sessions. For mental health, there was 20 sessions during COVID and that was then scaled back to 10, which was where it was sitting, pre-existing, pre-COVID. The lovely thing about having the 20 sessions was that then your patients could touch base fortnightly. That doesn't mean that all patients will need 20 sessions, and the other part built into the mental healthcare plan is they have to come back and see their GP every five visits as well. So you need to go to them, "How are you going? What's working? What's not working? Should we try medication or seeing someone else? What is your support at home? What else do you need in your village?" And that might be another five sessions; that might be another 20 sessions. But then by touching base, you can have those conversations.

Physios, we love our pelvic floor physios. We are lucky enough to be spoilt for choice where we live to have some wonderful pelvic floor physios. But even if they are eligible under an extended primary care program then with those five sessions, by the time they've used one or two during pregnancy, that's a really limited number,

particularly if they've had a really large birth trauma and then the out-of-pocket costs that are faced from the physio sessions alone are really significant.

The CHAIR: What sorts of changes would you like to see there?

REBEKAH HOFFMAN: I think the changes really need to be targeted and based on the individual. The GPs are the ones that are often in the place best set to lead that and to be able to decide that, because not all of my patients will need 10 physio sessions but they all probably need one or two, so one during pregnancy and one after pregnancy. But some will need them weekly for six months. Some come out of pregnancy in wheelchairs and need some really significant time at a physio. Other mums really need intimate care with breastfeeding and lactation support. Others really need care with their mental health or may have had increased trauma with domestic violence or other traumas during pregnancy to work through. I think that as a GP for most of my patients, I'm very well placed to be able to sit there and work with them and go, "These are the supports available to you. This is what you need," because often they don't know themselves. But GPs working locally in their area know that and know that about their patients.

The CHAIR: My understanding is that it would be good for GPs themselves to have more flexibility in regard to how many Medicare-rebated sessions that their patients have and so the GP can say, "Okay, you might need 20 psychological sessions, so I'm going to recommend that." And then that way it's not kind of a cut-out system for every single person but rather it's the GP that allows that to be tailored, which also stops that whole cap that is currently in place which obviously doesn't work for many people.

REBEKAH HOFFMAN: Absolutely, because it's never a one size fits all. It's not even a one size fits most. It's every single pregnant patient you see is a different pregnant patient.

The Hon. SARAH MITCHELL: Thank you both for being here today. I wanted to pick up a little bit on what Dr Cohn asked about in relation to the provision of care in rural communities and regional areas because, as she rightly pointed out—and she and I both live in country areas—often it is a GP-led model of that healthcare delivery for people having babies. In terms of your rural generalist program, is there an anaesthetics component to that as well? One of the things that has happened in the north-west, where I live, at the moment is when you lose someone who has that speciality, there's often then a referral to another centre and you lose that continuity of care. Is that something you hear and is that part of what you look at with that rural generalist program as well?

REBEKAH HOFFMAN: The rural generalist program then sub-specialise in one area. They may elect to sub-specialise in more than one but that might be obstetrician, that might be emergency medicine, that might be anaesthetics. It's unlikely that they would specialise in more than one.

The Hon. SARAH MITCHELL: But are you hearing from your membership of just not having enough with the obstetrics speciality but also with the anaesthetics? Because, if there is an emergency then that local hospital can't manage that case. But is there anything that we could recommend around improving that particular area as well in your expertise?

REBEKAH HOFFMAN: Absolutely. I did a stint last year with the Royal Flying Doctors where you would actually fly into a regional town to provide their pregnancy care. But most of the women in those regional towns would have to leave to access delivery care, particularly if they were planning on delivering before mid-thirties, so before 32 to 34 weeks, which means they're removed from their supports, from their networks, often from their other children, to give birth and then go back to the community later. So, yes, that's safe because that means they're delivering somewhere that can provide high-needs care, but you're losing all of the supports that they've built in their community to be able to do that. I don't have a solution for you, but I know for the women I saw there, they really struggled with that.

The Hon. SARAH MITCHELL: And that's what I hear, too, locally.

The Hon. NATASHA MACLAREN-JONES: I have a couple of questions. One is around ensuring correct information and that more information is provided. We heard throughout a number of hearings that people want more information, but I wanted to know if you have a view of how we could more efficiently provide that accurate information to women when they're coming forward?

REBEKAH HOFFMAN: To women or to GPs?

The Hon. NATASHA MACLAREN-JONES: To women.

REBEKAH HOFFMAN: Sure. Again, every woman is different and everyone's going to want to get information in different ways. Often with my younger pregnant women, they want to get it online and they want to get it on social media and they like video format, and so that population really enjoy getting their information from that format. My older women, or some, really like research and they want to get numbers and they want you

to sit down with them and say, "Your risks are one-in-700. What that means is this." And then there are others that don't want anything and they just want you to tell them what to do. So everything needs to be available. There needs to be a video for the language literature level of an eight-year-old who talks through what the risks are through to the evidence and the research papers that we can then go, "This is what you need and this is what you need."

The Hon. NATASHA MACLAREN-JONES: Should that be centralised? Because I'm mindful that obviously if someone is out there looking at Google doctor, they can come up with all kinds of research where some of it's accurate and some of it's not. How do you ensure that? Does it need to be centralised through the Department of Health or through the GP network? What is the best way? And the same with, I suppose, using online and social media as another means.

REBEKAH HOFFMAN: It can still be State-based information and then regionally localised. So the information can still be exactly the same, particularly when it comes to risk, for all across the State and then regionally localised through things like HealthPathways.

The Hon. NATASHA MACLAREN-JONES: The other one is in relation to consent. We have heard throughout the hearings a number of individuals who raised concerns that they felt that consent was not obtained correctly. Do you have any advice or view in relation to how that can be improved and to also ensure protections for clinicians as well?

REBEKAH HOFFMAN: Absolutely. As a GP, we get consent all the time for our patients, whether it's before starting a new medication or putting a Mirena in or for doing a skin check. It's about making sure the patient understands what you're consenting for and the risks they're consenting for. Again, it's having all of the information across all of the levels because some of your patients won't understand what a C-section means. They will need you to really and specifically give a very basic level of information to understand. But the time needs to be there. The respect of the patient needs to be there to take the time to consent properly.

The Hon. NATASHA MACLAREN-JONES: Do you feel that GPs have that ability now time-wise to actually ensure informed consent?

REBEKAH HOFFMAN: I think we take the time when it's needed. I think again there's a spectrum of when you have to take the time and in emergencies. If your patient has anaphylaxis and the treatment is to give them adrenaline, you may just be saying to them, "I'm going to give you some adrenaline now. Three, two, one, there it is," because that's the emergency saving procedure you're doing to save their life. But if six months earlier they had come and seen me and said, "I think I get a rash when I have peanuts," then we have much more time to talk about what anaphylaxis is, what EpiPens are, what that is. So yes, consent is very, very important, but so is treating an emergency.

The Hon. EMILY SUVAAL: Thanks so much to you both for appearing today and for giving up your valuable time to be here. It's appreciated by all members of the Committee. I wanted to start by asking—in the NSW Health *A Blueprint for Action – Maternity Care in NSW*, it states all women should have access to a known GP, and that's something that I note was supported by a wide array of clinicians, obstetricians, midwives and lots of different sub-specialties within the sector. Can you recommend what we can do to better strengthen and support the role of GPs in maternity care?

REBEKAH HOFFMAN: Our national survey last year has identified that 85 per cent of people have a GP and have a named GP, and most of those have actually seen their GP in the last 12 months. The problem with that is the 15 per cent that don't are probably our most vulnerable populations. They're the groups that actively need to be worked with to identify a GP, to have one and to be encouraged to see them regularly, and the reasons, again, are often financial. It is often that they can't afford to see their GP for routine preventative care or for pregnancy planning because they're paying for accommodation or paying for fuel, or they're deciding, "What's more important, filling up my car with petrol or seeing my GP?" The reason people often don't see a GP is that financial component. I would love all of our patients to have a regular GP and to visit us every single year to talk about their healthcare goals, their wellbeing and how we can optimise their health for the coming year, but, unfortunately, often they have also got difficulty just paying their rent and their mortgage.

The Hon. EMILY SUVAAL: Obviously that 15 per cent is of the whole population, but is there anything specifically for maternity care that you could suggest or recommend that we do in terms of strengthening that important role that GPs play?

REBEKAH HOFFMAN: I think, again, GPs are often already where people go for that first port of call. I'd love GPs not just to be that first port of call but then also have the regular visits along the way. We often see them at that very first visit and then, even if they go off into our wonderful midwifery group programs, we're often seeing them again for their whooping cough and their vaccinations at about the 20- to 30-week mark, and then we

see them, when they've given birth, at two weeks, six weeks, four months and six months. So we have got good opportunity for regular longitudinal care. I would love to see that strengthened.

I'd love that it be additional visits that are funded. There is additional funding for whoever is the primary care obstetrician or GP to have a one-off additional visit at around the 28-week mark, but that can only go to one provider. So if the obstetrician is the lead provider then that rebate will go to them. The GP can't access that funding as well. If that was expanded so that the GP could also access that funding and the patients were encouraged to see them, then we can talk about pelvic floor, what to expect, to expect the unexpected, their supports at home and all of the other things that GPs can do really well.

The Hon. EMILY SUVAAL: The two-week and six-week visits that you referred to are obviously a really crucial time postnatally as well. Indeed, you may be the first person that someone has ventured out of the house to see. What can we do to better strengthen and support the role that GPs can play in those instrumental and key periods as well?

REBEKAH HOFFMAN: I think most GPs already do a really good job in this space. Often we really love this space. The two-week visit is currently an optional one. It's when, if they've gone home within the first four days of hospital, they're then asked to see their GP at two weeks. I'd love that to be an essential one, because getting out of the house at two weeks is actually vitally important—one, because they know they can do it then. Often mums, dads and bubs won't leave the house unless they have a medical appointment to go to. Having a two-week appointment and achieving that and getting out and seeing their GP to do a weigh in, to do a baby check, to listen to their heart and to listen to mum is actually more important than what we've been credit for.

The Hon. EMILY SUVAAL: Did you have anything to add to that?

ISABELLA SUKKAR: No.

The Hon. EMILY SUVAAL: A final question around the role of our wonderful GP obstetricians in regional New South Wales: What can we do to continue to support this workforce?

REBEKAH HOFFMAN: There are a number of issues that people don't want to go regionally and rurally, and that's probably what needs to be paid attention to. Doctors go regionally when their partners can get jobs, when their kids can be educated and when they're not on call by themselves and isolated. It really needs to be places where there's more than one GP obs, that ideally it's shared between two or three, because being on call as a solo GP obs is a really tricky position. But it's more than just the individual; it's the community. It needs to support the partner and their children as well.

I guess the bigger picture is for the FSP—the doctors who are trained overseas and are fully qualified coming to Australia and doing their supervised training in Australia. The largest number of doctors we have that are coming into Australia from there are actually from the UK. They've decided that they've got enough of the NHS and they would love to come to Australia. We go, "Great. Amazing. Welcome. Come." Up until two to three years ago there was funding for them to do their supervised training in Australia. We lost that funding about two years ago, so now they self-fund. They self-fund to the tune of about \$30,000 a year, and it takes about 18 months to do the paperwork to get here. In comparison, in New Zealand it costs them \$4,000 and takes six weeks. So if you're deciding where to go as a fully-trained family doctor or obstetrician, the stacks are weighed against us.

The Hon. EMILY SUVAAL: That's really interesting. Thank you for that additional piece of information. Thanks, Chair. That's all my questions.

The CHAIR: We do have a few more minutes left, Dr Amanda Cohn.

Dr AMANDA COHN: We've had a lot of evidence to the inquiry from people with special interests in particular aspects of maternity care. Earlier today we had breastfeeding advocates, we've heard from disability advocacy groups, we've heard about the need for culturally safe care and trauma-informed care, and there's a lot of talk of how health professionals should be better educated. I appreciate that for NSW Health and NSW Health employees it's a different picture from trying to provide additional education for GPs, because you are largely independent contractors in private businesses whose time isn't actually funded to do this sort of thing. What do we need to recommend in terms of incentives or support to actually encourage GPs to do some of that further training that's needed to provide safer care for all those different groups?

REBEKAH HOFFMAN: Thank you for acknowledging that. GPs are independent contractors; they're small businesses themselves. They're not paid a base salary by NSW Health or by anyone else. They're paid by charging the patient for their time. We are still required to do CPD as are all AHPRA-registered staff and people. We're required to do 50 hours of CPD a year. What I would say is: Make it free, make it quick and effective, and make it online, because all of those things are attractive for GPs. If it's something that we can go, "This is a really

important topic. It's not going to cost me money and I can do it in my own time," that's been shown to be really effective.

The CHAIR: Wonderful. Thank you so much for coming to give evidence today. If the Committee has further questions or if there were any questions taken on notice, the Committee secretariat will be in contact with you about that. We thank you again for your time today.

(The witnesses withdrew.)

(Short adjournment)

Dr EVELINE STAUB, Councillor and Neonatal Intensive Care Physician, Royal North Shore Hospital, affirmed and examined

Dr ELIZABETH SKINNER, Academic and Lecturer, Faculty of Nursing and Midwifery, University of Technology Sydney; Published Author and Reviewer on Birth Trauma; Co-founder of the Australasian Birth Trauma Association; and Expert/Trustee, UK Birth Trauma Association, sworn and examined

The CHAIR: I now welcome our next witnesses. Do either of you have a short opening statement that you'd like to give?

EVELINE STAUB: I do have an opening statement.

The CHAIR: We'll start with you.

EVELINE STAUB: Thank you. The Australian Medical Association (NSW) would like to thank the Select Committee on Birth Trauma for accepting a subsequent submission to this inquiry and for the chance to appear before you today. I am an AMA (NSW) councillor and the head of department of neonatology at Royal North Shore Hospital in St Leonards. Neonatology is the subspeciality of paediatrics that cares for newborn infants. I have been practising as an accredited neonatologist for 12 years, including 10 in Australia, with many more years of training before becoming a recognised specialist. Neonatology teams attend deliveries to help newborns after birth. We are the team for the baby, helping them as required to transition into the life outside of the womb.

When needed, infants suffering problems after birth are admitted to the neonatal intensive care unit or NICU. The NICU at Royal North Shore Hospital provides comprehensive intensive care for the sickest and most critically unwell babies from northern Sydney and across the State. While this inquiry has heard a great deal about the experiences and trauma suffered by birthing parents, AMA (NSW) believes it is critical for the Committee to hear submissions on behalf of those charged with caring for the baby in the mother-baby dyad immediately upon delivery. As you will see from the AMA (NSW) subsequent submission, we outline the clinical problems of the babies associated with complications that can arise from any birth and the difficulties in predicting those complications. Sometimes we know which babies are going to be in distress and which babies will need admission to the NICU—for example, those born early. But most of the time when my team gets called to help babies born at term, it is for cases that until that point showed little or no indication of needing assistance.

There is a saying in neonatology. It is a challenging saying, but the saying is "Time is brain". Quite literally, with every minute that a baby is in distress during delivery—by which we mean does not receive enough oxygen during delivery—the risk increases that this child can suffer lifelong brain damage or worse. Once a baby reaches this level of emergency, it is vital that specialist care is provided as soon as possible. As minutes tick by, so too does a baby's chance of a normal life or a life at all. Many parents are completely unaware what the potential consequences are when their baby suffers from a lack of oxygen during birth and what the obstetric and midwifery staff do to try to avoid this situation at all costs. One of the most common comments I hear from families whose babies I care for in the NICU is "We never knew this could happen". This is why AMA (NSW) advocates for increased antenatal education for all parents, which includes how events during delivery can be unpredictable and can require a fast change of tack to avoid adverse outcomes for the baby.

In my home country of Switzerland, it is routine for neonatologists or paediatricians to be involved in antenatal education to advise parents about the potential for unplanned outcomes and the care that could be provided as a result. This ensures that parents are better prepared when things do not go as hoped and gives them a greater understanding of what interventions doctors might require to save a baby in times of emergency. If parents are armed with this education before such time as it is needed, they are less likely to be traumatised when issues occur and will have more time to consider and discuss their wishes prior to a time of high-stress emergency. AMA (NSW) believes comprehensive education involving neonatologists and paediatricians should be made available as part of every birthing parent's antenatal preparation and that funding should be made available to allow such programs to be formulated and implemented across the State. Thank you for your time. I'm open to questions.

The CHAIR: Thank you. Dr Skinner, did you have a short opening statement you'd like to make?

ELIZABETH SKINNER: Yes. I haven't written it down.

The CHAIR: That's okay.

ELIZABETH SKINNER: My background is trauma nursing, intensive care. I've worked in London, Sydney and Melbourne over the last couple of decades and am an educator. I did a PhD with the faculty of medicine in the department of obstetrics and gynaecology and neonatology. I've worked in NICUs in several major

hospitals, so I totally uphold what Ms Staub was talking about. The reason I did my PhD was because I saw some very bad outcomes. I went to London and I liaised—I'm an expert at the Birth Trauma Association there, which they've had since 2003. I thought it was really important we needed one, so we started it in 2016.¹ In London the PTSD team at City, University of London I liaise with constantly now and they've done amazing work with childbirth. It connected with my research. I agree with everything that Ms Staub has just said and I look forward to questions.

Dr AMANDA COHN: Thanks so much for being here and for sharing your expertise with us today. My first question is for Dr Skinner. I was interested in your written submission. You talked about evidence that some management changes that were aiming to reduce caesarean section rates actually ended up increasing the prevalence of perineal trauma. It's very interesting that this inquiry has been going on for several months now and I don't think we've talked about the Towards Normal Birth initiative in New South Wales, which I'm sure you'd be familiar with.

ELIZABETH SKINNER: Yes, I was looking it up this morning. My PhD finished in 2019 and it was a big struggle all the way through that PhD, because nothing had been really done, but I can see now it's been changed and there are a lot of really positive outcomes.²

Dr AMANDA COHN: I'm interested in your perspective on that kind of top-down directive to either do or not do a particular type of intervention and what impact that's had on birth trauma.

ELIZABETH SKINNER: I just want, like everybody, the best outcome for mothers. I'm not into it for having total caesarean sections. If there's a big baby born and if there's forceps looking like they're going to be used, my research showed that it would be better to have a caesarean section if possible. Because I did—with urogynaecologists and that's what I review with now in London, where the levator ani muscle, which is attached to the os pubis, snaps and you get terrible prolapses. The vagina has three—the bowel, the bladder and the uterus possibly. The mothers don't know that's going to happen—trying to look at caesars to avert that.³

Dr AMANDA COHN: You mentioned the levator ani avulsion in your answer just now, and we had some really compelling evidence earlier in this inquiry from people who have that injury about the really profound impact it's had on their lives. Do you have recommendations for us in terms of how we can pick that up earlier and provide people with better support?

ELIZABETH SKINNER: Definitely. I think that there need to be guidelines. All the way through the PhD, there were no guidelines anywhere and that's where the Towards Normal Birth came in. It was never mentioned that that was happening. The difference between pelvic floor and perineal injury—with the 40 women I interviewed for two years, which was off a huge database from a urogynaecologist and they'd all been examined. It was the horrendous stories, absolutely horrendous stories. Twenty-two of the 40 had OASIS—obstetric anal sphincter injuries—as well as levator. So the question was how to avert this: guidelines, information, informed consent.

Dr AMANDA COHN: Yes, we've had a lot about prevention in this inquiry, but what are the opportunities for earlier intervention and management?

ELIZABETH SKINNER: That's what I said—the big baby, the first child—which was what the evidence says. That's what the doctors I work with in London say: to avert that if it's a big baby and a small person, an Asian person. They were the collagen—there's a guy in Bristol that's doing stuff with that. Look at the research. There's hundreds of papers. Michigan's Professor DeLancey.

Dr AMANDA COHN: I have another question for Dr Staub, but feel free to both chime in. We've had lots of discussion in this inquiry about antenatal care and generally people wanting more information. When, in your opinion, is the most appropriate time to provide that or what modality is the most appropriate time to provide that?

EVELINE STAUB: It's a very good question because, obviously, you want to provide this information—particularly around potential adverse outcomes of the baby and what would be done about it and what is being

¹ [Correspondence](#) from Dr Elizabeth Skinner providing transcript clarifications on 30 April 2024, p 1.

² As above.

³ [Correspondence](#) from Dr Elizabeth Skinner providing transcript clarifications on 30 April 2024, p 2.

done to try and prevent it—as close to delivery as possible but then also, obviously, get the parents to know that some stuff can happen earlier. I don't think there is a right or wrong time point for that. If there was a curriculum to be developed around antenatal education, we'd work out the proper time points. But our point is mainly that, somewhere in there, there needs to be information about what could potentially happen to the baby without this being scaremongering but more in the framework of knowledge is empowerment and it will help parents to not be so traumatised after it. Not in the first antenatal education but somewhere closer to the time of delivery will probably be appropriate. But that's going to be the subject of the development of curriculum, as to when exactly.

ELIZABETH SKINNER: I agree, totally.

The Hon. EMILY SUVAAL: Thank you to you both for appearing today and giving up time to give evidence to this valuable Committee. I might start with a question to yourself, Dr Skinner. Thinking of the obviously extensive research work that you've undertaken, what recommendations would you have that the Committee consider in how we might better support women following a physical birth trauma? Quite a broad question.

ELIZABETH SKINNER: Yes, that's a huge, huge question. I heard, when I was sitting in before, "increase psychological support"—definitely. It's picking up the signs and symptoms—for the nursing staff, the midwifery staff, the GPs to pick up the signs and symptoms because a lot of it is they give them an EPDS, which is the Edinburgh Postnatal Depression Scale. In my PhD I did a comparison. It's like apples and oranges: They may have depression but PTSD is a totally different story. Guidelines for the staff on how to pick this up. London's been trying to do this. The NHS is obviously having problems but they're trying to do that. That's City, University of London and their psychologist that I worked with, Professor Susan Ayers. So, yes, you're looking at guidelines, support for the father—the father is often just as traumatised. But don't let them go home with it—picking up these symptoms. If you're letting people go home and into the community, which is what was happening when I was interviewing these people—it was just terrible.

Also, a lot of the psychologists—I actually in-serviced psychologists at one of the places. Gidget House—you might have heard of it—they didn't even know what levator ani was. They didn't know what pelvic floor injuries were. One woman went to a psychiatrist and they told her she was making it up and they referred her to me, which was awful because she was ready to suicide.⁴ So these are really awful, awful stories. So, like I said, don't let them go home, and implement guidelines. What London was trying to do, or is trying to do as we speak, is have in-services for all the staff because I know, having worked at major hospitals myself while I was doing this research, the staff had no idea. They kept saying, "Oh, can you give us in-services on this. We can see they're really traumatised but we don't know how to deal with it." So I've sort of been on the front line, I suppose.

The Hon. EMILY SUVAAL: So just to clarify, you're talking more about the psychological birth trauma and PTSD—so not letting someone go home.

ELIZABETH SKINNER: Oh, and the other.

The Hon. EMILY SUVAAL: Physical birth injuries as well, okay. Because you mentioned the Edinburgh depression scale—

ELIZABETH SKINNER: That's it.

The Hon. EMILY SUVAAL: Are you saying that that is not good at—you said "apples and oranges".

ELIZABETH SKINNER: It's good to pick up depression but you need to have a PTSD scale. So there's quite a few—once again, I'm going to go back to Susan Ayers because they've developed a scale. Perth contacted me and they wanted that scale. So some different people—yes. So that's the psychological side. The other side—3D/4D ultrasound. A lot of these people, or most of them, don't know what a urogynaecologist is and so it's thrown to the GPs, and GPs can't do everything. I mean, they're wonderful, and I was sitting in there hearing all this wonderful stuff the GPs do do, but they can't do everything. They've got injuries that they don't know anything about and 3D/4D ultrasound could be in hospitals to find out where they've got levator ani damage.

The Hon. EMILY SUVAAL: My next question is to Dr Staub. We've heard a lot about, obviously, the need to consider what women's psychological and physical outcomes during the birth process are going to be. Could you just explain to the Committee what we should consider from a fetal or a newborn perspective?

EVELINE STAUB: In what sense? The outcomes of the baby?

⁴ [Correspondence](#) from Dr Elizabeth Skinner providing transcript clarifications on 30 April 2024, pp 2-3.

The Hon. EMILY SUVAAL: Yes.

EVELINE STAUB: In the education for the women or just—

The Hon. EMILY SUVAAL: Just generally speaking. We've heard about the need to consider, throughout the birthing process, the importance of preserving both a woman's physical and psychological outcomes. But I just wondered if you could let the Committee know, from the perspective of a newborn or, indeed, a fetus.

EVELINE STAUB: Sure, yes, absolutely. I think that the quite simple answer to that is the health of the baby over all and an intact outcome without distress to a point where we fear that the baby is going to have damage from it, particularly in terms of their brain. I think a lot of the submissions into this inquiry have talked about the difficulties of recognising when is an intervention required and the time pressure that staff are under to make that decision. Eventually, the approach often is you fear the worst for the best possible outcome—so intervene at a point where we're confident that the baby is not going to be harmed significantly. But, again, this dyad of both a mother and a baby that need to be looked after in this process of delivery needs very much attention to the mother: her good outcome, not just physically but also psychologically. But then there's this other person that needs looking after as well, and decisions that are being made and discussions that are being held need to take both into account. Again, the most simple answer to that is we want a healthy baby at the end of this.

The Hon. EMILY SUVAAL: Obviously, when a newborn baby's admitted to a NICU—in particular, obviously, the NICU like the one that you work in—that's quite a distressing time for families. How can we best support families during this time?

EVELINE STAUB: A lot of it is good and honest information for the parents. It is empowerment for them that, even if temporarily we take care of their baby, their most precious little person, they're still parents and there's a lot they can still do. Even though it looks like we're taking over, that's not true. We always say that the parents are very much part of the team. They can visit at any hour, and it's not just visiting; it's being there for the babies. It's talking to them, holding them, helping with care as much as is feasible in the circumstances, and making sure they realise they're the most important people in that baby's life and we're just there temporarily to make sure the baby is fine and can go home with them. So, really, it's a lot around empowerment and information. It's very confronting to have a baby in the NICU, and it needs compassionate but honest information about what is going on.

The Hon. EMILY SUVAAL: I wonder if I could take you back to your previous response when you talked about the pressures that are on staff. Is this around, in terms of your opening statement, "time is brain"?

EVELINE STAUB: I think these are discussions about what potentially might happen to the baby and what the outcome might look like. That information cannot be provided while a woman is in pain and delivering as we speak. That's just not an appropriate time to give them this information, which is why it needs to happen before that so that they are aware that sometimes things do not go as hoped and planned, and might need intervention in order, yes, of course, to save the mother and for a good outcome for the mother but also for the baby. Our point very much is that this is not information that can happen in the moment. It's too much—it's too emotional; it's too much pain. There's too much going on.

The Hon. EMILY SUVAAL: We heard an example earlier on in the inquiry: a scenario where someone might present to the woman some options, seek informed consent, and step outside and give them some time. How realistic is that in the scenario we—

EVELINE STAUB: It is not realistic. If we talk about literally minutes where the distress of the baby can go from bad to worse and then start causing brain damage, those are five, 10, 15 minutes you don't have. While some babies might be okay still after 15 minutes, some aren't. We don't know in advance which baby is going to be okay after 15 minutes and which one is going to have severe brain damage after five minutes, which is why we need to go in with the attitude that every baby needs swift intervention.

The Hon. SARAH MITCHELL: I have a few questions and I want to start with you, Dr Skinner. Thank you for your very comprehensive submission in terms of the research and the work that you are doing and have done over many years, I should say. One part that stood out to me is when you said that some of the PTSD symptoms that women who have experienced birth trauma go through are similar to those that are often described as what war veterans experience, which I thought was quite a compelling line. Could you maybe elucidate or elaborate on that a little bit more? Obviously this Committee will help in terms of raising awareness of birth trauma, but do you think there needs to be more available in the public domain around what some women experience and how not just health professionals but the general community can be more aware of these issues?

ELIZABETH SKINNER: Yes, I do. No-one was more shocked than me when, in the beginning, one of the women said, "Don't tell me I have PND. I don't; I have PTSD." And I thought that I've got to talk to some really good people, so that's why I got onto London. The symptoms that they were all suffering from—most of them had even four to five symptoms. They were re-experiencing it constantly, they were having nightmares, and there were avoidance and numbness, which definitely need to be put out there. There's lots of Facebook pages where people are talking about it, but that's not enough. It needs to be through the health department. It needs to be formatted and it needs to have guidelines. The staff in the hospitals need to be able to have guidelines. That's why Susan Ayers wrote out this tool, if you like, or instrument.

But for a long time they were using the same one as the war veterans, which is terrifying—that it's exactly the same. In one of the chapters that I wrote, I had to go into the history of how that was never looked at properly either for years and years. It wasn't until the 1980s or something that that was looked at. For the DSM, there isn't anything for PTSD. There wasn't anything for PND until the '90s and Cox et al in Edinburgh—it's just way, way back there. I belong to an association called the Marcé association—I've presented internationally and here—and they're on the same page. NSW Health would benefit, or the mothers would benefit greatly, and the fathers. The fathers are the silent people; they're watching this. And so you have marital breakdowns, you have sexual dysfunction because of all those prolapses and they don't know what is going on. They went into a delivery thinking it was going to be a natural birth and all was going to be good, and, yes, sometimes—I've seen some lovely natural births. I'm not against them. But these outcomes are a disaster.

The Hon. SARAH MITCHELL: That leads me to my second question, which is around support for partners and the family unit as a whole. We've heard evidence about how much information people need beforehand but also about the role of the partner or support person. Where do you think the gaps are in terms of the information that is available for partners throughout this process?

ELIZABETH SKINNER: Zero, absolute zero. I spoke to London—I speak to them all the time—and I found seven men who spoke to me for hours, and they tried everything. They tried to talk to doctors. They tried to talk to—my PhD was 2015 to 2019. It may be better now—there are some men coming forward with this stuff—but zero, because their wives or partners were just numb. They said they were totally changed—absolutely, totally changed—from one person before the delivery to one person after the delivery, and there was just a no-go zone. There was zero information and they said, "Where do we look? We look on the internet and we can't find it." I suppose in deliveries we often think that these husbands, partners or support people are medical, but they're not.

The Hon. SARAH MITCHELL: That's consistent with some of the evidence that we've heard. Dr Staub, one of the things that we've heard in some earlier hearing days from other medical professionals is that as we start to see women having babies older and with more fertility treatments that is leading to more necessary medical interventions. In your experience, can you talk about whether you've seen an increase in that, particularly in the last five to 10 years. Do you think that those medical advancements that allow women with other comorbidities or age factors to have babies a bit later than they normally would have had an impact on birth trauma or the outcomes for children?

EVELINE STAUB: The medical evidence is definitely there—that advanced maternal age and assisted reproduction does lead to more complications around birth. I can't speak for the obstetrics side because I am obviously on the neonatal side. But even on the neonatal side we know that the rate of adverse outcomes for infants is higher in mothers with advanced maternal age and after reproductive assistance: more preterm birth but also other complications like gestational diabetes and hypertension that may lead to growth restriction in the baby, more monitoring required after birth and, therefore, also more admission to the neonatal intensive care unit.

The Hon. SARAH MITCHELL: Again, this is a general question. In your experience, do you think that the mothers or women are prepared for that potential—not complication. I'm not finding my words very well. Are women educated that maybe there is a higher risk related to their personal circumstances?

EVELINE STAUB: Some but definitely not the majority, I would say, from my perspective. Again, I'm speaking from a perspective where I meet these families in that worst-case scenario where their baby needs to come to the NICU. I can't speak for all those that I never get to meet; I hope that they were aware of it. But very many that come under my care and the care of my colleagues will say, "We never knew this could happen" or "We weren't aware that this is potentially a problem", even though they say, "Yes, I knew my baby was small but I didn't realise what then happens after if the baby is small"—as in they get cold, their blood sugar is low, they don't feed well and hence need admission to the NICU, for example. That bit kind of then doesn't happen.

The Hon. SARAH MITCHELL: Again, I know this has been touched on a little bit. In some of that prenatal education space, I think the Committee is grappling with how much information is too much. Statistics

can be interpreted in different ways depending on how you look at things. Is there a gap in terms of the information that's available, particularly to people who might be in a higher risk category, and could that be improved?

EVELINE STAUB: I feel, from my perspective, yes. It is a fine line between providing good information that's valuable and scaring people, and we don't want to do that—absolutely not. We feel it's probably more traumatising to stick your head in the sand, for lack of better words, than having that information that "what happens if". It's very much along the lines of, "Look, we really wish and hope it's all going to go to plan but we see X, Y and Z complication leading up to the birth. This is what sometimes happens to the babies. If it happens, we're there for you. Yes, it might mean temporary separation, but you're still that baby's mum. Please, come with us to the NICU. We will show you this is what you can do for your baby while it's in the NICU." It's empowering education rather than, "You're 40 and this is going to happen to the baby." You can't do that.

The Hon. SARAH MITCHELL: Yes, and obviously every circumstance and every birth is different.

EVELINE STAUB: Absolutely, yes. Again, the same information might not be valuable in the same way for every parent. But, by and large, coming from that experience that so many parents tell us—"This world is completely new to us. We didn't even know that you as a specialist existed."—that just speaks for a larger demand or a larger requirement of some education in that space.

The CHAIR: I will follow up with a question, Dr Staub, from something you said earlier today during your evidence. I think you were talking about a window of five to 15 minutes to give families that time to make a decision or for informed consent and that that could lead to different outcomes for that baby. At the same time, during this inquiry, we've heard from women a range of different stories. One story that really comes to mind is a woman that was told that her baby was in distress and she needed an emergency C-section. As she was wheeled in for surgery, the doctor said, "We're going for our dinner break now and we'll come back and do the surgery an hour or so later." How do we marry this up? If we're hearing that five minutes could make a difference, but then it's okay to also in an emergency have a dinner break and come back in an hour, you can see how some of these stories aren't matching with what is being said on the other side. That is what's leading to a lot of confusion and distress.

EVELINE STAUB: I absolutely agree. I am not sure I can comment on the dinner break situation.

The CHAIR: Sorry, that was just an example.

EVELINE STAUB: I completely understand where you're coming from. From my expertise, from the neonatal side, I get called when it gets dire. I get to see very few very normal beautiful births. But I do get called to situations where an emergency caesarean section had to happen but then the baby comes out and is lovely and is doing really well and can stay with the mum. Again, I don't think I can comment on this because it's very much obstetric decision-making. I think the only thing I can say is that all the tools that we have to monitor babies during delivery are not perfect, and I think herein lies the difficulty.

The CHAIR: Would I be right in saying that the whole idea of informed consent and information ideally needs to be provided before there's any kind of extreme emergency so that it's in place particularly for those times when someone like you might be called in where it's a really extreme emergency and there may not be time? However, my understanding from having heard from a few witnesses now is that there is a bit of a scale. There are low-level emergencies and in those situations consent and information and possibly time in some situations should still be incorporated and reconfirming that consent and information where we can, but the consent for extreme emergency situations where specialists like you come in should have been obtained prior to ever being in that situation.

EVELINE STAUB: I absolutely agree. Whenever possible there should be a discussion around, "This is what we are planning to do. Are you okay for us to do this?" Absolutely. I'm coming more from that side of this absolute emergency where it is really hard to gain that informed consent because it is so stressful. I believe there was a statement in the session before us where one of the GP representatives talked about the situation of anaphylaxis and giving adrenaline, where you just do what you need to do in order to avoid adverse outcomes. That's when this perspective and consent is important, where the consent in the moment is really difficult and you can't say this is informed consent because this is just trying to save lives.

The CHAIR: The other thing that has come up a lot is the dialogue. It's not specific to this session or your evidence, but something that's constantly coming up throughout this inquiry is this whole idea that there are two patients. My understanding from a lot of the individuals and mothers that are coming forward is that obviously they want their baby prioritised but they're also recognising that, when the baby is prioritised and they aren't, that creates the trauma and that causes long-term impacts for that really important relationship in those early stages straight after birth. Obviously, sometimes that's completely unavoidable. I think what a lot of these individual mothers are saying is that we need to make sure that they're treated equally rather than only prioritising one patient

over the other. How do we get there, in your area, to make sure that there's no accidental trauma that can affect that bond? What are things that are avoidable that we need to change in the system?

EVELINE STAUB: I'm not sure we know that answer, to be very honest. In the situation, you are dealing with the mum who is there physically and the baby who is not yet born and we can only get indirect signals. To get those priorities right, I would think, is extremely difficult to do. I'm not sure I can make any recommendations.

The CHAIR: I'm happy for you to take it on notice, if you want to think about it.

EVELINE STAUB: Yes, I could do that. I don't think I can give you an answer right now, so I might take it on notice.

The CHAIR: Dr Skinner, I will throw that question to you as well. I'm happy for you to also take it on notice, if you would like. How do we find that balance where a lot of these women are saying that—and I want to make it clear that I don't think women are saying that they want to be prioritised over the baby. I think they're saying that they need to also be recognised as a patient themselves because, when we are only focused on the baby, we create trauma and then we have failed the baby as well in that sense because we have created the trauma in those early stages of bonding. What do you think we need to do to ensure that the way that women are treated is better through this birthing process so that we can avoid trauma in the first place?

ELIZABETH SKINNER: This is postnatal?

The CHAIR: At any stage—before, during or after.

ELIZABETH SKINNER: Informed consent is the big thing, and we've got risk factors. There are international urogynecologists that know this. I think the guidelines need to be formatted. As we are saying, we don't want to frighten them, but the mothers all said, "We wanted to know. We don't know what a rectocele is and that's what we've got. Our bowel is prolapsed. We've got all these things and you're talking this language that we don't know." I think the guidelines—and there are hundreds of international peer reviewed papers that are written. I review them too. I think we need to have informed consent, just as if I'm having, I don't know, a toenail removed and I'm getting informed consent, not in a state where you're going to frighten them but in the antenatal period. I know there are a lot of great doctors out there—obstetricians, some of the hospitals—that are doing just that. They are saying, "This is way it could go, and this is the way we don't want it to go." I think that is good. I was recently listening to that sort of stuff and the mothers were saying, "Yes, they told me that I would probably end up with a caesar." So I think—is that clear?

The CHAIR: That's useful. Thank you. I've got another question for you, Dr Skinner. You've obviously done a lot of research in the space and now run that postnatal education service for women who endured vaginal birth damage and also emotional trauma. I assume you set up this service because there was a gap in this sort of care. What additional services and supports are needed for women across New South Wales—regional and rural as well as Sydney—that have experienced physical or psychological birth trauma?

ELIZABETH SKINNER: The service was only set up prior to COVID, and then COVID happened. It was set up because the people in Perth St John of God wanted that research and they heard me speak at a conference. They said, "Can you teach all of"—it was originally set up to teach health professionals: psychiatrists, psychologists, also social workers. It was a whole gamut. I did that online. I haven't done a lot with it, and funding—funding, funding, funding. I know that is the dirty word, but it's to help parents. Like I said, I haven't done a lot with it, and the parents that contact me are often too scared and they feel shame. They feel that they haven't lived up to "yummy mummy", and the dad feels, "I don't want to talk about my sex life to a stranger." I don't know how we can do that. It's not just me. I would love a lot of people to come on board here and teach our nurses how much—that's what I'm in the business of teaching—to know all of this and to walk alongside this. It's a drop in the ocean, the stuff I did, at the moment—but here's hoping.

The CHAIR: You'd obviously like to see some more funding for that service to really roll out?

ELIZABETH SKINNER: Absolutely.

The CHAIR: What would funding do? What sort of support service?

ELIZABETH SKINNER: Well, there's education, postnatal stuff. It's for the health professionals. It would help them because they don't really understand the levator ani, quite reasonably. So get a whole lot of people on board to do that, but also the disasters afterwards, so that you can direct them to talk to psychologists and psychiatrists. You don't want people wandering around with PTSD like that woman. There were multiple people like that, but that one sticks out in my head. She was going to take some children under a train, and if I hadn't been called in—she heard a thing I did on the media and contacted someone in the medical school and

they contacted me. It's kind of like, no, you don't want to do that. It was two children going to go under a train. It's just ugh.

The CHAIR: I understand. For the Committee's recommendations, can I get a little bit of an elevator pitch in regard to that program and where it's up to, and whether it is ready to roll out or needs more work to develop it?

ELIZABETH SKINNER: No, it needs more work. COVID happened.

The CHAIR: It sort of pulled you away from that?

ELIZABETH SKINNER: Absolutely, yes. I set up the site and I've done a whole lot of stuff, and I did that stuff with Perth, but then COVID happened.

The CHAIR: So it needs—

ELIZABETH SKINNER: A lot. A lot needs to be done.

The CHAIR: You are predicting my next questions.

ELIZABETH SKINNER: That's why I didn't—I'm glad you brought it up because I think it's really important. I need people, manpower.

The CHAIR: Or womanpower, maybe!

ELIZABETH SKINNER: Womanpower, yes.

The Hon. MARK BANASIAK: Picking up on some of your comments, Dr Skinner, to Ms Hurst's questions, you spoke about guidelines. Sometimes doctors probably give it to patients in doctor-speak rather than normal-speak. Do we need to spend some more time in medical training teaching doctors how to translate that to normal, real-world speak? In other words, in terms of, "Yes, this is the procedure. This may be the risk. This is what it would look like for you if things don't go right." Do we need to help doctors break it down into more digestible speak for patients?

ELIZABETH SKINNER: I think the doctors are doing a great job. Those doctors at the particular hospital, I think they're doing a great job but I just don't know whether they've read the research. The doctors themselves often tell the mothers, "It's going to be all right." There's sort of a gap there. There needs to be more education, definitely. How much can the dollar stretch?

The Hon. MARK BANASIAK: In terms of doctors not reading the research and not keeping up to date with the research, I'd draw a similar analogy with teaching. You go through your teaching degree, you get your spiel about the educational theorists, and then you go out and teach. All that stuff that you learn at university sort of goes out the window when you're actually out in the real world doing it all, and you don't really have time to continually go back and check what the latest research is saying. Do you think that is potentially the issue here?

ELIZABETH SKINNER: It is the issue. We need to have a team working together—doctors and nurses and midwives—on how to attack this. Yes. But, you know, just some stuff in medical school where they just have a session or two, I don't know whether that is going to work. I am big on more in-servicing when you're out there on the floor. You've got your GPs, and conferences are good.

The Hon. MARK BANASIAK: That's obviously all happening now. We need to obviously do more to make sure that we are hitting the mark, because you're saying that you're getting doctors that aren't actually knowing the latest research.

ELIZABETH SKINNER: Well, the mothers on the—I'm only going by all the sites that are growing on all the different Facebooks et cetera. They're still there, and they're still not able to talk to their husbands, and they're still not coping. They're going overseas and spending huge amounts of money to get surgery, and they're not sure what to do.

The Hon. MARK BANASIAK: So it's the case that the in-services and the conferences aren't really enough in terms of keeping doctors apprised?

ELIZABETH SKINNER: Like I said, sitting and listening to the GPs before—and I've worked with GPs. They're fantastic people. And all the neonatologists—there is only so much we can do. I think some guidelines of how to approach mothers, antenatally and postnatally—and fathers. The father is always left out.

The Hon. EMILY SUVAAL: I have a follow-up question regarding workforce that I am happy for you both to answer. Specifically, the example that you gave, Dr Staub, about neonatologists or paediatricians ideally providing some of that antenatal education, which sounds amazing. But in the world we exist in, here in New

South Wales, and the shortages—the lack of paediatricians and neonatologists that we have, and your comments earlier that you're a finite resource—what can we do in the interim, if we can't have the ideal world where we have paediatricians and neonatologists giving that expert antenatal care? What is a good stepping stone?

EVELINE STAUB: It is an excellent point that you're making that we don't have the luxury of enough paediatricians and neonatologists to do this all face to face. I think we would welcome the opportunity to develop a multidisciplinary curriculum where everyone has their say and their input and thinking about the delivery thereof. Obviously, we have learned now through COVID that it doesn't all need to be face to face. Not all people respond to the same way of education. Some need visual, some need audible influence, others want pamphlets, and it needs to cover all of these aspects.

But we'll definitely welcome the chance to work with NSW Health on this sort of education and also tailor it to particular situations. A woman in the inner city of Sydney is not the same situation as someone who lives regionally or rurally, where we need to talk a lot more about the setting of birth. There might be a need for the baby to be transferred out by NETS if the need arises, whereas someone delivering at North Shore might not need that. It needs to be tailored to particular situations.

The Hon. EMILY SUVAAL: Do you have anything to add, Dr Skinner?

ELIZABETH SKINNER: No, I agree totally.

The Hon. EMILY SUVAAL: I'm just wondering, again, if you'll indulge me in a follow-up question. In my own experience, doing a tour of the NICU ward prior to having my baby—it was a high risk—I wonder whether or not that should be an option at least, given what you've also said about not knowing who you're going to see. You know the high risk, but there's also a cohort that you don't anticipate needing to see. For them it could be even more traumatic because they haven't had the benefit of the lead-up. Would that be something that would be at all useful or beneficial in that antenatal period also?

EVELINE STAUB: Absolutely. I'm really glad to hear that you had the opportunity to have that NICU tour—

The Hon. EMILY SUVAAL: Yes, shout-out to John Hunter Hospital.

EVELINE STAUB: —because it is quite confronting if you've not had warning, and absolutely even more so in women who've never even heard of a NICU existing. There is a number of NICUs now who have virtual tours available on their website.

The Hon. EMILY SUVAAL: Awesome.

EVELINE STAUB: Things like that definitely could be incorporated into that curriculum. It needs some visual input, absolutely. Where it's often not enough, it needs that visual impression of what a baby looks like in the NICU, absolutely.

The Hon. EMILY SUVAAL: But then people also need to know that the virtual tour exists and is an option for them to do.

EVELINE STAUB: Yes, absolutely. It needs to be part of that information, absolutely. I couldn't agree more.

The CHAIR: Are there any further questions from the Committee? In that case, thank you both so much for coming today and providing evidence. We really appreciate your time. If there were any questions that were taken on notice, or if the Committee has any further questions that we didn't ask you today but think of later, the Committee secretariat will be in contact with you about those. Thank you very much.

(The witnesses withdrew.)

Ms DEB WILLCOX, AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Health, on former affirmation

Ms DEB MATHA, Director, Maternity, Policy and Strategy, Health and Social Policy Branch, Ministry of Health, affirmed and examined

Ms JACINTA SELBY, Principal Midwifery Manager, Sydney Local Health District, and Midwifery Manager, Concord MGP, sworn and examined

Ms JULIE SWAIN, Deputy Director of Nursing and Midwifery – Women's and Newborn Health, Western Sydney Local Health District, affirmed and examined

Dr ANDREW PESCE, Clinical Network Director – Women's Health, Western Sydney Local Health District, affirmed and examined

The CHAIR: I now welcome our next and last witnesses to the inquiry into birth trauma. To begin, do any of you have a short opening statement you'd like to give?

ANDREW PESCE: Yes. This is a test of whether a doctor can read his own handwriting! Thank you for the opportunity to appear as a witness and make an opening statement. I appear in my capacity as clinical network director. I have been an obstetrician for 36 years. I've worked across the spectrum of obstetric practice, including rural, metropolitan, private practice, and public hospital maternity service, including as a collaborating obstetrician working with privately practising midwives as well as public case load midwives. When I trained, all of our focus was on decreasing perinatal mortality and long-term severe disability. Though this is a clear objective, unfortunately we've always had to work with significant uncertainty when risk escalates. The less than perfect tests of fetal wellbeing and the risk of catastrophic outcomes that is the responsibility of the clinician induces a whole lot of stress for the clinician, as well as the woman and her partner.

It's clear that in our pursuit of what we have seen as maternal and fetal safety we have failed to respond to the needs of many women. Continuity models of care are a significant step forward in addressing this, as my experience as well as the research demonstrate that care from a known and trusted caregiver is likely to be perceived as caring and understanding and decreases the perception of a failure of care. In Western Sydney we've attempted to improve continuity of care, including being one of the few districts with credentialing for privately practising midwives and a significant case load midwifery program. But in spite of this, when risk escalates it is likely that an obstetrician will be responding to that at the time. That obstetrician has likely never had any real contact with the woman previously. It's a challenge to ensure that women in this situation feel that they're being listened to and can take an adequate role and participate in the decision-making process.

We've heard much in the way that antenatal education can improve the situation, and I agree with everything I've heard. But, in my view, we also need to recognise the difficulties facing clinicians in situations of significant risk escalation, especially when recommended care options significantly differ from women's stated preferences. I believe this is something which can be addressed—that education can address this—and hasn't been so far. One of the priorities that I think we should focus on is clinician education in this area of escalating risk, and how to communicate appropriately at the time without overstating risk, but not understating it, and making sure a woman understands. Thank you.

The CHAIR: Thank you. Ms Willcox, did you indicate that you also had a statement?

DEB WILLCOX: That would be great, Chair. I appreciate that. Thanks for having me return today. I just wanted to say we have had representatives from the ministry attend every hearing since the inquiry started and we've read every submission—I haven't personally, I can confess, but my colleagues certainly have and I've read many also. I think all we can say is that we've all been moved personally and professionally by the stories that have been shared and the information given by some very brave individuals. We're very grateful to them for that. We're obviously equally sorry that the care for those people, as their stories described, didn't meet their expectations or the level of care that they should receive. On behalf of the ministry, I again apologise for that.

I suppose if there is an upside to any of this, some of the information we've heard and the stories that have been shared have really strengthened our resolve on the reform agenda that we'd set sail on, slowed up by COVID: our blueprint, *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*. Many of the things that—around 18,000 people responded to surveys at the time and 1,000 face-to-face consultations with groups. It really has—what we've heard—validated the work and the priorities that have come out of that earlier consultation, so there is some comfort and there is some alignment around the issues raised. Our job now is to get on and to make sure that we implement this work as effectively and as swiftly as possible.

The other thing that's become very clear to us is that earlier policy documents and work that's been done tried to give markers or targets on measures of how we might improve. Whilst all of those things are important around levels of intervention and caesarean versus natural birthing—all of those things are critical, but what is loud and clear is that a person's experience is equally important. I think we really want to drive that as part of our reform package, very strongly, as well.

I talked in my opening statement when the inquiry commenced to some of the elements of the blueprint, but we understand the need for socially and culturally respectful care. We understand it's important, obviously, to have healthy outcomes—as Dr Pesce has talked about—and continuity of care, particularly in midwifery. We understand the need for information to make that consent real and meaningful, and we know that women want choice. It's just how we, as a system, enable that choice to be present and all of those other factors done in the safest and most holistic way possible. As I said, it's our job now to get on and implement the blueprint.

I could talk—probably at some point through the questioning it'll come up—around what we're actually doing, hopefully. But we have stood up our governance structures, in particular an expert advisory group which I co-chair with a consumer, which has obstetric and maternity leads from every local health district around the State. We also have a consumer group with a bunch of tremendous consumers with lived experience, who we are engaging strongly with and will help guide our work. Again, thank you for the opportunity to return today and again to acknowledge the women who have shared their stories, and the submissions that they and many other groups and individuals have provided. It's very much appreciated and again strengthens our resolve for what we need to do. Thank you again.

The CHAIR: Thank you. Was there anybody else with an opening statement?

JULIE SWAIN: I have one. I knew there was a strong emphasis on continuity of care, so I wanted to just share with you what is happening in our district. First of all, I'd like to thank the Committee for this opportunity and acknowledge that the voices of our consumers are the most important voices on this matter. We hope to assist in amplifying those voices. Western Sydney Local Health District is one of the largest LHDs in New South Wales, with around 10,000 births per year. There are currently just over 400 FTE midwives across the district, and 65 per cent of those work in a part-time capacity. We have been leaders in implementing continuity-of-midwifery-care models and are aiming to meet the need of our diverse community, many of which have complex health and psychosocial needs, in the context of predominantly low socio-economics.

My hospital, Westmead Hospital, is a maternity tertiary referral hospital and one of the largest maternity services in New South Wales. It's been at the forefront of implementation and evaluation. Westmead has grown its women-centred collaborative continuity-of-midwifery models for women from diverse backgrounds and health needs, with close to 30 per cent of the women now currently receiving care within the continuity model. I know that Dr Pesce mentioned that earlier.

The models include one called Dragonfly case load, which is Aboriginal specific. There's a MAPS model for first time mothers and a MAPS model named PEARLS for women with complex pregnancies. We have a publicly funded home birth MGP. We have student-led MAPS SMiLE clinics, and we also have antenatal midwifery-led clinics for Chinese- and Dari-speaking women. We know that there's a lot more that we can do with more capacity and capabilities. These models have been able to demonstrate impressive clinical outcomes when compared to State and national figures, and sustain maternal satisfaction within these models.

Westmead, as you know, is unique as the only service in New South Wales to provide access to privately practising midwives in collaboration with a senior obstetrician. Expansion of this highly valued and trauma-protective model has its limitations in regard to some policy infrastructures and the insurance for midwives under different funding models. Alongside Westmead, there's Blacktown maternity service in the early adopters of midwifery models of care. It was one of the first to open a birth centre in New South Wales following the Shearman report in 1989. The continuity of midwifery care provides for 600 to 625 women there.

Models available include the MAPS models, models for women with low to moderate complexities, women with psychosocial needs, and women of Aboriginality and their babies. We also have the AMIHS model, which is located at Mount Druitt. We also know that we need to grow our own midwives towards case load practice and working in continuative models. Our student midwifery group practice models are currently in their infancy and are a strategy to create a workforce pipeline and exemplar midwifery clinical education models.

To enable sustainability and growth of these models, Westmead have grown their own skilled workforce through the development of student midwives during their training and for the new graduate midwifery case load models and MAPS models, to provide that pipeline of midwives to enable us to expand these models. Across those maternity services, there are dedicated managers, CMCs and educators to drive and sustain the models of

care. Western Sydney Local Health District is also the only New South Wales LHD to have a professor of midwifery who is an expert in MGP and continuity-of-midwifery-care models.

The CHAIR: Thank you. I might start with a couple of questions myself. Ms Willcox, we've had thousands of individual submissions to this inquiry. We've also heard from several women who have come forward and given their individual stories. Of course, this inquiry also inspired an inquiry in the UK. We've heard research that one in four women have experienced some kind of birth trauma. I'm told that the politician conducting the inquiry in the UK was also inundated with women coming forward who had had similar experiences, so this isn't something that is New South Wales specific; it's not even Australia specific. This is probably a conversation that's been a long time coming. With that in mind, it seems to me that the changes that we're making now and what the Committee is looking into are much bigger than what we're dealing with. What's the path forward from here? What other aspects do we really need to be considering to be at the forefront of the change that's really needed here, so that we're not looking at statistics of one in four women?

DEB WILLCOX: Thank you Chair. Yes, you're quite right: This is a significant health and social policy issue. But as I said in my opening statement, I appreciate there's a large body of work to be done, but there is quite a bit of alignment, as I said, around the things that are causing concern to women and their partners and families. As we bring forward and prioritise our work through the expert advisory group and start our implementation, I think the things around education and informed consent are obviously key bits of information that women need to help them make the very best choices possible.

I think we heard a lot around the postnatal debriefing—those opportunities to talk about the experience shortly thereafter. I think there's a lot around the experience and the communication pathways that we can do. Again, the things that we've started to initiate from the blueprint, as I say, strongly align to what seem to be themes that have come through. I deeply appreciate the scale and that some of those experiences were terrible and require dedicated investigation or a dedicated approach to them. But as a system, I think we got some very strong messages that we can certainly work on. We've got, as I said, a lot of alignment with our consumers and with our clinical advisers as well.

The CHAIR: We've heard from psychologists and educators today, and we've heard from physiotherapists previously. What work is being done in that space into that follow-up care and making sure that every person, no matter what their income is, actually has access to that follow-up care if they've experienced trauma?

DEB WILLCOX: In terms of physical trauma, there would be an opportunity for debriefing with the clinical staff, and there are experienced counsellors and psychologists available. I acknowledge there are workforce pressures. I wouldn't say that the scale of that level of allied health support is equal across our local health districts, but it is available. In terms of physiotherapy support, it's just one component of the physical support. We do have publicly available physiotherapists in our local health districts, and referrals can be made during pregnancy to ensure that those follow-up appointments do occur. But there is nothing more important than that relationship between the clinician that is caring for that woman and her family, whether that be the midwife or the obstetrician, to look at the totality of that person's experience and make the necessary referrals, whether it's psychosocial or a clinical input into their follow-up care.

The CHAIR: What we've heard today is that a lot of those referrals are very limited. We heard from GPs as well that they're limited on the number of psychological sessions that are available to women. Is there any work that's being done to make sure that there's more availability there, or is that something that this inquiry has to look at in regard to recommendations federally?

DEB WILLCOX: I might throw to Ms Matha in relation to specifics around the follow-up care, but in terms of GPs and access to psychologists, those are Medicare-billed psychology appointments through the Commonwealth Government. Obviously we're in a position to make representation in that regard, what's in our gift to do something about, but I'll ask Ms Matha to talk to those.

DEB MATHA: Can I just say it's my first opportunity to talk to the Committee. I have been at four of the last six hearings. Unfortunately, I couldn't make the first two: I was on leave. As a midwife in the system for over 35 years, obviously these stories and submissions that women have shared have been very distressing and certainly keeping us focused on the work that we need to do. I just want to echo what Ms Wilcox said in the opening statement, but assure the Committee that the work we're doing is keeping front and centre around what we've heard through the inquiry. Thank you for allowing us to come today and share some of the work we're doing.

If I could just pick up on the psychosocial issues and certainly what I think you're asking, Chair, around that follow-up. We have had psychosocial screening in place for many years—a couple of decades in New South Wales. We're reviewing those at the moment, so you have heard some of the conversation around the antenatal risk questionnaire, the screening we do there and then doing that postnatal screening as well. For those women

that are identified as needing more support, there are pathways for care. Some of that includes the Perinatal Infant Mental Health Services that we have that are supported by mental health services across New South Wales. We know most districts have perinatal infant mental health coordinators plus clinicians there to support those women. It's not ideal still, but there still is absolutely some follow-up there. We are reviewing those guidelines and we will be publishing those in the next few months and ensuring that the tools that we use are the validated tools that have been recommended through the Australian National Perinatal Mental Health Guideline that was published last year.

The CHAIR: Ms Wilcox, I wanted to get an update with regard to Wagga Wagga Base Hospital and I also wanted to specifically ask about the consumer engagement process to design midwifery models of care at Wagga Wagga. I've been advised that no other women that were put forward by the Maternity Consumer Network who had made complaints about their treatment at Wagga Wagga Base Hospital were contacted by the hospital as part of this process. I am wondering if you are able to provide information as to why those women weren't included and, if you aren't able to do that, to take it on notice—if you could provide some information there.

DEB WILLCOX: I'm happy to take that on notice. I mean, we would require people with a concern or questions or complaint about care to come forward directly to the service and then we can investigate. But I'm happy to take the specifics of that on notice.

The CHAIR: That was specifically not so much about their complaints but around the consumer engagement process for the midwifery models of care. A group of women, whose names were put forward to be included in that, given their personal experiences, weren't included in that process. I am just wondering why that may have happened.

DEB WILLCOX: I'll have to take the specifics on notice, I'm sorry, Chair. But I was aware when we first had these discussions, when the Murrumbidgee Local Health District was establishing these groups, that some of those consumers would be invited because they are obviously key to this inquiry and key in terms of getting feedback about their experiences to inform it. I will take the detail of that one on notice. There have been a number of steps taken. They have stood up the maternity consumer group, but again noting that the members of that may not be as everyone expected. We'll check on that.

They're improving access to birthing education by adding some virtuals to their face-to-face care and they've stood up a virtual antenatal care project pilot at Tumut hospital and are looking at opportunities to expand it. They've improved their follow-up after discharge. They've got three new mid-grade medical staff complementing their current obstetrics and gynaecology team and a new social worker is being recruited. The actual complaints that were brought forward did go into the Health Care Complaints Commission, and that process is underway. There is some additional work done looking at their complaints and how they can, in general, improve how they handle those as a district.

The CHAIR: Thank you. Before I pass on to other Committee members, I've got some questions for Ms Selby, particularly around the MGP programs. We've talked a lot about the benefits of continuity of care in this inquiry, which is something that your MGP programs offer. Can you share some of the feedback that you've received from women who participated in that model of care and what the benefits have been?

JACINTA SELBY: Absolutely. I think we get a lot of feedback particularly from our midwifery group practices because, commonly, the women do have a really positive experience. A lot of that is around feeling that they've built that relationship with the midwife. With the rapport they've built, they've felt that the midwife has known them, known what their wishes are, are there to advocate for them when things maybe do go away from what they were expecting, particularly I guess through labour and birth. The midwives are able to, when the obstetric team or other specialities are required to support the woman during the pregnancy, be present and also be there to support her.

A lot of the feedback is in relation to the relationship and the trust that they develop; the midwives being a really strong advocate for them and their families. They're very inclusive as far as the significant people for the women—whether that be partners, other family members, friends. I think they're the main factors that seem to consistently come. As a result of that I think we do see very good outcomes, from a psychological wellbeing perspective and emotional, but also, we do know that it does increase their chances of a normal delivery, requirements of less analgesia in labour. I've reached out to a woman recently who ended up with a forceps delivery, which wasn't part of her plan but because she was so well supported by the midwife and in conjunction with the medical team, she's come away and wants that to be part of the birth story and different things. I don't think it has to be that everything comes away normal or even meets the initial expectations of the woman. I think it's about having the opportunity to talk about those things antenatally to really look at what the woman's expectations are and to support her around that when it changes.

In my experience, there are very few women who don't want the safety for themselves and their baby, but they want to be heard and they want the consent process. They don't want fearmongering. I've heard some talk about we should give all this information to women. I think women tend to be very anxious in pregnancy, so I think to give them information of every possible outcome is not always realistic and maybe would not be the benefit for most women, but to be able to talk about any issues or any concerns that they have to empower them to be able to do their own research, to do labour, birth, parenting training in their antenatal period. All of those factors, I think, help.

The CHAIR: In regard to the MGP program, the feedback we've heard is that a lot of women aren't able to access it because the places are so limited or they are risked out of the program. What needs to change to be able to offer that program to more people? Is it simply just a matter of funding? How do we make sure that people who want to be part of this can be?

JACINTA SELBY: I think that's probably multifactorial. Absolutely, it is funding. I don't know where to start. I think most units are increasing the number of models of care. Since midwifery practice was introduced, there's also been the midwifery antenatal and postnatal service, which offers continuity—but not during the labour and birth—for the women. I guess because of the way the program has been designed, and I guess as different units have been establishing, they have aimed it at lower risk women because of being able to support them through. But what I certainly know in our district we're doing, and I suspect others are doing the same, is that we have a no-exit model. Whilst women tend to be on the lower- to medium-risk scale on entry, if they do become more complex in their pregnancy, we actually keep them within the model and the midwives continue to support them while they see the other specialists and the obstetric team and things.

As far as what's needed, we are certainly challenged. It is a statewide issue around having adequate numbers of midwives who are wanting to work in the model. Continuity is really important to most midwives, but also there needs to be that work-life balance. Due to the ways of working with MGPs—certainly our MGPs all operate differently. The team themselves determine the way they work and what works for one team is very different. One of our teams works very much case load. Even on their days off they will often come in to care for women in labour, but other teams work strictly to the days they're on call. I guess there's the interest for the midwives coming through, or even the midwives there, to work to their full scope, which is the beauty of the model also.

But while there are all those other competing things, like your work-life balance—I think Julie mentioned earlier that the majority of our workforce are part time. I'm not saying they can't work in in MGP with part time, but it's about working around that and then it's also around the level of expertise of the teams. When you're looking at working with higher risk women and we've got a very junior base—again, that's statewide. We are all trying to grow midwives and to bolster our midwifery numbers, but due to COVID and just due to the age of our workforce, we are working with a very junior staff. I think it causes a lot of anxiety for them, so it's also making sure we've got the support networks around them through educators, CMCs and the like so that they're well supported and then it doesn't become distressing for them as well. I'm not sure if that answered your question.

The CHAIR: It does. I've got a couple of quick follow-up questions from it. I was really glad to hear you say that it's switched now so that women aren't risked out after they've already entered the program, because we did hear a lot of feedback around that becoming problematic. But in regard to women that are deemed higher risk in those early stages so they're not entered into that program at all, obviously women who are higher risk would benefit a lot from being able to be in a program like this. How far away are we from making sure that MGP programs can be offered to women who are deemed in those early stages to be higher risk?

JACINTA SELBY: I can't speak for other units. We've certainly been looking at it as an option. What we are doing in the interim is we're working so that all women have continuity during their pregnancy. That's through either our high-risk women commonly being seen by their CMCs or they're seen consistently by the same midwives in the clinic, and we're certainly building that. I can't speak for other MGPs in relation to the no-exit model that we're using and that we've implemented. I guess there are a lot of factors.

The thing with MGP is that it offers a lot of flexibility to women and families. A lot of the times they may have their appointments differ, whereas once women are more complex, they're having to work more strictly, I guess, within the unit confines of when the specialists are available. I think there are a number of factors. We've looked probably more towards a MAPS-type model for our higher risk women, and certainly that's what we're exploring. I know many units already have high-risk models for MAPS that they've implemented.

The CHAIR: Why is that model more appropriate?

JACINTA SELBY: It's a lot because a lot of our high-risk women, I guess, already have quite set plans around the labour and birthing, but also then the MAPS teams tend to be located more within the hospital. For us,

our MGPs are often located out. We have a lot of outreach services, where they're coming from child family health centres and within the community. To have those women coming into hospital as well for medical appointments isn't overly convenient, so I think MAPS is actually based in and works from our clinics. So that's really the reason, looking more towards that.

The CHAIR: In regard to what you were saying about the challenges around staffing around midwifery group practice, and the fact that we've got a real junior staff at the moment, what sorts of recommendations should this inquiry be making? How do we overcome this and make sure that we've got the number of midwives that we need?

JACINTA SELBY: It's a very good question. I think people become midwives for all different reasons. I guess what keeps midwives there differs as well. I think it's around support. It's around really building the culture through the Mentoring in Midwifery Program that all the districts have now implemented and through having your support through your educators. We have clinical resource midwives. Obviously our CMC group provide a lot of support. If we can really provide a safe culture for the staff, where they have that support and they have those people to contact for advice and things when they're feeling a little bit uncertain about the work they're doing, then that would be a really good step towards improving our MGPs. Working around that whole work-life balance and the on-call component—as I said, teams vary the way of working within that team, and some are probably much more suited to a work-life balance than others. It's probably around finding a team that works with you but also putting students through MGPs, which I know we're doing a lot of, so that from the beginning of their training, that's the sort of midwifery care that they're providing, hoping that that gives them a lot of drive and passion towards the benefits of continuity, not just for them professionally but also for the women and their families.

Dr AMANDA COHN: Firstly, I wanted to acknowledge that through your opening statements and through your answers so far—and certainly, Ms Matha, in sitting in for most of our hearings—it's fairly clear that you've heard what we've heard, which is the extraordinary number of people who've experienced harm in a system that's meant to provide care and support for them. I acknowledge that you've already responded to that today, and that's much appreciated. What I wanted to ask is: Have you heard the voices of your staff? We've also heard from health workers on an individual basis through their unions and through their professional associations about the trauma they've experienced. They are with patients on the best days of their lives and the worst days of their lives, but they're also working in a system where they've told us loud and clear that they can't provide the care that they were trained to do. They can't provide the kind of care that made them want to go into those professions and that that is deeply traumatising. That's contributing to burnout and that's contributing to some of your workforce shortages. What's being done to look after health workers in NSW Health?

DEB WILLCOX: It's a big question, Dr Cohn. You're quite right—it's always distressing to hear our staff expressing some of the emotions that we know were expressed. However, it's important to also acknowledge—and I'm not trying to gloss over some of the difficult things that have been heard—that we still have a very, very large number of women who come into our care who have a positive birthing experience, and staff every day come into work giving their best and their all to ensure that's the case. I do want to acknowledge the clinicians that are out there who do work incredibly hard and, in the main, provide incredibly high quality, safe care. For them to hear some of these stories too has its own level of distress for them.

You probably heard our Secretary in other parliamentary committees talk about the importance of culture. We take the culture and the support and the safe work environment for our staff extremely seriously. It's probably one of our number one priorities. Jacinta touched very briefly on some of the things, such as the mentoring program, that are happening specifically to midwives. Our role as system managers is really about all staff in the system and how we create a space that is safe and that people feel free to speak up when something is not right without any retribution. There is a significant body of work in that regard. I think you've heard some of it through our Estimates Committee with our Director of People, Culture and Governance, so I won't re-prosecute it. I can't do justice to the vast expanse of work that's underway.

We do have the measures around our People Matter surveys, and that work can then get right down to ward and unit level so that local management can understand the issues that are concerning their staff—what's working well and what isn't. All of our local health districts have action plans in place and staff-led committees to make the changes that their staff believe need to be made to make it a safer and more supportive workplace. In terms of our midwifery and obstetrics staff, you're quite right—they're some of the best and worst days in people's lives. I've had the privilege to meet with a number of women who have come forward in this inquiry and talked about their experience and now are engaging with us to give some good guidance around how we might improve things. But I will just pause there. Deb, if there's anything in particular around midwifery, and maybe Andrew in terms of medical staff—they may wish to talk about their own experiences. Andrew, did you want to—

ANDREW PESCE: It's certainly something which we're aware of in our district. We're very fortunate to have a very highly engaged senior medical staff team, who act not only as role models but as the vocational carers for our junior medical officers. I have to say, at my stage in my career—and my career has gone through lots of stages—the thing that keeps me engaged now is trying to make sure that our junior obstetricians have the very best chance to be—they're wonderful people, and I want to try to help them be the best they can be. We do surveys of our junior medical staff. It does work.

If you've got a committed team—for example, for various reasons, one of our facilities in the district was the lowest evaluated service in the district three years ago, and this year it was the highest, because by listening to what the JMOs are saying and thinking about how we can respond and showing that you do want to respond, you can turn things around. But it has to be very granular. It can't be a system-wide evaluation. It really has to be focused on teams and subdivisions within teams so that the people who can change it for those particular people in those smaller environments can really focus on solutions.

DEB MATHA: Could I just add, Dr Cohn, to your question. Certainly, from our perspective, relationships are really important. Just drawing on what happened in COVID, I know we've heard from some of the women today about experiences in COVID and how distressing they were. It certainly was distressing for the workforce. We set up communities of practice across all the clinical streams. Certainly the one we had for maternity, I think, was absolutely fantastic for us in the ministry, as we were trying to deal with the pandemic and get guidance out to the system, but also hearing from the clinicians—and, certainly, my colleagues that are at the table today were members of that community of practice and now join us on the expert advisory group.

Those relationships have been really important. They can make calls to us, raise issues. Equally, we're there to reach out to them to do a sense check around certain matters. Certainly, when we want to consult more broadly on pieces of work, we're there. So those relationships, for me, have been foundational for the work we've been doing, and I really do treasure those. I have heard good feedback from my colleagues—I won't put them on the spot here—around how important it is to have that relationship with us in the ministry.

Dr AMANDA COHN: Ms Willcox, you already talked today about the blueprint for action, which you tabled to this Committee last year. That document was published in March 2023, so it's now more than a year old. You mentioned that there had been a committee set up, co-chaired by yourself with a consumer representative, which is wonderful. What are the next steps for actually implementing that document?

DEB WILLCOX: The committee, as I said, has—the expert advisory group has representatives from obstetrics and midwifery leads from every local health district, so really good clinical engagement on the group. The areas that have come forward, as you will have read the blueprint, cover a wide range of areas. The areas of priority that have come forward, both out of this committee and from the clinicians themselves and consumers, are around the informed decision-making and the valid consent and guidance for partnering with women who choose to have the care outside of the clinical recommendations; maternity continuity models of care in midwifery; we've heard about trauma-informed care in maternity settings; postnatal debriefing, including improving the opportunity for women to ask questions and receive feedback; and receiving care that's socially and culturally respectful.

They are the things that have lifted up both out of this inquiry but out of the clinical consumer groups themselves, that they say are the pieces of work we've got to take forward. Deb could probably talk in terms of the stages of where the work is up to, but we've started getting our guidance around the consent process, what the education packages might look like and being approved. Things are definitely underway. We've met twice already. We just had a meeting in March. The next one will be in May. The reason they're a distance apart is so we can try to get as much work done in between time so that we're not just meeting and not actually getting on with the job at hand. Deb, are there some specific process steps that have occurred that's probably worth the Committee knowing?

DEB MATHA: Sure. We do have a consumer reference group as well that we've set up, as Ms Willcox said, and three of those consumers sit on the expert advisory group. We've had two meetings with the consumer reference group, and our focus there is around the information for parents that we've seen certainly coming up as the priorities. We've started looking at what we have on our website for Health. We've got the "pregnancy and the first five years" website. We've done a detailed look at what are the topics there, asked the consumers. We did a deep dive with them at the last meeting, what sorts of topics would they like to see. The second part of that work will be what sorts of topics would they like to see on the local health district websites to help them find that navigation around models of care, and if they've got issues or complaints, having a one-stop-shop on a website there.

We've started really doing some deep diving into that information as to what consumers want. That has been really fruitful already. Once we pull that together more, that will go out for further consultation. This group

knows that they're there to help guide us; they're not there to make the decisions. We note that with our consumer reference group, we were keen to get membership that provided a real cross-section of consumers with lived experience of maternity. We still have a few gaps in that group—and I was thinking about that today—with hearing the stories about being young parents, so we will be looking at doing further consultation with young parents and with LGBTIQ parents. We've started connecting with Rainbow Families, so we've got those connections, and certainly people with disability. So we'll be looking to organisations that we can go to for consulting with them and certainly for Aboriginal communities as well.

Dr AMANDA COHN: I wanted to ask one very specific question, which was about the birthing program at Ryde. I understand that that was a very high-ranking service in terms of surveys of patient experience, and it was in *The Sydney Morning Herald* in 2017. I have been told that that service was closed during COVID because the space needed to be used as a vaccination hub, but that it now hasn't reopened and that the community group was promised that they would be consulted during the redevelopment process. They've told me that they weren't actually told the service wasn't coming back until a year after the decision had been made. Why wasn't that communicated with the community group?

DEB WILLCOX: I was the chief executive at Northern Sydney Local Health District during COVID, so I can comment, with that hat on, that we did need the space during COVID for clinics. As for consultation with the community or consumer group subsequently, I can't comment. I can take that on notice and just check where that dialogue got to. I think it's fair to say—there was no intention to keep any sorts of plans from the community, and we'd had some discussions in my time as chief executive. There had been a decreasing volume of women coming into the Ryde birthing service, and that was principally due to the age group of the women and some of the complexity around their care that wasn't suitable for birthing at Ryde. So there was a serious discussion with the Clinical Excellence Commission and the chief obstetric adviser at the time to track that activity and volume and match the capability assessment of the Ryde birthing unit with the complexity of the women who were coming into care.

I don't have the statistics on me, but a number of women that were planned to come into Ryde ultimately were transferred to Royal North Shore for birthing for those very reasons. We did have a concurrent issue around volume that we were tracking closely, and my assumption is that that work continued and we've come out the other side of COVID. They've continued to track and monitor and said that's not a service that they can rightly continue, with their changing demographic in the area. They do have midwifery continuity of care in terms of the antenatal/postnatal care component and, where possible, the midwives can go across to Royal North Shore. Again, they don't work 24 hours a day, seven days a week, so there will always be a risk that they may not get the same midwife. But the aim is to give continuity to that model of care for that woman when they transition over to Royal North Shore Hospital, and then they can have their postnatal care back in the community of Ryde.

Dr AMANDA COHN: Thank you. I appreciate you taking on notice that particular piece about the consultation with community around that decision.

DEB WILLCOX: Yes, I will. No problem.

The Hon. MARK BANASIAK: Picking up on the questions around the blueprint as well, you listed several things that have come through the advisory group as well as this Committee that you were going to work on. What will happen to the actions and objectives that don't sit within those half a dozen things that you listed off? Will they fall away or will work be done on those in the background as well?

DEB WILLCOX: No, definitely not. I can assure you that the entirety of the blueprint will be implemented. What we've done, in consultation with clinical teams and consumers, is to say which ones should we put forward and prioritised. Where can we get quick traction on some things that align with much that we've heard out of this Committee from women and through submissions. We knew it to be relevant and important. It's just a timing issue. Some of the work in that short list that I read through will have to be shared with other parts of the Ministry of Health, not all of it is in the remit of us looking after maternity services. Things around informed consent and women making decisions to not go with the recommended care have got some legal and ethical considerations, so we're doing some work with our legal team around that. We want to have some pretty deep and thoughtful discussions with clinicians and consumers as we progress that.

Deb mentioned the website. It sounds like, "You're just doing a website," but getting good information up there that's easy to access gives women and families better guidance. We've heard for a long time that it's something they want. That can progress quite easily. Work around continuity of care and midwifery models of care. Again, we'll be working with our Nursing and Midwifery Office and workforce teams, and our local health districts to see how we can supplement and strengthen those. Not every model will be the same but what's the mix and choice that we can provide to women to optimise continuity?

The Hon. MARK BANASIAK: Pardon my bluntness, but I've been in the public service for close to 20 years myself.

DEB WILLCOX: Longer than me.

The Hon. MARK BANASIAK: I've seen glossy brochures and documents like this come through. They generally have a shelf life and then disappear after they've gathered dust on the shelf. What are we putting in place to ensure this isn't just another dust-gathering document? You read a lot of these actions and you get a sense that they're ongoing. It's a reflection of the continual improvement lens that you've designed them with. How do you make sure that this doesn't just fall away after five years and we move onto the next glossy document that gets put out?

DEB WILLCOX: It is important that any document, policy or guideline that we produce is iterative, that we continue—it's like painting the Harbour Bridge. You're constantly getting your evidence and information, responding to committees, consumers and clinicians. So it is ongoing. This plan has had—as I said, over 18,000 people contribute. It is deeply embedded within the performance framework of the Ministry of Health that I'm accountable to in my service agreement and my performance agreement with the Secretary of Health. We will monitor and measure this. We will be accountable to this Committee and accountable to the clinicians and the consumers that are working with us on this body of work. I accept that there's a perception that we leave things on shelves to get dusty, but all I can do is give you my professional commitment that this is hardwired into the frameworks of the ministry with reporting and outcomes, and that we all have a duty to respond to this.

The Hon. MARK BANASIAK: How do we make sure that hardwiring is going all the way down to the day-to-day practice? We know our midwives, our doctors, our health professionals or any of our public service professionals get busy with their day-to-day job of what they do and they don't always have time to go back to that document that says X, Y and Z. How are you making sure that there is that constant hardwiring back to, essentially, the coalface?

DEB WILLCOX: Yes, indeed. The first part, of course, is to have them involved in terms of how we implement this, because there's not much point in me having a view about how something is imminent. I'm not on the ground with a woman in front of me in a birthing suite or an antenatal clinic. That's the first thing; to get that clinical input into how we implement. My hope—it's not just a hope, my professional view would be that many of the things that we want to drive through the blueprint is going to make life, if I dare say, a little less complex and stressful. If we can get information and education for women and get clarity around some of these consent issues, if we can strengthen continuity of care, if we can better arm women with the information they need, I would but hope that those interactions with our clinical teams would be more purposeful, productive and that relationship will improve the experience for both clinician and the woman.

We will continue to work closely with our clinical teams as we implement this. If we take the wrong course, they're not backward in coming forward in telling us that we've gone in the wrong direction. Please know that our intention is not to load them up with more administrative tasks. We've just spent the last six to nine months in the ministry working on another body of work—getting survey information and interviews from staff to say what is the white noise and the distractors for you. We've got a whole body of work to try to start and pull that away. Our job is to say: How can we get improvements that work for both women birthing and their families but also for our clinical teams?

The Hon. SARAH MITCHELL: What I wanted to ask has been covered quite well by everybody, so I'm happy.

The Hon. EMILY SUVAAL: Thanks to you all for appearing today and indeed to those who have come back. Firstly, Ms Selby and Ms Swain, we've heard through a number of submissions and evidence about the need to increase access to midwifery continuity of care. In your experience, what do you see as some of the enablers but also some of the barriers to this?

JULIE SWAIN: The barriers. I know in my district where we work with very pro-continuity of care that our consultants are very pro as well and support us in those models. To increase those models, you need midwives to want to work in those models and, pretty much, that's the barrier. Like I said, 65 per cent of our midwives are part time. The majority of ages is between 30 and 49, which is predominantly child-bearing women in the early parts. So they're having babies. They have maternity leave. They come back for six months, and they go off and have another baby. There's nothing wrong with that. That's just part of our life and that's just part of our workforce. We appreciate that and we support them.

But midwives are not breaking down the door to get into our case load models as much as we would like them to. With the expressions of interest, it's really difficult to recruit into those models. Hence, the MAPS model is a hybrid-style model of a case load which midwives are more likely to find suitable for them with little children,

school hours and so forth. It is about we're trying to be flexible as well as invent models and be innovative about how those models run, to enable women to have continuity of a known midwife or a known carer involved in their care. More midwives would be great, yes—happy for that.

The Hon. EMILY SUVAAL: Did you have anything to add, Ms Selby?

JACINTA SELBY: I agree. I think one of the barriers is having midwives wanting to work in that model. Some of the things that we can continue to do to try and help is to support the midwives from day one in their career to work within those models but also to have flexibility within those models that maybe do provide a better work-life balance, while still obviously providing the continuity and things that is what makes it the gold standard of care. For us—and I know, again, a lot of districts are doing the same—it is looking at options for putting new graduate midwives into MGP so that from the beginning of their professional career they're working in that model and building their skills, knowledge, competence and, hopefully, confidence by having adequate support around them to do that.

The Hon. EMILY SUVAAL: My next question is to Dr Pesce. During this inquiry we've heard again that midwifery continuity of care should be something that's provided to all women. Obviously for women who have risk factors, obstetrician will also likely need to play a role. What's the best way to achieve this collaborative care that will ensure the best outcomes for women but also their values?

ANDREW PESCE: I think we've addressed continuity with midwives reasonably well. It can always be improved, but we've taken great steps. It's very difficult to have the same continuity for obstetricians in the public system. Obviously it works in private practice, but we're talking about the majority of women seeking public care and that's the bit that NSW Health is responsible for. It is a difficult problem. There are models where continuity of care is broken up into teams and the teams include the obstetricians and the medical staff. That requires a significant re-organisation of current work practices and is a real challenge, especially when a lot of health districts probably are understaffed and treading water just to try and do what they're currently doing. It is possible to do. There's a model, I believe, at Monash in Melbourne where the medical teams are divided up into three or four groups and those groups maintain continuity for a particular cohort of women and the midwives that work with them. That's, I think, the closest that I have seen as a systemic response to that question.

The Hon. EMILY SUVAAL: A final question, while time permits, to Ms Selby again and Ms Swain. We've certainly heard during this inquiry about the challenges that some midwives have in working the 24-hour on-call roster in terms of the case load that we are talking about. How do we respect midwives' personal caring commitments but also make sure that women can access this model of care that they're so desiring? What are the ways we can respect that, if there is anything more that we can be doing?

JULIE SWAIN: I think, like Jacinta said, it's flexibility. Our models are made up of different groups within that group and each midwife is encouraged to work in a manner which suits her. She can work within a team, for example. It's about flexibility and not trying to micromanage them and enabling them to basically provide the service that they do in the best way that fits in with their lifestyle to a degree. Many midwives do it incredibly successfully. We notice that when some of the juniors come on board it's a bit of a struggle for them because they are overzealous and they can't let go and they want to do everything for the woman, and they end up getting quite burnt out. So we want to try and avoid—we encourage them to say, "No, there's a time when you have to divert your phone and you need to have some downtime." If they're working within a really good team, they support each other and they all understand how that operates and what works best for that team because we don't want the team to implode when everybody is not getting the downtime they need. It's important that we provide as much resources and support to them as possible to do that. But their autonomy is key to their success.

JACINTA SELBY: I think also, I guess, the MGP midwives are working according to the annualised salary agreement, which in itself offers quite a bit of flexibility. I think that the other ways of supporting our midwives in that is regular clinical supervision, which I think has been pivotal to the success of some of our teams to really allow them to nut out some of the issues that arise and also to keep that cohesion within the team. I think that often the team share that same philosophy but they all come with different pressures and things.

Talking to midwives who are really comfortable and happy in MGP, I think that a lot of people don't understand the flexibility it actually does offer them. My team often will say to me that they are able to go to something at school for their child. They were able to work their visits and things around. Obviously if a woman comes into labour or birth, then that may impact on those plans. But if they have a team who are working really well together, then it may be that another team member goes in and supports the woman until they can come in. Provided that they have support at home to be able to up and leave at certain times, it actually offers a huge amount of flexibility. So I guess it's about selling the advantages of midwives working within an MGP and providing, again, that support around them to work through any issues that do arise.

DEB WILLCOX: I have an update on the membership of the committee down in Murrumbidgee and the Maternity Consumer Network. This is advice from the chief executive of the Murrumbidgee Local Health District. All representatives recommended by the Maternity Consumer Network were contacted last year by the local health district midwifery co-lead. Of the five people recommended by the network, unfortunately only one was able to join the co-design committee. Another network-nominated consumer assisted in the development of the maternal-assisted caesarean section local health district guideline. Just to let you know there was a process around that but if there are women part of that network who feel like they didn't get that opportunity, I would be very pleased for them to come forward and we can follow that up.

The CHAIR: Thank you so much for that. That brings us to the end of the hearing today but also to the end of the inquiry. Thank you to our witnesses. I believe there were some questions taken on notice but the Committee may also have further questions that we didn't get to today, which the Committee's secretariat will be in contact with you about. Thank you for your time today and thank you for your evidence. I also want to take a moment to thank the Committee, as well as the Committee secretariat, as well as Hansard and everybody else within Parliament, of course all of our witnesses, and most importantly I also want to thank the thousands of women who actually put those submissions into this inquiry but also the women that very bravely came forward and gave evidence at this inquiry. It has been an extremely important inquiry to do. Thank you.

DEB WILLCOX: Thank you very much, Chair. Thank you for how sensitively you have managed this and thank you for allowing us to come back today. We much appreciate it. All the very best with your deliberations.

(The witnesses withdrew.)

The Committee adjourned at 17:15.