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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005

TUESDAY, 18 JULY 2006

MELBOURNE

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Tuesday, 18 July 2006

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Barnett, Nettle and Polley

Substitute members: Senator Stott Despoja for Senator Nettle

Participating members: Senators Abetz, Allison, Bartlett, Bernardi, Mark Bishop, Boswell, Bob Brown, Carol Brown, George Campbell, Carr, Chapman, Colebeck, Coonan, Crossin, Eggleston, Evans, Faulkner, Ferris, Fielding, Forshaw, Heffernan, Hogg, Hurley, Joyce, Lightfoot, Ludwig, Lundy, Mackay, McEwen, McGauran, McLucas, Milne, Nash, Nettle, O'Brien, Parry, Patterson, Payne, Robert Ray, Siewert, Stephens, Stott Despoja, Watson, Webber, Wong and Wortley

Senators in attendance: Senators Adams, Barnett, Humphrey, Moore, Nettle, Polley, Stott Despoja and Webber.

Terms of reference for the inquiry:

Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005.

WITNESSES

Committee met at 9.00 am

TONTI-FILIPPINI, Dr Nicholas, Private capacity

COLLINS, Ms Jacinta, Board Member, Caroline Chisholm Society

D'ELIA, Ms Mary Louise, Chief Executive Officer, Caroline Chisholm Society

RIORDAN, Ms Marcia Jane, Executive Officer, Respect Life Office, Catholic Archdiocese of Melbourne

FRANCIS, Mrs Babette Avita, National and Overseas Coordinator, Endeavour Forum Inc.

FRANCIS, Mr Charles Hugh, Legal Adviser, Endeavour Forum Inc.

ACTING CHAIR (Senator Moore)—Welcome. Do you have any comments to make on the capacity in which you appear?

Dr Tonti-Filippini—I am a consultant ethicist.

ACTING CHAIR—I think you have all had experience at these hearings before. We are continuing our inquiry on the Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005. As you can see, the format we are using is of having people together so that we can have a discussion and get through as much information as we can. I would just remind everybody that we are on a tight time frame. You all have information on parliamentary privilege and the protection of witnesses and evidence. I now ask you if you would like to make a short opening statement, and then we will move to questions. Mr and Mrs Francis, would you like to start?

Mrs Francis—Endeavour Forum is an NGO which has consultant status with ECOSOC of the United Nations. Although we do not conduct a pregnancy-counselling service, many of our supporters work in what we call pregnancy support services. They provide accommodation, financial help, baby equipment, transport help and other help for women, and we believe this is the sort of activity this bill seeks to destroy, so we are very concerned about it. Many women considering abortion come from dysfunctional families or have a lack of education or a lack of financial support. If they have the abortion, they are left with these problems—they are not resolved—whereas if they have the baby they are immediately connected to Australia's excellent help network plus a pregnancy support community which continues to help them with ongoing problems and helps to resolve some of these issues.

I would like to deal in detail with the criticisms Senator Stott Despoja has made of pregnancy support services for providing information on the increased risk of breast cancer from induced abortion. I have a lot of scientific information on that and I would like to go through that in some detail. Also, I have the transcript of a Channel 7 program shown in Adelaide a couple of nights ago where a 15-year-old girl who was more or less coerced into having an abortion without the knowledge and consent of her parents was suicidal and deeply depressed. She said she would never do it again. These are the sorts of cases in which the abortion providers do not acknowledge the post-abortion syndrome, which pregnancy support services deal with because we help women even after they have had the abortion and try to resolve their feelings of unresolved grief.

I also would like to deal with some of the criticisms Senator Stott Despoja made in today's *Herald Sun*, where she says that pregnancy counselling services frighten women about infertility following an abortion. I would have thought the public information on this issue was sufficient to not warrant this kind of criticism. You have the classic case of Germaine Greer, who boasted about her three abortions while at university and then, at age 36, was desperate to get pregnant. In *Wonder Women: The Myth of Having It All*, Virginia Hausegger talks about Carrie, who was desperately trying to get pregnant. She knew she was fertile because she had had an abortion seven years ago. That was a woman who could not get pregnant. There is also the latest thing from the United Kingdom about women having abortions and having a hard time getting pregnant. I have all this documentation, which I can provide to senators. I also want to give you copies of the consent form of an abortion clinic in Texas which acknowledges the link between abortion and breast cancer.

There are mental health risks from abortion. I really cannot see why psychiatrists in Australia can ever say, 'This is good for the mental health of the woman'. There were studies in Finland and California. The Finnish study was a 12-month follow-up and showed that women have a greater risk of death from all causes following an abortion compared to women who carried their babies to term or women who were never pregnant. The California study, which went on for eight years, showed that death from all causes was higher for women who had had abortions than for women who were not pregnant or who carried their babies to term. The recent New Zealand studies showed that mental health problems were greater in women who had abortions. I will deal with these in more detail and I have all the documentation to back it up.

Mr Francis—I have been a lawyer for over 50 years. I was appointed a QC in 1969, and in 2003 I was awarded an AM for services to the law. This bill seems to me to proceed on the entirely erroneous principle that the option of referring a woman for an abortion should be an integral part of pregnancy counselling. The term 'pregnancy counselling' does not, by definition, include the option of referring for abortion. When one advertises pregnancy counselling, it is neither misleading nor deceptive not to mention that you do not refer the people being counselled for abortion. Since making my original submission, I have looked further at the question of whether the Commonwealth has the constitutional power to pass this bill, and I now say quite categorically that this bill is beyond the powers of the Commonwealth. I suggest that finding out the opinion of the Commonwealth Attorney-General or the Commonwealth Solicitor-General as to whether the bill, if enacted, would be constitutional should be done at an early stage rather than wasting time on this inquiry.

As a result of acting in abortion cases, I have learned that it is always very bad advice to refer any woman for an abortion unless the pregnancy is a serious threat to her life. In general, that situation does not arise today because of advances in medical science. In any event, it should not be pregnancy counselling services but medical people that make this decision. The reason that referring a woman for abortion is bad advice is that there are so many medical risks in every abortion that no responsible person should ever advise a woman to have an abortion.

In my legal practice, I gained first-hand knowledge of some of these risks. This began in 1997, with a case known as 'Ellen's case'. Ellen sought my advice because she had suffered

very significant psychiatric problems following an abortion and could not work. At the time the abortion was performed, it was already well known that abortions could leave women with serious psychiatric problems, but Ellen was never advised of this risk. The Australian High Court in Whitaker's case said that before performing any operation the medical man has an express duty to warn of any material risk. I advised Ellen that she could sue on the basis of failure to give her any warning of the risk, and she sued. Interestingly, about the same time a very similar case, known as 'Cynthia's case', was commenced in New South Wales. These cases are believed to be the first two cases of this kind in the world. Ellen's case was settled in September 1998 and, as a world first, it received wide publicity. There was an excellent article in the Melbourne *Herald Sun* on 29 September 1998 which gave a very accurate picture of the case, which was also widely publicised overseas. Approximately 10 per cent on women who have abortions have similar problems. I provide to you photostats of the news item on Ellen's case, which makes excellent reading.

As a result of acting in Ellen's case, I was subsequently asked to act for and advise a number of women in relation to problems resulting from abortions. Because of my expertise gained in this field I have been asked to lecture on abortion problems and abortion cases in both Australia and overseas and in particular in the United States. I have also lectured at the House of Lords in England and at a medical conference in Buffalo, New York. Articles by me on these topics have been published in the United States and Australia.

In acting for women who have psychiatric problems following an abortion, I came to know these women personally and to realise how dysfunctional they can be. One such woman, a single woman, was still highly dysfunctional three years later, and there was no indication that she would ever be able to work again. There are many such women in Victoria. Some are being treated at the clinic of a group called Victims of Abortion, run by an expert psychologist, Anne Lastman. Anne Lastman works full time treating these women and has to turn women away because of her workload.

In May 2000 I was approached by a woman who is known by the pseudonym 'Meg' and who had suffered psychiatric consequences as a result of an abortion. When I took her history, because I was familiar with much of the scientific information on the abortion and breast cancer link, I identified her as falling into a higher risk area than the average person. We obtained advice from Professor Brind, who confirmed that she was at significant risk of developing breast cancer. We then sued on both bases: the failure to warn of the psychiatric problems and the breast cancer risk. This again was the first case of its kind in the world. In August 2001 the case was settled. Although it received no publicity in Australia, it eventually received some publicity in England and in the United States. There were a number of news items about it, and I provide photostats of one.

My advice was subsequently sought in relation to bringing similar cases in the United States. One such case, in Pennsylvania, in which I assisted, was successfully settled. Far more significant was a case brought to trial in 2005 in Oregon, USA, against All Women's Health Services, an abortion clinic in Portland. On 24 January 2005 All Women's Health Services conceded that there was a link between abortion and breast cancer. It agreed that it had failed to warn of the risk and it agreed to judgment against it and that damages should be assessed.

In my experience, abortion clinics, hospitals and doctors who perform abortions never give their patients adequate warning of the risks of abortion. Proper warning of the risks is only given by voluntary pregnancy counselling services. It is scarcely surprising that abortion clinics and abortionists and their supporters want to cut off the provision of any of the sorely needed funds to these counselling services. They regard these services as the enemies of their very profitable business.

To my mind, sadly, this bill reeks of malice, as is demonstrated in particular by the proposed penalties. If the proposed bill became law, the offences created would in reality be of a fairly trivial nature. Yet the individual conducting the counselling services free of charge may suffer a maximum penalty of $220,000 and a corporation may suffer a penalty of $1,100,000. These proposed penalties are out of all proportion and speak for themselves. In my view, no reasonable member of parliament could ever support this bill. Thank you.

CHAIR—Thanks, Mr Francis. Dr Tonti-Filippini, would you like to go next.

Dr Tonti-Filippini—Thank you. I am appearing here in my own capacity, but in the spirit of truth in advertising I think I should probably acknowledge various connections. I am a senior lecturer at the John Paul II Institute for Marriage and Family but do not speak for the institute. The John Paul II Institute is a postgraduate institute that is accredited for providing postgraduate degrees in Australia. It is associated with the Pontifical Lateran University in Rome and the degrees are dually accredited in Europe and in Australia. I am also a member of the Australian Health Ethics Committee but cannot speak for that committee and its various subcommittees. I have also been a consultant to UNESCO, to the German federal department of health and welfare, to the Australian Minister for Health and Ageing and to the office of the Australian Prime Minister. I think that is about all I can be accused of! I do not speak for any of those.

My submission is very simple. As a medical ethicist I thought I should make a submission, and it was simply to say that it is not my understanding that referral for medical procedures is normally part of professional counselling, so, from that point of view, I thought the bill was mistaken. I support the idea of truth in advertising but I do not think it is appropriate to force pregnancy counselling into a medical model by requiring it to refer for abortion. It is not normally the practice in counselling to issue referrals. Referral for specialist medical procedures is done by medical practitioners.

My understanding of pregnancy counselling is that when a woman presents and discovers that she is pregnant, whether then or earlier, the counsellors would normally ask whether she has seen her doctor and, if she has not, recommend that she see her doctor or another doctor. Normally, the recommendation that she seek medical advice is a part of professional pregnancy counselling. Whatever she decides to do with the pregnancy, she will need to have that recommendation that she see a doctor. It seems to me to be a mistake to take pregnancy counselling out of the area it is in and push it into a medical model of being required to refer, which is basically a medical matter.

One other issue that I thought I should raise, which I did not raise in my submission, is that the restrictions in that respect on pregnancy counselling are one directional. If you were to make a requirement of that kind—that specifies which referrals must be provided—then

surely there ought to also be a requirement that referrals go towards pregnancy support if the woman has decided to continue with the pregnancy. I do not actually think that those referrals are an appropriate part of pregnancy counselling. Its role is not to send the woman in any particular direction but simply to advise her of what the options are.

CHAIR—Thank you, Dr Tonti-Filippini. Ms Riordan, would you like to go next?

Ms Riordan—No, thank you.

Dr Tonti-Filippini—I should say that I did ask Ms Riordan to accompany me. She is more expert than I am in pregnancy counselling matters. I thought she would be better able to answer questions.

CHAIR—That is fine. That is perfectly acceptable. Thank you for that. Ms D'Elia and Ms Collins, which of you would like to go first?

Ms D'Elia—Thanks for the opportunity to speak with you today. The Caroline Chisholm Society was established 37 years ago to provide a range of practical and emotional supports for pregnant women. The society is an independent, non-profit charitable organisation. We are not an advocacy group. Rather, we focus on a professional practice model to provide practical and emotional support at what is often a very difficult time for many women who discover that they are pregnant. We are not affiliated with any other pregnancy service providers and we are not a church based agency. We are independent. For example, we are not a Catholic, Baptist or Anglican agency.

We welcome an attempt to provide a framework for quality counselling in this area. However, as an agency which has been involved in the sector for many years, we could cite many examples of poor directive or judgmental practice in pregnancy counselling from those who philosophically sit at both extreme spectrums of the debate—either pro choice or pro life. For instance, apart from some of the examples already submitted in this inquiry to support the bill, we could also cite many examples of poor practice or misinformation at the other extreme. We do not believe that simply insisting that there be a statement around referral for abortion or non-referral for abortion is going to achieve good practice in this area.

As an agency we support women being provided with high-quality, independent, non-directive counselling in regard to all options about their pregnancy. We believe that pregnant women should receive informed and independent medical advice, particularly if considering termination. We are not a medical service and as such do not provide referrals for termination of pregnancy as that is not our role. We offer a space for women to explore what they would like to do, to think about the impact that these options may have in their lives and to explore the perceived barriers in moving forward with one option over another.

The Caroline Chisholm Society believes it is critical to ensure that professional counselling standards are met in all pregnancy-counselling services. We believe that this bill does not address this issue and relies instead upon a definition of non-directive counselling which is not in line with current clinical practice. The society opposes the bill for the reasons stated in our submission and here today, and we would be pleased to answer any further questions that you may have. Thank you.

CHAIR—Thanks, Ms D'Elia. Ms Collins, do you wish to make an opening statement as well?

Ms Collins—I might contribute a couple of brief opening comments, and other matters might be dealt with in questions as well. I am from the board of the Caroline Chisholm Society. I encouraged the board to make a submission to this inquiry because I thought it was important that we highlight that there are some agencies operating in this field that have been operating for some time from a professional practice model, who unfortunately during the process of the political debate associated with this inquiry have in some ways been tarred with the same brush, so to speak. I am a member of the Caroline Chisholm Society board because it is based on a professional practice model. I myself come from a social work background and was happy to join the board of Caroline Chisholm because I was satisfied with the quality of their service delivery.

Unfortunately, I think the public debate of pro-life versus pro-choice is colouring some of the debate in relation to the issue of how we achieve best practice in this area. I, personally, have never felt particularly comfortable with the dichotomy between pro-life and pro-choice but I have an empathy, or perhaps indeed a sympathy, from my own experience for women who are confronted with an unplanned or unwanted pregnancy. I choose to express that empathy or sympathy by doing what I can to better support women who are confronted with that situation so that women feel that they have real choices about what their options may be. That is the approach I take to my work with the Caroline Chisholm Society.

I should add, as indeed did Nick, that in the spirit of transparency I should also indicate that I do social policy consultancy work, during my time out of the Senate, for some organisations that might also be associated with service delivery in this area. They could probably be easily regarded as within the umbrella of Catholic Social Services Australia, who I understand you have heard from already in Canberra.

But even with respect to this bill I think some of the talk about church based agencies falls into this trap as well. People not familiar with the delivery of services through some of the church based agencies will not understand that, for instance, Catholic Social Services Australia, and the organisations within its umbrella, have focused very strongly on professional service delivery across a range of social services for quite some time. I think if senators go back and have a look at the submission from Catholic Social Services Australia—which I had no input to, I should say—you will see that that is reflected in the nature of their discussion about how they would deal with these issues.

As Mary indicated, anecdotally I have come across problems across the spectrum also in terms of service delivery in this area. My concern is that the approach in this bill does not cover the breadth of those problems. Even some of the submissions that have been supporting the bill imply that they would like to see better professional development and accreditation, and that path taken to try and improve the professionalism of service delivery in this area. That is, indeed, to be commended.

I will conclude on one final point, in terms of where you are seeking to deal with non-directive counselling. There has been reference to some agencies that are regarded—at least by some—as being the only ones that deal with all-options pregnancy counselling. The

Caroline Chisholm Society would regard themselves as dealing with all-options pregnancy counselling. As Mary indicated, they are independent. Unfortunately, there was some misunderstanding that they were associated with the Australian Federation of Pregnancy Support Services when Tony Abbott gave funding for a volunteer program within Caroline Chisholm and to keep the Shepparton service of the agency operating. That connection does not exist.

Going back, though, to the issue of objectivity: in this debate, objectivity is often in the eye of the beholder. I have taken some time to review the material of some of the other services that have been referred to in this debate. Children By Choice, for instance, deal with my discomfort with the pro-life, pro-choice dichotomy in an interesting way: they suggest that you can be pro life and pro choice. I would suggest that there are also other options that others might feel are appropriate. Whilst it is obvious that Children By Choice do struggle to present a value-free or objective perspective, my concern is that at the same time their history refers to organisations such as the Catholic Church or the Vatican as being anti woman and fundamentalist. I do not think that approach is particularly helpful.

Other organisations such as Reproductive Choice Australia also seek to present an unbiased or objective perspective. Unfortunately, when you look at what they characterise as appropriate options counselling—when you get through stage 1 and stage 2 of what they regard as the process—you see that stage 3 deals solely with pre-termination issues and does not deal with other issues women might have, such as ambivalence about a termination, and what support might be appropriate in those circumstances.

Overnight I looked at the Bessie Smyth Foundation submission. Its perspective or view that a termination clinic would offer directive counselling is erroneous. That is not my experience and I think some of the other submissions to you will also say that there are some—I would not say all—services where there are concerns about directive counselling within termination clinics. When you talk to Children By Choice, that might be a good opportunity to explore their concerns about ensuring that women receive counselling independent of a termination procedure, and indeed the circumstances around why they were not prepared to refer women to termination clinics in Queensland when they first opened, instead continuing their referrals to New South Wales.

I think that the committee should spend some time looking at precisely what you mean by 'referral for termination'. The discussion to date has not really been about what should be best practice in a referral for termination. My own view is similar to what Nick Tonti-Filippini presented, which is that objective, independent medical advice should be part of that process as well. That concludes my statement.

CHAIR—Thank you very much for those presentations. We have a lot of senators at the table and quite a number of you at the witness table, so we will need to manage this process carefully. I invite senators to ask questions but I might ask if, at this stage, we can limit our questions to one or two directed to a particular witness in order to be able to get through in the time provided. I will start with one question to Mr Francis: you mentioned that you felt that the legislation before us was beyond the power of the Commonwealth to pass. Can you expand on that a little bit? Can you explain, for example, how the Commonwealth can exercise control over advertising relating to tobacco use but not over this kind of advertising?

Mr Francis—The reason why is that these counselling services are provided free. The Commonwealth has power in relation to trade practices, but counselling services are not within the ambit of trade practices. They are a free service and as such they do not fall within the ambit of the Commonwealth's powers.

CHAIR—Okay. Thank you very much.

Senator MOORE—I would like the committee to comment on it, because, to follow on from Ms Collins's comments, it is more about trying to balance the intent of the legislation, which is to be open so that a woman who is in this position, or her family and friends who are working with her, can have absolute security when she is seeking advice or information in that she knows exactly the background of the person or the organisation that is providing that advice. It is in the same way that, if you are looking for advice in any way, you have that confidence. Ms Collins, I am taking up the point that you raised about getting strong, solid practice, which I think is also taken up by the Royal Women's Hospital in their submission. Whole chunks of the evidence in the submissions are identical, so there is movement forward there.

As Mr Francis pointed out, the intent of this legislation was stimulated by advertising. How can we best ensure that advertising for any service clearly indicates what information a person is going to get and what the background of the organisation is? It is the intent to get that, so I would like comment. I know that people have very different views about what the best process is and all that kind of stuff, but I want to focus in on the intent, which is about truth in advertising. How would you ensure that, in the advertising process, I as a consumer would have absolute confidence in knowing exactly on what basis the organisation is offering the advice and what their value base is—because this is a value based argument; we cannot run away from that. I would like comment from members of the panel, and I do not care who goes first.

Mrs Francis—I would like to make the comment that the pregnancy support services have been accused of deception, but it is actually the abortion providers who prevent women from getting the information. In a report provided to the National Health and Medical Research Council, which was mercifully shredded because it was so inaccurate, the abortion provider said, 'When you're estimating the gestational age of the baby, turn the screen away from the woman so she can't see her baby.' That would be malpractice in any other area of surgery. If you are having a hip replacement or a knee arthroscopy, the surgeon goes through with you exactly what has been done. With a hip replacement, you see a video of what has been done, but the abortion provider says to turn the screen away from the woman. They are the ones who are deceiving women and keeping information from them, and they vehemently oppose any legislation which requires the abortion provider to provide information to the woman on the health risks of abortion or even on foetal development. If they were even required to let a woman see a picture of a baby growing in utero, the abortion providers would strongly oppose that. They are the ones who are concealing information from women; it is not the pregnancy support services.

Senator MOORE—Mrs Francis or Mr Francis, do either of you have a comment on my question, which was about the adverting? How do you actually know what the values base of the organisation is? I take your point, Mrs Francis, but that was not my question.

Mr Francis—It is not usual for any organisation to indicate what values it has when it is providing information. The values are a separate issue. Certainly, if anyone goes there, they are entitled to ask and they will be told, but to my mind the values are only background. The important question is whether they are providing true information.

Dr Tonti-Filippini—I do not think it is realistic to go down that path. I think that the better path is to go down the path that you do with every other profession, and that is to require professional standards and accreditation. I would much rather we go down that path. When you go to a doctor, unless you know the doctor very well, you usually do not know what the doctor's private views are in relation to whatever it is you might be seeking. It does not intrude in the conversation. What you expect when you go to a doctor is professional advice that gives you the options and gives you accurate medical information about what is available to you and what the effects of that would be.

That is what I would like to see happen in pregnancy counselling—accurate, full, comprehensive material information, as is required by every other profession in that respect. To me that resolves the problem that is attempted to be addressed by this bill. I think the policy would be better addressing professional standards and accreditation to ensure that pregnancy counselling meets the requirements that are there for every other profession.

Ms D'Elia—I think that there is some key thinking behind looking for truth in advertising that perhaps does not address more broadly the counselling relationship and the situation that a woman might find herself in when she realises that she is pregnant. In my professional experience I have been involved in pregnancy counselling for over 20 years. I do not do so much now that I sit at a more senior level. My perspective is that very often the initial reaction from many women and their partner or friends is: 'You must terminate this pregnancy because this, this and this are a problem.' One of the concerns for me is that if we move down a path which states there is no referral or there is referral then we are not looking at whether or not there is good counselling practice in those different places; we are simply saying, 'This is a service that may or may not be provided.'

There are many women, and I meet them all the time, who will not have the opportunity, if this is where we move with this legislation, of exploring all of the options that are open to them and thinking about what that might mean for them. The best example that I want to give to you is not so much what we hear on the counselling line, although it reflects what we hear on the counselling line, but what happens when I speak publicly about the work that we do at Caroline Chisholm Society. I talk about the fact that we are interested in supporting women who wish to continue their pregnancy and we provide a range of services in pregnancy and early parenting. When I speak to the general community—I go to service clubs and schools—women come up to me and they say, 'I wish I had known about your service when I was pregnant. I wish I had known that there were supports out there to continue my pregnancy.' I think that is a really sad position for us to be in as a community—that so many women make that statement days, weeks and years after having terminated their pregnancy or perhaps having moved forward with their pregnancy but struggled with it.

In response to your question, thinking about women in crisis and looking at crisis theory, very often we look for the quick fix that will take us out of the pain that we are feeling and move us forward so that we can forget about this terrible position that we are in. We do it in

grief and in a whole range of situations. We do it if we do something wrong at work. We think: 'How can I get myself out of this position that might shame me, embarrass me or in a whole range of other ways cause me to feel distress?' Crisis work will have us think about giving people a space to think about what their options might be, not grab what might appear to be the quick fix, and an opportunity to explore them.

I am concerned that this definition of non-directive counselling with a referral for termination or no referral for termination required as a statement perhaps takes us away from really concentrating on good professional practice in this area and thinking about accreditation in the field so that when people see an advertisement they see the words 'pregnancy counselling' and perhaps a little logo that says that the service is accredited. I think there are lots of examples. My staff go and do counselling service provision training in the areas of grief and loss, family violence and sexual assault as well so that they are well able to support women and families in a whole range of situations that they find in being pregnant and in supporting their families. I would see that as a much better approach.

Ms Collins—Could I add that there is much that you can follow in other areas of counselling where these issues have been addressed. I see the process as being that of professionalisation. In the standards that both the Commonwealth and the states require in some other areas of counselling, there is some guidance about trying to ensure that best practice is delivered—for instance, in the standards that are required in funded services for family counselling, other forms of family support and relationships counselling. You will find now that the funding models used by government require professional service delivery, not the use of volunteers. That is one avenue.

The other aspect in relation to this bill, and picking up from a point that Mary just made a moment ago in terms of the referral for termination issue, is that what is not clear at the moment either is what the sector, or indeed the law, even regards as an appropriate referral for termination. The laws of each state differ, and if you look at the evidence before you there are different views. When the AMA appeared before you, they said that they understood that you did require a doctor's referral for abortion. In reality, often a doctor within a clinic can conduct that referral, but that is certainly not what seems to be implied from the evidence that came from the AMA or their understanding of the situation. If you look at the submission of the Bessie Smyth Foundation, they say that it is not the case that a medical referral is required for a termination. I think there is still much in that area that needs to be addressed in terms of what is good practice before we go down the path of saying, 'We're going to use these sorts of phrases to prescribe how people delivering services can advertise.' That is probably the main problem I see with this particular approach.

Senator BARNETT—Could I put a question on notice to Mr and Mrs Francis about the constitutional legal question. Mr Francis, would you offer your views in writing to the committee subsequent to today's proceedings, because this a very important matter. You have alluded to it and you have expressed your views, but perhaps you could expand on those views to the committee. I would very much appreciate that.

Mr Francis—I can do that. I should point out that the Commonwealth has no powers other than those given to it by the Constitution, and there is no power that covers this situation.

Senator BARNETT—I am aware of that, particularly section 51(xx) and the power of the Trade Practices Act. If you could follow that up that would be most appreciated. Mrs Francis, you mentioned in your submission to the committee a range of criticisms and concerns with respect to the health risks and the health impact of abortion, such as post-abortion syndrome. You have mentioned infertility in disagreement with Senator Stott Despoja's article in the newspaper. Can you evidence that? You referred to a number of sources when you put that to the committee. Could you provide evidence of those sources, either now or perhaps subsequent to today's hearing, where you evidence the negative, adverse impacts, as you see them, of the abortion procedure?

Mrs Francis—I actually have the evidence here. I thought there were going to be eight senators, so I got eight copies of a 29-minute DVD on the abortion-breast cancer link specifically. It deals with the science of it and the evidence of women who have had abortions and then developed breast cancer. I would like to put that in evidence. I also have the booklet we distribute on breast cancer risks and prevention. I just have one copy of that. It is very useful information. We have actually been trying to persuade the Australian health department to have a public debate on this issue of abortion and breast cancer, because the fact is that the incidence of breast cancer is rising horrendously. The incidence between 1987 and 1997, about 28 to 38 years after abortion was de facto legalised by the Menhennitt and Levine rulings, draws at 40 per cent—and the health department are doing nothing to prevent or lower the incidence. All they are emphasising is early diagnosis and treatment, which is very important, but it is important to prevent it in the first place, because breast cancer is a very unpleasant disease. It is not like flu, which you get over.

One of the facts that is not in dispute is that the earlier that a woman has her first full-term pregnancy and the more babies she has the lower her risk of breast cancer. That is not in dispute. So if this 15-year-old girl who had an abortion in Adelaide had had her baby and carried it to term, she would have had a substantially lower risk of breast cancer than she does now because she has had an abortion. Women who have babies under the age of 30 lower their risk. Those who do not have babies until 35 or later have a higher incidence of breast cancer. Women who do not have children at all have a higher incidence of breast cancer. This is not in dispute. What is controversial is whether the abortion itself increases the risk. We have a lot of evidence that it does. There are a lot of statistical studies. We would like a scientific debate. Senator, maybe you could take that on as your next project on the health department.

Senator BARNETT—Thank you, but where I am coming from is that you referred to a number of sources. Subsequent to considering what you have shared with us today, if you want to back up your views with evidence and sources—

Mrs Francis—Yes. They are in the World Health Organisation paper which I gave to the secretariat. The references are in that. I also have 'Induced Abortion and the Risk of Premature Births'. This is very important because—

Senator BARNETT—If there is anything that you wish to table for the committee then now is the time, or you could do it subsequent to today's hearing. That is what I am really asking. If you think there is further evidence that we need to know about, you need to give it to us.

Mrs Francis—I would like to table all these, including 'Induced Abortion as an Independent Risk Factor for Breast Cancer' and the Australian cerebral palsy lawsuit. I wonder whether you are aware of the case of Kristy Bruce v Alan Kaye in the New South Wales Supreme Court, where Kristy Bruce sued her mother's obstetrician because she was deprived of oxygen during the birth process, was born with cerebral palsy and is now in a wheelchair. She cannot speak or walk. The court found that the mother's uterus ruptured during the birth, and this was not because of the negligence of the obstetrician but because she had had previous abortions and the uterus had been damaged. This is what happens. The uterus and the cervix are often damaged in an abortion and a mother has a great risk of having premature births in subsequent deliveries. That is the major cause of death and disability of newborns. I will table all that. Here is another document about the World Health Organisation. Senator Stott Despoja referred to the World Health Organisation denying the link between abortion and breast cancer. We have a document on that.

Senator BARNETT—That is fine. Thank you. Dr Tonti-Filippini, could I ask you a question. This is not in your submission, but you made reference to an important point: restrictions are one-directional under this bill. Could you expand on that and advise the committee a little bit further about what you mean by that?

Dr Tonti-Filippini—The substantial requirement in the bill is that pregnancy counselling services refer for abortion. That is really the major requirement. Surely, if they are non-directive and if they are going to be required to refer for anything, they should be required to refer for the range of possible services, including abortion. I do not think that it is proper that they do refer, but what I am saying is that, if you are going to require them to refer, why only for abortion? Why not require them to refer, if the woman wants it, to pregnancy support services?

Senator BARNETT—So you are saying that there would be one law for one group of providers and another law for another group of providers?

Dr Tonti-Filippini—Yes. It is very unbalanced. As I said, my view is that it is not appropriate to require a pregnancy counselling service or any counselling service to give a medical referral. That is the proper function of a medical practitioner.

Mr Francis—Could I add that, in my experience, abortion clinics and hospitals that perform abortions give no adequate counselling about any of the risks. I have found that in all the cases in which I have been involved.

Senator POLLEY—Some of my questions have already been asked. I would like to place on record that I appreciate the comments that were made in relation to accreditation. I think that would go a long way to resolving people's concerns. I was interested in getting people's comments on the definition of 'referral'. My understanding is also that it is something that a doctor rather than a counsellor does. Also, in some of the submissions that we have read, there have been comments in relation to fake counselling. Perhaps accreditation may assist us in that. We seem to be focusing our attention on Christian based counselling services. Does anyone have a comment in relation to the counselling services that are provided at abortion clinics and whether or not people would see that there is perhaps a financial incentive for a certain method of counselling?

Ms Riordan—Mary might like to comment about this as well. I do not have direct experience of what happens, but we certainly have concerns. A number of women that we are in contact with who have had abortions have come back recently or over a number of years and said that they felt they had no other option and were maybe rushed into making a decision before they had all the facts and all the consequences before them. Something that we were pleased to see in the debate earlier in the year was that many people in the Australian parliament were saying that they did not like abortion and they wished that we did not have so many abortions. If we are going to do something to make sure that women have options other than abortion, we should ensure that there are agencies other than abortion clinics that are able to assist women and we should make sure that if they wish to keep their child, despite difficulties, they are generally able to. We would like to see us go in that direction.

Mrs Francis—I would like to mention that an abortion clinic in Croydon, here in Victoria, sent letters to a doctor who is on our committee, encouraging her to send her patients wanting an abortion to his clinic. He said that the only requirement was that she should give notice of the patient's blood group. There was no requirement that she provide any reason for the abortion or why she was referring for abortion. He sent her a whole bundle of forms so that she could send her patients to his clinic. So the requirements of the abortion provider are non-existent. They terminate just to make money, I think.

Ms D'Elia—I would be concerned about some of the practices, as I noted in my opening statement. We are concerned that there are often examples where women talk about having their counselling on the same day that they have a termination. We would argue very strongly that some time between counselling and the procedure, to consider what some of the different options might be, is quite important. Women talk about attending clinics with their partner and feeling that they are quite pressured to continue because they have not had any opportunity for space or time from that time in the counselling room.

We also hear of women talking about that experience at the clinic as being more about pre-termination counselling. I think this is really important. For example, it says, 'This is what the procedure will look like; this is what to expect,' and those types of things. There is perhaps not as much time spent on whether or not this decision is right for them. I have heard women say that, because they have come to a clinic that provides termination, there is some kind of assumption that that is the decision that they need to take. We see that there are a range of concerns. We very much want to see counselling as being independent of providers who may have an interest in the service of termination.

Ms Collins—I could add one other aspect there. For instance, Senator Stott Despoja is probably familiar with the approach that was taken in South Australia, which was to keep the for-profit sector out of the delivery of terminations. As I understand it, that was essentially the motive behind the government taking over the regulation of termination services. It was about how to guarantee more independent practice rather than just something that government wanted to do, so to speak.

The concern is about what occurs or what can occur in termination clinics. In talking to Children by Choice about their perspective, I found that their concern is that people understand that decision-making counselling is distinct from pre-termination counselling. That people think that they are getting decision-making counselling when they turn up to a

termination clinic and in reality they get pre-termination counselling is an important one to explore. Indeed, their advice, as they indicate on their website, is that you should consider counselling as distinct from the termination procedure and understand that many clinics do not offer decision-making counselling, only pre-termination counselling.

There is even built in to this debate some confusion about what we are talking about when we talk about counselling. What I think we are talking about in terms of counselling is decision-making counselling, which should be non-directive. But the best way to guarantee that, in my view, is to go down the path of professional service delivery and accreditation—those sorts of things.

Ms D'Elia—If I could add to that, it would be interesting to look at the model. Here in Victoria, when we are providing pregnancy counselling and decision-making counselling we have a process in addition to that beginning decision-making process. If someone is looking at adoption, for example, then there are specialised agencies that provide the pre-adoption counselling. A similar distinction in terms of termination would also be helpful.

Senator POLLEY—We have also been given submissions in relation to the medical impact of abortions We have heard evidence from Mrs Francis on this. But we also have evidence before us that there is no psychological damage or mental illness associated with having had an abortion. I was wondering whether people questioned that. In terms of accreditation of counselling, that becomes more important than ever now that RU486 is available in Australia with the implications that that is going to have. Counselling in terms of all options should be foremost in people's minds. I would be interested in people's comments.

Mrs Francis—A study which I mentioned in my opening statement, the New Zealand health study, which is by a pro-choice researcher, Fergusson, found that the mental health problems of women after abortion were more severe than those of women who had carried their babies to term. That is the most significant one. My husband has information of earlier studies, such as the Rawlinson report in England.

Mr Francis—The Rawlinson report—

Senator POLLEY—You should table those, because we are short of time. Can you table something?

Mr Francis—I have not got the Rawlinson report here. I have no doubt—

CHAIR—Could you obtain it for us? You could give it to the committee later.

Mr Francis—I am sure you would have it in the parliament. It was a report delivered by the House of Lords in England in 1997. They investigated abortion. One of their findings was that more than 80 per cent of the women who had abortions had adverse psychological effects. Some of those psychological effects were not serious, of course. My recollection is that they found that between five and 10 per cent had serious psychological consequences. But there is a mass of material on this. Probably the best book on this topic is the book *Deeply Damaged* by Professor Ney. He is a New Zealand psychiatrist working in Canada. He has written a book on all the damage that abortion does to women. The 3rd edition of it appeared in 1997.

Mrs Francis—Senator Polley, a website that has a volume of information about this that would fill this room is the website of the Elliot Institute in the USA run by Dr David Reardon. The website is afterabortion.org. He has a wealth of information on the psychological and physical consequences of abortion.

Ms D'Elia—I would like to make a comment in response to your question. What we find is that very often women's distress following termination of pregnancy presents itself when they find themselves pregnant with a planned pregnancy. Women begin to read pregnancy books and get a range of information and they begin to wonder and think about what might have been. Very often, they are then disturbed by the fact that they were not given a good range of choices at the time they discovered they were pregnant for the first time. We hear about that distress from women.

What I would like to say, I guess, in regard to that is that all of you senators here—and I know there have been inquiries at a federal and also at a state level—should think about the experiences of women who, many years ago when they found themselves pregnant, if they were single were simply told, 'We're going to remove your child,' or were not told that but it simply happened anyway or were told that their child had died. My comment to you is that these women will tell you that there was not a good decision-making process. There was not good counselling. Therefore, those women talk about an incredible pain that they feel. I feel terribly for those women, because they were not given the sort of counselling that we are talking about here today.

It has got nothing to do with whether you refer for a service. That is not a helpful statement. What is helpful is thinking about good counselling. When I talk to women who had adoption experience in the 50s, 60s, 70s, 80s or 90s, the difference is that if they feel okay with the experience then, generally speaking, they have had good counselling. It does not necessarily mean that they have had a referral; they have had good counselling, and they have often had good medical support so that the referral has been about medical support to their pregnancy.

The women who are disturbed and distressed—and we hear their voices very strongly from those experiences in the 50s and 60s—are the women who were not given good counselling options around what they might want to do and were not supported in what their choice was—not what the counsellor thought, not what their mother thought, not what the boyfriend thought. We have high statistics from the Royal Women's Hospital here in Melbourne around the incidence of violence in early pregnancy. Many women report to us that the violence that is perpetrated upon them is directly related to whether they continue with their pregnancy. We know that these are pressures. I would very much want to be cautioning this committee to be thinking about the impact of a decision of a termination that is taken without due regard to the decision-making process. Very often we hear women that are very distressed perhaps months or years afterwards who will say, 'I was not given the right information. I was not given a range of supports. I did not know that there was support for me to study and have my baby. I did not know that I could continue in my career.' Those women in our community are very distressed about not being given supports and options to continue their pregnancy. That is what I am interested in exploring with women in the counselling room and I hope that all of my staff do that in a very professional manner. We need to explore all of those options so that

a woman can go away and think about her decision, where it sits with her value and belief system and what she wants, knowing that there is a range of support for her if she wishes to continue with pregnancy.

Senator ADAMS—Mrs Francis, thank you for appearing. I note all the documentation you have given us to read. With reference to breast cancer, in your last statement you were saying about breast cancer risks arising. The way I would look at that is that technology has increased and with breast screening throughout Australia and with an increased population obviously breast cancer is going to be more evident because we have got the technology to prove that it is there. I am a breast cancer survivor of nine years. Have you read the Royal Australian and New Zealand College of Obstetricians and Gynaecologists publication *Termination of pregnancy: a resource for health professionals, 2005?* Have you read that?

Mrs Francis—No, I have not read that.

Senator ADAMS—I suggest that perhaps you do. They have said:

The evidence does not support an association between termination of pregnancy and infertility, ectopic pregnancy or breast cancer.

… … …

A comprehensive analysis of data from 53 studies including 83,000 women with breast cancer concluded that 'pregnancies that end as a spontaneous or induced abortion do not increase a women's risk of developing breast cancer' and that studies of breast cancer with retrospective recording of induced abortion yielded misleading results.

I really think that perhaps the evidence you have given us is a lot older than 2005, so I suggest you read that documentation. That is just a comment that I want to make. Mr Francis, do you believe it appropriate for pregnancy counsellors who are not trained medical practitioners to provide information on the potential health risks and dangers associated with abortion, including the link to breast cancer that you have mentioned in your submission?

Mr Francis—I think they should provide information. In relation to the breast cancer risk, they should at least tell the patient that there is a lot of material that indicates that risk exists, although there is other material that contradicts it. They should at least know about the medical controversy on the subject. The article does not affect my mind much because the prior material is so strong that it cannot be altered by one article like that. I think there were about 38 statistical surveys. Professor Brind, who is the world expert on the subject, had his statistician, Chinchilli, who is pro choice, do a statistical analysis. They came to the conclusion that there is a link. Professor Brind has found the scientific reason for the link, and nobody has ever disputed that scientific reason. There have been experiments on rats by Russo and Russo in which they aborted rats, and 77 per cent of the aborted rats got breast cancer, compared with a very low instance amongst those who went to full term pregnancy.

Senator ADAMS—I will make a quick comment on that which comes from some of the evidence that I have before me. It has been subsequently pointed out that the Brind study which you are commenting on relied heavily on data from self-reporting, which can bias the results. On the other hand, the data in the Scandinavian studies mentioned earlier—I will not read that all out but you would be aware of that—

Mr Francis—Which Scandinavian studies are they?

Senator ADAMS—There is that of Dr Mads Melbye and colleagues from the Danish Epidemiologic Science Centre. That is a study that was done between 1935 and 1978 of approximately 1.5 million women. As I was saying, the data in these Scandinavian studies used data from relevant national registers and not from self-reporting. So we have a conflict there. I just wanted to mention that.

Mrs Francis—To respond to Senator Adams, the Melbye study is fully dealt with in our book on abortion and breast cancer. Professor Brind debated Professor Burton of the Anti-Cancer Council. Dr Melbye made a major mistake. He assumed abortion had been legalised in Denmark in 1973. The law had only been bit a loosened. It was actually legalised in 1939, so he missed about 60,000 abortions in the Danish life statistics, of which we have a copy here. Melbye also acknowledged that second trimester abortions increased breast cancer risk and he also said that pre-term deliveries increase breast cancer. Those are also in papers in the literature. So even if you have a premature baby under 32 weeks, that increases your breast cancer risk.

In the literature I have given you is the latest analysis by Joel Brind: 'Induced abortion as an independent risk factor for breast cancer: a critical review of recent studies based on prospective data'. It appeared in the *Journal of the American Physicians and Surgeons* of winter 2005, so that is as recent as you can get. Also among the papers given is a German study showing that abortion increases breast cancer risk and that pregnancies help. Senator Adams, if you talk to any anti-cancer specialist, they will tell you that the more babies a woman has, the longer she breastfeeds for and the earlier in her life that she has those babies, the lower her risk. That is not in dispute, and abortion is contraindicated in all of those areas. There is a protective effect of early pregnancy and breastfeeding which is destroyed by abortion.

Senator STOTT DESPOJA—Thank you for providing submissions to the bill, particularly to those of you who have addressed the bill. I think that this committee process is quite a constructive one and I think there are some amendments that could be made as a consequence of some of the ideas that have come forward this morning. I do not necessarily believe that the committee process is a waste of time. Mr Francis, I am sorry you feel that way. But I would like to acknowledge some of the issues that have been brought up.

The first one is—and I agree strongly with the notion of it—some kind of regulatory framework or standards. I want to put to those who have put forward that idea that I am in total agreement. But, as you would know, it is possible for, say, a business, a professional organisation or a non-profit organisation to have a code of standards or a framework but at the same time be subject to the Trade Practices Act—that is obviously not the case in the non-profit sector—and have separate rules for advertising. That is why I dealt with advertising specifically in this bill. It is because such services were not subject to the TPA. Chair, I will provide to the committee the legal advice that we have. Our legal advice says quite strongly that this can stand as a separate bill because the TPA does not cover these matters.

I will start with Dr Tonti-Filippini. This is not the first time I have sought or received advice from you on a private member's bill or an ethical issue. I think that you, and the Caroline Chisholm Society as well, have an interesting point, one that I am increasingly inclined to agree with, and that is the issue of the definition of 'non-directive' counselling. I

think that is something that the committee can examine—how we define non-directive—but at the same time you would understand that one of the intents of the bill for me was to look at the issue of all-options counselling. Whether or not you confuse that with the definition of 'non-directive' may be something different; that is something we can talk about.

Dr Tonti-Filippini, I want to clarify something with you: do you recognise that this bill does not make it a requirement that pregnancy counselling services provide referrals for termination? This is about preventing people from suggesting or giving the impression that they provide all-options counselling, or my definition of non-directive counselling. People are only penalised if they are responsible for presenting their services in a misleading or deceptive way. This is not going to affect the operation of pregnancy counselling services in Australia, regardless of their perspective or the services they provide. It is certainly not the intention of the bill to 'destroy' those services, to quote other people—quite the contrary: it is about people being up-front about the services they provide.

Dr Tonti-Filippini—My understanding of the bill is that, in relation to the funding of non-directive pregnancy counselling services, they would be required to refer women for abortion.

Senator STOTT DESPOJA—They are required to be up-front about whether they do or do not.

Dr Tonti-Filippini—I think there are restrictions in relation to what can be funded, are there not?

Senator STOTT DESPOJA—Only in relation to whether people fail to disclose what services they provide. So they can still provide whatever services they wish to, but there is a requirement only in the case of an agreement with the Commonwealth that they disclose that particular service. I am not suggesting we necessarily—

Dr Tonti-Filippini—But my understanding is that the definition of 'non-directive' would compel them—that if they said they were non-directive and they were funded to be non-directive they would have to refer for abortion.

Senator STOTT DESPOJA—The requirement is only that they disclose whether they are directive or non-directive, or any other definition. It is only if they fail to disclose that that they are not entitled to funding. They just have to be up-front about the services they provide.

CHAIR—Rather than a dialogue, could we have some questions.

Senator STOTT DESPOJA—As the drafter of the bill I am just making it clear that there is no intent that people not be able to access funding, depending on what service they provide. However, there is a provision for Commonwealth funding not to be provided only if that disclosure is not made—if people are not up-front or they mislead about what services they provide. I am happy to pursue this; we can get more information. But I just wanted to make that clear in terms of the intent. Section 10 of the bill is intended to penalise only in the case of failure to disclose. It is not, nor is any other aspect of the bill, intended to penalise agencies for the services that may or may not be provided.

CHAIR—I think Dr Tonti-Filippini has responded to the comment you have made, so I think that is as far as we will take that. Any further questions?

Senator STOTT DESPOJA—Certainly. Again, this may be one for Dr Tonti-Filippini, Ms Collins, Ms D'Elia or indeed Ms Riordan. I think that your comments about referrals are also interesting—and, yes, deciding on a definition of 'referral' is a key issue. I note that the Caroline Chisholm Society submission quotes from the Australian Association of Social Workers Code of Ethics. Indeed, you say:

- Recognition that all Counsellors have values; their role is to provide ethical, non-directive, independent counselling.

When I refer to that code of ethics, under section 4.1.3, Social Work Service, part (e) says:

> When making referrals, social workers will aim to refer clients to competent and reputable service providers.

So there is an assumption in counselling, of course, that referrals are provided. If we get away from the specific mention in the bill—and I understand your concerns about the referral for termination—there is the concept of referral in social work and pregnancy counselling generally.

I would be interested to know now or on notice the Caroline Chisholm Society's definition of 'referral'. For example, if I were to request information on adoption services, would you refer me to a qualified organisation, specialist or whatever? If I requested a referral for termination, would you refer me to a GP or to a specialised service? Again, I understand that the definition of referral can be all things to all people, but I think the committee and the bill would be assisted by getting a sense of people's definitions.

Ms D'Elia—We do not refer for the termination of a pregnancy. We are not medical practitioners. That is the role of a medical practitioner. But we are happy to talk about all the options that are available for a woman to explore. We do explore all three options that are available. If someone was to ask for a referral for termination we would say that it is really important for them to seek further counselling and support from their GP or local hospital. We do not provide a direct referral to a termination clinic; we believe that it is important for there to be the intervention of a medical practitioner in that process. Indeed, we believe it is important for all pregnant women in early pregnancy to see their GP or local hospital, and that would be part of the process that we would be encouraging.

My other comment is that I welcome the fact that your intention in the legislation in talking about non-directive counselling and defining it in this way would not be to disadvantage pregnancy counselling services. However, my key concern would be that in the general public's mind that is very possibly exactly what you might do. If I were a member of the general public and what I see, at a point of crisis when I am thinking that I have no other options available to me, does not refer for termination services then I will look at that and say, 'They are not going to be able to help me.' That is perhaps a false assumption. If, however, your intention is to think about how people receive good, honest and open counselling then if I am able to open the phone book and see services listed with an accreditation beside them I can look at that, just as I look at the master builders logo or whatever, and I can say that I am going to receive a range of counselling services.

We would be very clear that we are not directive within our counselling and yet having to state that openly works in the reverse, if you like. By stating that I am not a non-directive service under your definition then in fact what I am stating is that I am directive, and my

social workers would walk out on that basis, and rightly so, because they would be misrepresented by the organisation if I were to sign a form that effectively said they were directive counsellors. Does that make sense?

Senator STOTT DESPOJA—I understand your point.

Ms D'Elia—I really do welcome the intent, which is to say: let us think about how women are given service provision here. But I am very concerned that, in looking for federal government funding to support the work that we do, you are asking me to be up-front and say that I do not fit a definition of non-directive counselling. That is a huge concern for our agency and, in fact, I do believe it would disadvantage the very good work that we provide in the community. I am really interested in teasing out with you what those possibilities might be so that we are not restricting under legislative framework some very good work that is happening in our community and that we are taking into account very clearly the situation that women find themselves in when they are in distress over a pregnancy. Often the role of a good counsellor is to slow that process for a week or a few days and really give the woman an opportunity to explore what this might mean. I go back to my earlier statement, which is that I think the advertising suggestion you have about non-directive and referral will in fact result in people not getting the services they need, as against what I believe is your intent, which is that they do get good counselling.

Senator STOTT DESPOJA—In terms of misleading or deceptive advertising, whether we are talking about master builders or, as in this case, pregnancy counselling services, what about a pregnancy counselling service that gives the absolute, distinct and explicit impression in its advertising and brochures that it provides information and referrals on all three options? Is there not a case for some form of transparency, or indeed penalty in the case of deception, where that counselling service does not in fact provide information that is both realistic and honest on those three services? I note that both you and Ms Collins talked about examples of misinformation. At whatever end of the spectrum, if an organisation gives an impression on three options, whether it is termination, adoption or keeping the child, should there not be a penalty in the same way that I would expect a building organisation that advertised a logo and yet was not legitimate would be penalised?

Ms D'Elia—If the counselling process is not provided in an ethical way there is the opportunity, for example, through the Australian Association of Social Workers or other registered bodies, for counsellors to be brought before an ethics board to look at their conduct. There is the opportunity within the organisation, within our training and within a whole range of processes for us to look at how those sorts of services are provided. Is that what you are asking?

Senator STOTT DESPOJA—I am specifically talking about advertising and the fact that for-profit organisations who advertise in a way that is deceptive or misleading are answerable and can be punished under the law. A pregnancy counselling service that gives a distinctly false impression through its advertising in an explicit or implicit way cannot be held to account in the same way. I acknowledge your point about counselling standards and ethics. Perhaps that professional training and standards debate is another one that I could ask you about, but I will not have time. But specifically to do with advertising, I do not see that there is recourse in the current environment. That is what this bill is intended to address.

Dr Tonti-Filippini—I agree that there should be penalties for false advertising. It is unfortunate if there is an area, because it escapes the Trade Practices Act, where people are providing services and advertising in a way that is misleading. But I am not sure that this bill addresses that. I think that the bill addresses one aspect—referral for the termination of pregnancy. I do not think that that is an appropriate measure of what counsellors do. I think that is what Mary has been saying.

Senator STOTT DESPOJA—I understand. Dr Tonti-Filippini, I get that loud and clear from your submission and from the work that I am aware you have done in the past. I guess that is why I was asking the general question, not even pertaining to the specifics of this bill—that is, the idea of false or deceptive advertising being outlawed. That was the answer I was after. Thank you.

Ms Collins—Can I briefly go back to a point that you raised previously, Senator? You picked up on the point about referrals. I think where you are heading on that is correct. There was suggestion in the *Hansard* of an earlier hearing that only doctors refer. That patently is not the case.

Senator STOTT DESPOJA—Exactly.

Ms Collins—I think what we are confusing here is one notion of referral as opposed to a more narrow concept of a medical referral. I have heard the language shift between the two on a few occasions. I made the point quite clearly that my own personal perspective is that a referral for termination should only occur with independent, objective medical advice.

Dr Tonti-Filippini—Can I just comment on that, because it is quite important. A referral for a termination of pregnancy, a referral for a surgical procedure, is a medical referral and should be treated that way.

Senator STOTT DESPOJA—Yes.

Dr Tonti-Filippini—You cannot expect counselling services to provide medical referrals.

Ms Collins—But further to that, and related to the concept in the AASW code, is that, for a counsellor to make a formal referral, they must be confident about the quality of the service to which they are referring. This is again why I refer to Children By Choice's comments about concern about some termination providers not providing adequate counselling. Say you are a social worker working in a pregnancy support agency, you have gone through the whole process of decision-making counselling with someone and they come out of that process still saying, 'No, I want to pursue the path of a termination.' I as the counsellor would find it problematic not to be satisfied that the next stage for that person does not involve independent, objective and informed medical advice.

Senator STOTT DESPOJA—Independent, objective and informed—that was the intent of the bill. I acknowledge your concerns and criticisms. I just want to put on the record that that was the intent. It was not born out of malice, as some might suggest today. I thank you for your contributions.

Senator WEBBER—My friend Claire Moore has been reading a fine book which is a little interesting. This goes to the heart of the bill rather than to some of the other discussions we have had today, in that there are a number of ads here. Centacare Catholic Community

Services advertise confidential free counselling, relinquishment counselling and adoption. As a woman, it is very clear to me the direction and options that that counselling would offer. Then Marie Stopes have in their ad at the top 'abortion', so it is very clear what direction their counselling and services would provide. But then there are others like Pregnancy Counselling Australia. Their ad says, 'Pregnant and upset?' I think those three examples highlight how important it is that ads are transparent and open about what kind of service you are going to get, because when I then looked at Pregnancy Counselling Australia's website I saw that they only talk about two of the three options. I think that highlights the need for that openness and transparency within that.

Like Senator Stott Despoja, there are a lot of things in the Caroline Chisholm Society's submission that I agree with, surprising as it may seem. One of the things that this committee can do, as Senator Stott Despoja has said, is make recommendations for changes to the bill. One of the things that I would be interested in is that we have talked a lot about the definition of non-directive. What do you think we need to do to tighten that definition up in relation to the advertising and the way I have read that out—because this is a bill about the advertising of counselling services and its transparency?

Ms Collins—Perhaps one way to deal with it, if it is sitting side by side with a model for appropriate service delivery, is to simply have a distinction between services—between those that will assert that they will make appropriate referrals and others. If you look more closely at the situation, I think in Queensland there is in part some of that discussion. If I understand the history correctly, the state government there funds what could be loosely coined as one pro-life organisation and one pro-choice organisation, both of which deliver pregnancy support counselling and both of which would claim to offer all-options counselling. I have no direct connection with Pregnancy Link, but just from reading their site I know they assert that they offer appropriate referral. In my view, if that sits with what we have talked about—what should be the appropriate response to someone who is after decision-making counselling persisting in a desire to pursue a termination and that they are directed towards appropriate medical advice—then I would regard that as appropriate, whereas if you have an agency that say, 'Under no circumstances will we discuss that option,' then they would not be appropriate. However, if you try and get more detail into a distinction about what is and is not appropriate, I think we will be chasing our tails forever, and that is probably best left at the level of professional best practice accreditation and regulation.

Senator MOORE—Do you think that could happen?

Ms Collins—I think it is more likely to happen through, I suppose, the process of professionalisation in this area.

Dr Tonti-Filippini—The question of professionalisation happens largely through government providing funding and then putting restrictions on that funding. That seems to be the simplest way to do it: you require them to be accredited by a body and to meet some public standards as to what is required by professionals in that area.

The other point I want to make is in relation to Jacinta's earlier remarks on the question of what the proper function of counselling is. We have had the distinction made between decision-making counselling and, in our case, pre-termination counselling. It seems to me that

it is quite legitimate for somebody to advertise themselves as providing decision making counselling in which they discuss all options, and do so in an objective way, without them having to be required to refer for anything—I think referral is a separate matter. The question really is: will they advise that person to go to an appropriate professional once it is indicated what direction they are taking? That is, will they make that link? What happens at that point is a different matter, and that is where you are moving into the pre-termination or pre-whatever process. It seems to me that professional standards for counselling would address the question of proper information giving and nondirection in that area.

Senator WEBBER—To expand on that, Jacinta mentioned earlier as an example the direction the government is taking on funding family counselling. When you go and see those counsellors they cannot tell you to stay in or to end the relationship. Having just come off the Select Committee on Mental Health—there is a number of us here—I can tell you that one of the other definitions that people often use for non-directive counselling is 'client centred counselling', meaning that it has to be about the needs of the client, not about the needs of the counsellor or the ideology of the organisation.

Senator ALLISON—Dr Tonti-Filippini, a number of submissions have given us what might be described as case studies of reactions that women have in approaching pregnancy counselling services. I will mention a few, if I may. One woman said:

They showed us a film that was really frightening showing the baby trying to get away from the instruments the doctor was using. Then they told us how bad it was to have an abortion and I would never be able to have any children.

A 40-year-old woman said:

This person was so obviously trying to talk me into going ahead with the pregnancy. When I mentioned that I knew there might be risks of Downe's Syndrome because I was older she said I had nothing to worry about.

Another young woman said:

The woman told me if I had an abortion I would never be able to get pregnant again and that I could die. And she said that they cut the baby up.

That particular case study concludes with the woman saying:

They shouldn't be allowed to scare people like that and tell lies.

As an ethicist, what is your response to that form of counselling?

Dr Tonti-Filippini—I do not regard that as professional counselling, and I do not regard it as helpful to a woman who is in distress. In any circumstance where somebody is distressed, you do not resolve their distress by adding to it. All the evidence in relation to this area is that you need to be supportive of the woman in order for her to make decisions; she will make good decisions when she feels supported. Obviously, one thing that is much more important is providing her with accurate information about what is happening, but not in a way that is calculated to add to the pressure on her. Counselling is not all about pressuring somebody. Whether it was in that direction or in the other direction—somebody telling them what a disaster pregnancy would be and so on—I think either way would be unfortunate.

Senator ALLISON—What advice would you give the committee about how we should remove this kind of poor counselling from the current arrangements?

Dr Tonti-Filippini—I do not think that people who are professionally qualified in any of the counselling disciplines of psychology, social work and so on could be expected to give that kind of counselling. The question is about professionalising the area to ensure that there are good standards so that, when a woman goes to somebody who advertises their services as a counsellor, she can identify that they are properly accredited and will provide professional counselling.

Senator ALLISON—Indeed. So the advertising should indicate whether or not the counsellors are voluntary, unskilled, untrained or—

Dr Tonti-Filippini—They can be voluntary and professional. That is not a dichotomy. The question is about whether they are professionally trained and whether they meet professional standards.

Senator ALLISON—I would like to press the point about advertising. You would endorse a system whereby that accreditation or professionalism was expressed as part of the advertising?

Dr Tonti-Filippini—I would very much like to see that. I have done some work in another area which is related, and that is infertility counselling. The same problem was occurring there. If you look at the National Health and Medical Research Council guidelines on reproductive technology, you will see that they specify that somebody has to be appropriately qualified in a counselling discipline. I would like to see the same thing done in relation to abortion.

Senator ALLISON—I have a point about the ethics board or ombudsman. Ms D'Elia, I think you mentioned that was an option available to women who might have gone through such an experience. Should it also be a requirement that people who call in to those services are told what they can do if they have an objection to the material that they have been told or when it is clearly false?

Ms D'Elia—The common practice amongst organisations today providing any range of services is that they have a complaints policy.

Senator ALLISON—I will ask you about the Caroline Chisholm Society. Someone rings in, they think they want an abortion and you give them advice. Do you also tell them in that conversation that, if they are not happy with the advice they receive, there are remedies?

Ms D'Elia—Probably not within that particular call, unless they were expressing some concern. However, if I look at, for example—

Senator ALLISON—What do you mean by 'expressing some concern'?

Ms D'Elia—If someone were to say in a counselling call, 'I'm not happy with this,' then obviously our counsellors would say, 'Would you like to speak to someone else or to someone more senior?' That is part of our policy in ensuring that you get the service that you need. In terms of, for example, our family services, where we have more face-to-face contact with people, then the policy around ensuring that people receive a service that they are comfortable with is in fact handed to them in writing. If we were to see someone in our counselling room

at Moonee Ponds, Bacchus Marsh or wherever, the policy is on the wall. That has become a fairly known practice for a whole range of services.

Senator ALLISON—Are you are able to advise the committee on whether other services do likewise?

Ms D'Elia—In fact, we have worked together with a couple of other services on their complaints policy, so I know that, for example, Catholic Family Services, Centacare and so forth would have those policies in place. I could not comment on other services. I would think that it would be fairly standard practice for anyone who uses quality frameworks within their service provision.

Senator ALLISON—Getting back to a remedy and saying that there should be professionalism in the service, I think we would all agree with that, but what are the steps in getting there? Should there not be some requirement within the law—whether it is through this bill or in some other way—to prevent that kind of so-called counselling?

Dr Tonti-Filippini—There are a couple of ways. We have different models. A model exists in the Privacy Act where organisations that retain private information are required to meet a certain set of standards and to have a statement of disclosure available to their clients as to what their policy is on privacy. You will notice that all organisations now keep information, from schools to anybody. One model is to do it in that sort of framework. The other is by deed of agreement. If we are talking about Commonwealth funded organisations then you just slot these things into the deed of agreement, as already exists for quite a lot of these funded structures. I am familiar with the structure in the family planning area in terms of the deed of agreement and what is required for people to meet those requirements. I do not see why the same could not be done in this area.

Senator ALLISON—In those circumstances, do you think the Department of Health should do spot checks? It can be quite a daunting prospect to make a complaint if you are a woman in a state of distress. Do you think there should be independent mechanisms to ensure that this kind of counselling does not happen?

Dr Tonti-Filippini—It is usually adequate to require that there be a complaints structure within the organisation and then for that organisation to be done by a deed of agreement. That seems to work for everything else. I am not sure you need to go to some kind of officer who receives complaints about this area. It is a possibility but that seems to me to be a more expensive option than what seems to work otherwise. These areas function if you just establish professional standards and make the professional standards and accreditation part of the funding process. It may be the case that there will then be organisations that are not funded and do not fall within your criteria, but I suspect that without funding they are not going to be terribly successful or very common. It would seem to be establishing something that is very heavy-handed to try to regulate just that little group of people. It seems to me that they are not that much of a problem. It is a question of expense, isn't it? Are you going to establish an office and officers to oversee what might be a very small number of people in the community? I would much rather see us going down the professional line and using the models that have worked elsewhere of agreements to professional standards and then those

professional standards having standards of accreditation so that people are accredited by an organisation that meets those standards and reaches an agreement to do so.

Senator NETTLE—I just want to alert Mrs Francis to the US National Cancer Institute which in 2003 concluded that abortion and miscarriage do not increase a woman's subsequent risk of developing breast cancer. Mr Francis, you comment at the end of your submission that Senator Stott Despoja would be better off spending her time ensuring that there was legislation that required medical professionals to provide people advice about the risks associated with medical procedures. You would be well aware that such legislation already exists given it is the basis on which the court cases you have outlined for us are ones that you have been involved in, wouldn't you?

Mr Francis—I am not directly aware of it. I do know the legal principles involved and I also know from my own experience—I do not know from the last year or so because I have not been in practice—that the counselling provided by abortion clinics and hospitals which perform abortions is grossly inadequate and improper at times.

Senator NETTLE—That legislation has been the basis of your cases. I will leave it there, thank you.

Mrs Francis—Senator Nettle, may I respond to your comment about the National Cancer Institute? Many of the heads of the National Cancer Institute in the United States are also connected with the abortion industry. Joe Brinck, who has been the main researchers on the abortion-breast cancer link, attended the workshop. He was not allowed to speak and they did not directly address the abortion-breast cancer link and in fact he spoke to Janet Daling, who published the major research in one of the northern states on how girls under 18 who had abortions and women over age 30 who had abortions were at greater risk. He said to her, 'Why aren't you speaking up here? Is it because you might lose a grant?' She said, 'You have just said it.' All the researchers on this thing are tremendously intimidated. The abortion industry is so powerful and has so many people on the payroll of the National Cancer Institute that they are trying to bury the abortion-breast cancer link as much as they can.

What they cannot dispute is that the younger a woman is when she has her first full-term pregnancy, the lower her risk. There is no excuse for any teenager in Australia to be aborted because she is not going to die of an unwanted pregnancy, but she may very well die of breast cancer, which is the major cause of death for pre-menopausal women and the third major cause of death for post-menopausal women. That early pregnancy gives her a substantial degree of protection, and the protection is added if she breastfeeds the baby for a substantial period of time.

Senator NETTLE—I am not able to comment on the background of people who form the US National Cancer Institute but, if you feel you are able to, feel free.

Mrs Francis—I have done that and I have also provided eight copies of a DVD which outlines the science of why abortion increases the risk of breast cancer. I do hope you will look at that. It includes testimony from women who have had abortions and have developed breast cancer plus the scientific information. With regard to the World Health Organisation, it has taken them ages to define the pill as a cancer risk. They have suddenly decided that the new low-dose contraceptive pill is a class 1 carcinogen in the same category as tobacco and

asbestos. I think they will come around eventually to acknowledging that abortion is also a cancer risk.

Senator NETTLE—Don't hold your breath!

Mrs Francis—Did you know that the World Health Organisation has declared the pill as a carcinogen?

CHAIR—We might have a debate across the table; I think questions have been asked. I thank all the witnesses at the table today. It has been a very interesting session. We are very grateful for your extended time here today.

Proceedings suspended from 10.46 am to 11.06 am

IGAI, Dr Aron, Contributor, Do Not Be Quiet

WICKHAM, Ms Sarah, National Women's Officer, National Union of Students

CANNOLD, Dr Leslie, Spokesperson, Reproductive Choice Australia

SCHALER-HAYNES, Ms Magda, Legal Counsel, Reproductive Choice Australia

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I think some of you are already experienced in appearing before parliamentary inquiries, so you probably do not need to know much about that. I invite each of you now to make an opening statement, and then the committee will proceed to ask you questions about your submissions.

Dr Cannold—Reproductive Choice Australia, as some of you may know, is a national coalition of over 20 organisations and individuals, including Children by Choice, the Public Health Association of Australia, the Australian Women's Health Network, the Women's Electoral Lobby and all state based pro-choice groups. Our goals are to maintain, extend and improve women's access to abortion both legally and practically; ensure access to non-directive counselling and information on pregnancy options; and advance the capacity of Australian women to exercise choice and control over their reproductive lives.

RCA strongly supports the Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005 or a bill very much like it becoming the law of this land. The bill should be commended for seeking to close a loophole in current legal arrangements that enables crisis pregnancy centres, which I am going to call CPCs from now on, to deny potential and actual users of their service the basic legal protection enjoyed by Australians of protection from deceptive or misleading advertising. It is our view that all Australians, whether or not they pay a fee for a service and regardless of their sex, religion or pregnancy status, have a right to truth in advertising.

RCA seeks to use this opportunity to remind the committee that behind the concept of truth in advertising is the view of citizens, patients and consumers as rational individuals whose autonomy or capacity to govern their own lives merits protection. Misleading or deceptive advertising seeks to manipulate the behaviour of citizens by providing false information on which they, trusting in its veracity, might choose to act. Truth in advertising laws say that, regardless of the benefits that might accrue to the advertiser of getting citizens to do what they want—to buy their products or to use their services—manipulating or coercing individuals into behaving in ways that, if they knew the truth, they might not, is an unjustified abuse of their autonomy and should not be legally allowed.

Small 'l' liberal states like Australia have consumer protection laws like those that prohibit misleading and deceptive advertising because they believe that the defence of individual liberties is the essential task of government. Citizens must be free to exercise their own values in pursuit of what they define as a good life. Of course, in pluralist nations like ours citizens will disagree about what a good life is and how they ought to go about living one. But alongside the right of each to control and direct their lives according to their values is the obligation to respect the right of others to do the same. The state has some positive obligations to protect the liberty of citizens to direct their own lives or to exercise what ethicists would

call autonomy. One is to ensure that citizens have the information they need to make informed choices.

The federal health minister noted as much recently when he advocated for consumer protection regulation to enable Australian citizens to make 'more informed choices about what they do with their lives'. He was speaking about the need for the federal government to regulate to ensure food labelling included 'prominent' and 'unmistakable' information about nutrition so Australians could make informed choices about what they eat. But the concept that the state has a role in ensuring that its citizens are provided with clear and honest information on which to base informed choices also holds true for pregnancy counselling. Real choice will founder on a glacier of lies.

RCA's understanding of the process being undertaken by this committee is that it is a collegial one in which the senators work with one another and the community to better understand the implications of the bill and to make constructive suggestions as to how it might be improved so it can move forward and be debated in both houses and come to a vote. Having carefully read through the transcript of the Canberra hearing and the submissions made to the committee as well as the bill itself, RCA would like to take note of what appear to be some key overlooked areas of consensus amongst both those supporting and opposing the bill. In so doing we hope to dispel any false impression that might be gained that the two sides are hopelessly divided and that the evidence is inconclusive about the need for the bill or one very much like it to become law.

I would like to now list what I see as these consensus areas. There is agreement amongst both supporters and opponents of the bill that transparency in advertising is an important principle worthy of support. Mrs Foster, the executive officer of the AFPSS, the agency in receipt of $300,000 of government funding and the umbrella organisation for 27 anti-choice pregnancy services in this country, confirms that Pregnancy Help Australia, which is their operating name, is supportive of the requirement of truth and transparency in advertising in relation to all counselling services, including pregnancy counselling. That is on page 40 of the transcript of the Canberra hearing.

There is agreement amongst both supporters and opponents of the bill that there are two sorts of counselling agencies that currently operate in Australia: one set that might be called anti-choice or pro-life and another that can be called pro-choice or all options. Again, I draw attention to the key testimony of the AFPSS on this matter. Mrs Foster, in answers to questions from Senator Stott Despoja, confirmed that the constitution of the AFPSS currently being revised will not be changed or in any way amended with regard to two key provisions: the first, the AFPSS's commitment to providing an organisational structure for state, regional and local pro-life pregnancy support service centres and the second, its commitment not to advise on, provide or refer directly or indirectly to abortion or abortifacients. Obviously, this philosophy, which Mrs Foster calls pro-life, is fundamentally different from that of a pro-choice organisation, which does not have a philosophical objection to advising on, providing or referring directly or indirectly to any of the three options—adoption, continuing or abortion—available to a woman facing an unplanned pregnancy.

Thirdly, there is an admission from the chief executive officer of the AFPSS and the director of counselling services, Debra Garrett, that while the AFPSS claims to support transparency it does not provide it to women. In the Canberra hearings Senator Nettle asked:

Do you list anywhere that you do not refer for termination or provide information to women about access to termination? Is that listed anywhere in your advertising or anywhere in your material?

Mrs Garrett said:

Not specifically.

Senator Nettle said:

... you do not indicate anywhere in your own material that you do not do that?

Mrs Foster said:

No.

It is the view of RCA that these two key points of agreement and the crucial admission by the umbrella organisation for state, regional and local anti-choice pregnancy support services should ensure support for the key features of this bill.

If we can all agree, as we seem to have done, that transparency matters and that meaningful distinctions exist between currently available types of pregnancy counselling services but that these are not being made evident to women in the advertisements and notices of these services, it becomes clear that disagreements about the bill are quibbles around the margins that do not go to the importance of the principle of transparency in advertising and the need for it to be guaranteed in law to all service users, not just fee-paying ones. I am quickly going to run through those quibbles and to propose what I think are very easy remedies to them so that we might basically be able to move forward and understand that none of them are fatal to the bill and all of them can be resolved so that we can come out of this process with something that we can move forward with.

One of the quibbles is about terminology. It is around the idea of identifying language that captures the key differences between 'pro-life' and 'pro-choice' counselling. Opponents of the bill have objected to the bill's use of the term 'refer' and 'non-directive', and I am sure you have all heard this ad nauseam. They insist on referring to pro-choice services as pro-abortion, as a means of supporting the false claim that pro-choice services are hampered by the same biases as pro-life ones. In this case, it is a philosophical opposition to adoption and mothering.

The debate about language is as charged as the abortion debate itself, but this is not a debate about abortion but one about transparency in advertising. It is RCA's view that quibbles about language need not bog this bill down. The language that should be used in advertisements and notices of CPCs is the language that alerts women to the nature of the service being offered—that is the point of the bill. Precisely what language does this is an empirical question; it is simply a question of fact. And the answer can be discovered by undertaking ethical, high-quality research into the question, 'What are the terms that women actually identify with each of these two types of services?' RCA proposes a process by which a reputable market research company—a company agreed to by senators on the committee who support and oppose the bill—be charged with surveying an adequate number of women

of reproductive age to discover what terms clearly and unambiguously indicate to them the nature of the service being advertised and for that language to be used in the legislation.

There have also been a lot of quibbles about what sort of organisation should need to transparently advertise. Historically, and to this day, it has been anti-choice pregnancy counselling services who have engaged in false advertising in order to lure women whom they describe as 'at risk of abortion, abortion minded or abortion vulnerable' into ringing their services. The deceptive and misleading aspects of the advertising are deliberately designed to entice women who would not choose, if they knew the agency was anti-choice, to ring them up to discuss their unplanned pregnancy.

I am going to table here two documents to support that statement. One is a research document by a company called Care Net, and in it you will find some very careful research in which anti-choice agencies go out and survey women and try to find out exactly what it is that leads them to be attracted or not attracted to ringing a particular counselling service. What are the words that attract them? What is the presentation that attracts them? Should it look like a medical facility? What will make them ring? Then there is a follow-up survey, which I am also going to table, which shows how much attention was paid by the anti-choice services in the US to this research. It basically shows that they took on board the suggestions made, and they changed the services in order to attract abortion vulnerable, abortion minded or women at risk of abortion into ringing their services. This is deliberately using women to try to find out what we can tell them that will make them call—the women who would otherwise not, if they really knew who we were.

It is not surprising, therefore, that the bill focuses on curtailing the reprehensible behaviour of those who are exploiting loopholes in the law. Having said that, pro-choice services never have had anything to hide when it comes to their philosophical approach to the issue of unplanned pregnancy or their referral patterns. Pro-choice service counsellors and staff are proud of the non-sectarian quality, all options nature of the service they provide and have no desire to disguise their pro-choice philosophy from potential service users. For this reason, RCA feels confident pro-choice services would have no objection to ensuring this tag or, again, one that is chosen in research by women as something that clearly identifies to them that this is a pro-choice service, being attached to all advertisements and notices. So it is no problem, I do not think, for both sides to clearly identify who they are.

Finally, there have been quibbles about the 24-hour health and help pages. Opponents of the bill have made much of the legislation's restriction of their freedom to advertise on these pages. It should be noted that currently it is pro-choice services that suffer from this restriction, as only 24-hour services can place notices here, and the federal government only funds 24-hour phone services that have an anti-choice philosophy. One solution to this problem would be for the government to fund a pro-choice 24-hour pregnancy help line—transparently advertised, of course—that could take its place beside all other services advertising in this section. In any case, RCA believes the bill must specify the size, type and colour of the transparency labels to be affixed to all services in this area of the book and all other sections of the book, as well as in all notices and advertisements that are going to be covered by the legislation. If the phrase 'this service does not provide referrals for terminations of pregnancy' or 'this is a pro-life service', or whatever phrase is chosen in a

legitimate focus group process, is in red 14-point Arial font print, for instance, at least it will be easy for women to clearly recognise the leaning of the services in that section. In other words, they can see at a glance that all the services in the health and help section are anti choice.

I conclude by saying that in our submission and in this opening statement we have attempted to make clear our reasons for believing in truth in advertising and our reasons for supporting the current bill or one very similar to it. We feel it is important for those opposing the bill to explain why they feel it is better for the pregnancy counselling environment—one which we feel sure they would agree focuses on women, some very young, all at a vulnerable time in their lives—to remain unregulated with regard to advertising. As you have heard this morning, it is not an issue they have been very willing to take up directly. Rather, their testimony implies that their often medically uninformed view is that the costs of abortion are so high that deception may be justified—that, if deception enables anti-choice organisations to provide the services they believe women need, then this deception should be allowed legally and the committee should turn a blind eye to it.

RCA would like to ask why, if anti-choice CPCs have nothing to hide, they would object to this legislation, the primary purpose of which is to ensure pregnant women have the same rights as other Australian citizens: the right to full and honest information about the nature of the pregnancy counselling services available to them. It is not up to anti-choice counsellors or indeed any counsellors, no matter how well meaning they may be, to decide what kinds of services women need and want to access; that is a choice for women. If anti-choice CPCs do have something to hide, if they are relying on deception to manipulate women who if they knew the truth would choose not to contact them, Australians will have the right to ask why the senators on this committee, having had this problem brought to their attention, chose not to act quickly and in a bipartisan manner to solve it. That is all we have to say.

CHAIR—Thank you. Ms Wickham?

Ms Wickham—As I said in the introduction, my name is Sarah Wickham and I am the 2006 national women's officer for the National Union of Students. I come here today not as an expert in any particular field or with any spectacular knowledge or insight into this bill or some of the areas and issues surrounding it, but I do come here as a representative of the views of female university students, many of whom have used these pregnancy counselling services.

For what it is worth—and I do think it is important—I will give you my definition and understanding of the words 'non-directive' and 'referral'. I believe these to be an accurate reflection of the views of many young women who would take the time to read this private member's bill or, more importantly, when faced with such a huge decision because of a pregnancy, of what they would understand those words in an advertising statement meant when searching for a safe and informative service to use.

I take the term 'non-directive counselling', in this instance, to mean that, if I were to use the services of a 24-hour pregnancy counselling help line, it would be the role of the counsellors to tell me all of the choices that were available to me and give me the information on this variety of choices. I also think that, if and when I decide on a particular course of

action or direction in this matter, it is the responsibility of the counsellor from the help line to help and support me in that decision. I and the young women that I have spoken to in the past few weeks view the word 'referral' more broadly than just a medical term—for example, a referral that a doctor would give to a patient in order for them to see a specialist, or something of that kind.

Personally, I think it is only logical, and it makes sense, that a 24-hour emergency help line should be able to direct or refer me to my next step or point of call in my local area, once I have made up my mind, or, at the very least, should explore ideas such as the ones Marie Coleman put forward in Canberra for the last Senate inquiry. On my campus, and on many of the campuses that I represent, women come into the women's offices, the unions and the SRCs, asking and looking for advice on places to go and for support for when they find themselves in that kind of situation. We definitely refer them on, and I think that is part of our responsibility.

Young people look to the government as a body of power and influence—an authority figure. And they know that the vast majority of Australians believe in a woman's right to choose, that abortion is not illegal anywhere in this country and that it is currently subsidised—many may argue not heavily enough—by Medicare. It is only logical that young women would expect government bodies, or organisations funded by the government, to reflect something along those lines. I have heard several stories from women on the campuses—and many more stories from campus women's offices—who have had bad experiences while using these services. Part of the reason it is so important this bill is passed is that it is the government funded organisations that are telling some of these young women that what they are contemplating is immoral. I do not think that that is acceptable for any government.

I also think that it is important to come up with some other ways that we can independently test the pregnancy counselling services. To solely rely on the evidence that an organisation chooses to report back, or on complaints, is not good enough. Much like victims of domestic violence, many women are so relieved when the situation is over that they do not want to revisit a traumatic experience by putting in a complaint about how someone from a help line used graphic terms to describe how they are killing their unborn child. I am not saying that anti-choice organisations should not have the right to exist or be listed in the Yellow Pages—as long as they are up-front in all their advertising that they do not offer counselling or referral for all three options.

The most vital part of the bill is when women or young woman, as in my case—most of whom are scared and vulnerable but, equally, some who are not—are looking for help and support in difficult situations. They should be able to come and use a service that they understand. This bill is designed to put an end to misleading and deceptive advertising, and I do not believe that a pregnancy counselling service that does not provide all three options is truly a non-directive service. Equally, I do not think it is the right thing for the government to do. Government services should be objective, nonbiased and nondirective. We all expect top-quality standards from other organisations and everything else in our life, as Leslie laid out earlier. I do not understand why that would change when it comes to pregnancy counselling services.

Dr Igai—I would like to remind the committee that the discussion today affects real individuals. This issue is not only an important matter of truth in advertising but also one that seriously affects people's physical and psychological wellbeing, as some of the stories in Erin Dolan's submission for Do Not Be Quiet make clear. My colleague Erin Dolan, who is currently overseas, has outlined in her submission first-hand accounts of how Pregnancy Counselling Australia's misleading advert has negatively affected women. Erin, a volunteer at a women's referral service had these stories told to her first-hand by women who had contact with Pregnancy Counselling Australia, whose phone number is located in the inside cover of every phone book in Australian, in the emergency section.

For example, one woman Erin spoke to called Pregnancy Counselling Australia wanting to know how to access an abortion. She felt that she was being judged for her decision and was angry that she had been duped into believing that it was a legitimate service. Instead of relating that Pregnancy Counselling Australia did not refer people to termination services, the phone worker discussed abortion in graphic terms until the caller felt compelled to hang up. I think that illustrates fairly clearly the way in which Pregnancy Counselling Australia is attracting people who are not attracted to their message.

Another caller to Pregnancy Counselling Australia never realised that she had called a right to life phone service. As Erin related it to me, the young woman believed she might be pregnant and wanted to know what her next step would be. Instead of suggesting she take a pregnancy test or visit a GP or anything like that, the phone worker discussed the option of adoption straight out. The woman later called a generalist women's service which gave her some basic information about the range of options appropriate to her individual circumstances. I think that is a big difference between a professional pro-choice organisation and Pregnancy Counselling Australia: Pregnancy Counselling Australia, in all these examples, does not think about the individual circumstances that arise. That is a key point.

Perhaps the worst story, and certainly the story that initiated the campaign, was of a young woman who was calling about her friend. It is not clear what was said to the pregnant woman by the phone worker of Pregnancy Counselling Australia. She had not called for a termination referral although she was clearly scared and confused by her unplanned pregnancy. Her friend, however, in describing what happened to her, used the term 'bullied'. The result was that the young pregnant woman would not contact any other service, even a GP, because her experience with Pregnancy Counselling Australia had been so awful. These are just three stories told to one person and they are likely to be a drop in the ocean for all the other stories out there about this so-called service.

It is clear that Pregnancy Counselling Australia have an agenda that is not expressed in their advertising. If they are proud of what they are doing then they should be open and honest about that advertising. How would an anti-choice phone service advertise if this bill were passed? And we do support the passing of this bill. Currently, Pregnancy Counselling Australia have on the front page of their website a picture of a distressed woman with the caption: 'Pregnant? Need help?' When this bill comes into effect that same advert could read: 'Pregnant? Need help? Interested in discussing your situation with someone opposed to abortion?' or something like that. Then again, if the bill is passed, hopefully they will not be receiving all the government funding they are receiving to provide this kind of misleading so-

called service. It is unlikely that Pregnancy Counselling Australia would receive the same number of calls as currently they are attracting from people who are not aware of the true nature of the service and are often distressed by comments that Pregnancy Counselling Australia's volunteers make.

CHAIR—Thank you very much for each of those opening statements.

Senator MOORE—I take it that most of you were here to hear the previous evidence. I want to explore some of the things that came out there. There was discussion around the issue of decision counselling and pre-termination counselling as two separate areas, in that the form of counselling around decision counselling would be affected by having the kind of labelling that we have discussed in this proposed legislation. In terms of advertising, if you clearly indicated that you were supportive of referral—and I am hesitant in using the word 'referral' because it has become such an important word in this discussion—or if there was information about termination services implicit in the process, that would somehow colour or impact on the effectiveness of decision counselling. I think that is a fair assessment of the discussion that we were having quite effectively with the previous witnesses. I would like to hear from each of you about how you feel about that.

Secondly, I am not from Victoria, so I only have the *Yellow Pages*—and I know that we have the representatives from them coming to see us soon. The Victorian process has two headings. It has 'Pregnancy counselling and related services' as one heading and immediately after that it has 'Pregnancy termination services'. It is in two separate blocks in the advertising. I would like to hear your views about how effective that is and whether that is useful as a clear delineation. If I am a person potentially wanting some support, can I feel confident that those two boxes are totally separate?

Dr Cannold—I think I know the testimony that you are referring to for your first question. It seems to me that there was a suggestion that, if there was clarity and truth in advertising and if words were used in advertising as the bill specifies, this would bias the woman towards not ringing that particular service. If the term used is 'giving the woman information' and she then makes an informed judgment on whether or not she wants to ring that service, this is what truth in advertising is about. It seems to me that what was being suggested there was that she should ring their service; she should ring a pro-life service because that is the kind of service that she needs.

The further suggestion was that she needs that sort of service because that is the only kind of service that will offer her a non-directive engagement in which all three options will be discussed, with the implication being that somehow any other service she might ring—a pro-choice service—would not offer her that opportunity. I would dispute that factually. In fact, it is completely counterintuitive because a pro-choice service is the only service that will discuss all three options, where anti-choice services are restricted because of the philosophical conflict of interest the counsellors and the organisations that do not believe in abortion have in discussing abortion. So I think it is a problematic assumption, and I think there is a whole paternalistic overlay on it that says, 'We think they need to ring us, and therefore we are worried that if the advertising makes clear to them who we are, they won't ring us.' As the documentation I have tabled here suggests, this is indeed very much a concern of crisis pregnancy centres. They are extremely concerned that the target audience for their services,

which is women who would otherwise not ring them—women who are vulnerable to and at risk of abortion—might not ring them if they knew better. All of the deception that the bill is trying to deal with has come about because of that issue.

There was some interesting information in one of the documents that was tabled in the Canberra hearing by Christina Richards, which I think is called 'CPCs: an obstacle to choice'. It was about some of the problems that are being encountered in the US around this, because, as these crisis pregnancy centres are being discussed more and more, women are becoming more aware that there are two sorts of services being advertised. They are trying to decipher the lack of clarity in the advertising and they are not ringing the crisis pregnancy centres because they are working out that they are pro-life and they do not want to ring them. Instead, the people ringing crisis pregnancy centres are women who have already decided that they want to keep the pregnancy and they want help from the crisis pregnancy centres to find supports to go forward. The crisis pregnancy centres have made it very clear that this is not what they want to be happening. They do not want women understanding who they are, because then the wrong women call. They want women who are at risk of having an abortion to call, not women who have already decided that they are going to keep their pregnancies and want support. That is not what the centres are there for. The second question is on the use of the distinction being made in the Victorian phone book.

Senator MOORE—Yes, the current Yellow Pages. In it there is a heading 'Pregnancy counselling and related services', with a whole lot of services listed, and then immediately after that there is 'Pregnancy termination services', with a whole lot of services listed. The inference is that you should be absolutely confident that decision-making is one area and pre-termination services, using that terminology, are a separate bit.

Dr Cannold—My view is that the second heading is quite clear. It is quite clear when you say, 'These are pregnancy termination services,' that what is underneath the heading are pregnancy termination services, but there remains a lack of clarity about the different types of pregnancy counselling services. So, as has been established as a point of agreement here, they are not all the same, and the problem really has been that women have not been able to distinguish between those that have a pro-life philosophy or whatever we want to call it and those that have a pro-choice philosophy or whatever we want to call it. I think that that is inadequate. I am sure the man from Sensis will be able to enlighten you about the various debates that have gone on here in Victoria in trying to achieve some clarity in the phone book. However, I can certainly tell from what I know of those debates that there has been a very fierce resistance from those who offer pro-life counselling to having the tag 'pro-life' attached to their service. They have fought for less clear labels after having lost the battle to have no labels at all.

Senator MOORE—Do either Ms Wickham or Dr Igai want to comment on either of those questions?

Dr Igai—Certainly with regard to the first I would reiterate that these services should not have to lie about what they are providing, if they are proud of that. Again, I think it is counterintuitive. In terms of your second question, I would reiterate the need for research, as Leslie spoke of, to find out what is the best way to bring the truth across to women. I point out that some of those stories, including the one that I mentioned in the submission where a

woman wanted an abortion and rang up Pregnancy Counselling Australia, illustrate factually that it is inadequate currently. She wanted an abortion yet rang them for a referral or to discuss her options. I think it is clear that it is unclear at the moment.

Ms Wickham—I think the same thing. I think that young women who have not made up their minds probably do need these labels so that they understand that they will get counselling and support for all three options and, likewise, if they have already chosen that they do want to keep the child, that they are going to the service that will directly benefit them. I do not think that the *Yellow Pages*, like Claire said, is completely adequate. A reason this has come to the Senate inquiry is that termination can be such a dirty word and it is something that attaches a stigma. A lot of young women are not sure immediately that that is what they want to do, because it will be a big black mark next to them. I think you are right that the counselling has to be more definitive and that a lot of women would choose to have counselling and perhaps after that go through with a termination. I think that the first part of the *Yellow Pages* needs to be a lot more definitive.

Senator STOTT DESPOJA—First of all, you would have seen, going through the last submissions, that there is a strong call, as I understand it, for consideration of some kind of regulatory framework for pregnancy counselling services in Australia. Dr Cannold, would you have a problem with such regulation being considered or some kind of standards framework being contemplated and enshrined in law?

Dr Cannold—I would certainly welcome that in addition to a provision that would ensure transparency in advertising. My understanding was that it was being suggested as an 'instead of' proposition, with the suggestion that somehow professionally trained, accredited people would not behave unethically in a counselling interaction. It was not even explicitly stated that they would not falsely advertise, but perhaps that was the implication too. I would certainly reject that claim. You have had a range of professionals here before you who have behaved in ways that, arguably, have not been completely transparent. Certainly, unfortunately, professionals are just as vulnerable as anybody else to possibly not being transparent. So I think accreditation is a wonderful thing. There has been a lot of valid concern about the quality of the training of some of the people who are on the other end of the phones, but it does not take the place of the need for the bill to ensure that there is transparent advertising.

Senator STOTT DESPOJA—So you would recognise that it is separate from but related to the debate that is before us.

Dr Cannold—It is all about quality of service. Of course, quality of service is terribly important, but, as you would know better than anyone, your bill is primarily not taking on the issue of whether this is a valid service or not; your bill is taking on the issue that women have a right to know what kind of service it is so that they can make a choice about whether or not to avail themselves of it. Obviously, accreditation does not go to that question; it goes to the question of whether the service is a quality one or not. That is very important but does not take away from what your bill is trying to do.

Senator STOTT DESPOJA—Indeed, that is the intent. You have given us some helpful ideas as to how we can perhaps overcome any impasse or maybe some terminology issues. I

found it interesting that you talked about the requirement of organisations on both sides to, for lack of a better term, be up-front. I am not sure, and I am not going to attempt to address it now, but it may be that the legislation is amended to ensure that organisations provide information as to whether or not they provide referrals in the case of terminations. I understand that Reproductive Choice Australia has no qualm about pro-choice organisations, of which you are aware, putting a statement in their advertisements, publications, brochures, literature or whatever that makes clear that they are a pro-choice organisation, options provider or whatever the terminology may be. There are no qualms about that?

Dr Cannold—No. Again, we are a representative organisation, so I can speak for a relatively broad church here. If you use the afternoon sessions and future hearings to ask pro-choice organisations about whether they would have a problem in making their philosophy clear—whatever words are decided as being the appropriate ones—I feel confident that nobody would object to that. I think there is pride involved. I think that goes back to what Dr Igai was saying—that in some ways, if people who are of the other philosophy are proud of what they are and what they stand for, there is a difficulty in understanding why there is a reluctance to make that clear. We have tried to offer some reasons as to why that is so and reasons that we do not feel are valid. We certainly do not want any suggestion that there is similar motivation for those on the pro-choice side to be in any way deceptive. We are quite proud of the services that are being provided and the all-options philosophy that guides them. We would be comfortable, happy and proud to let women know about that clearly in advertising.

Senator STOTT DESPOJA—I would want to overcome and certainly knock on the head any perception that this bill is intended to be or, indeed, is unbalanced. Perhaps your suggestion therefore gives us a way of making it very clear that this is expected of all counselling services. Dr Cannold, you made a comment—and forgive me if I quote you incorrectly—about the perception that is ascribed to some pro-choice organisations of having 'a philosophical objection to adoption and mothering'. In the evidence that we have heard this morning it has gone further than that, and in other evidence provided before the committee there has been a very strong suggestion—a blatant and explicit suggestion—that there is a conflict of interest for organisations who provide referrals for terminations or, indeed, terminations. Certainly, the health department gave the impression that the hotline, for example, or indeed the MBS item number for pregnancy counselling would not be provided to doctors or counsellors who just happen to work in abortion clinics or fertility clinics. The basis was on a conflict of interest. Do you have any evidence that supports the notion of a conflict of interest in Australia?

Dr Cannold—No. I think it is worth deconstructing it a bit. What has been said about the helpline in various submissions and in the testimony is the idea that somehow the only sort of conflict of interest that can exist is a financial one—that any other sorts of conflicts of interest, and certainly none that we need to worry about in this context, do not exist. That is obviously a false statement. A conflict of interest can be a philosophical conflict of interest. Say, for instance, that someone is committed to a pro-life philosophy and does not believe with all integrity that abortion is right. They believe it is murder, but they are in a position where they claim to provide a non-directive counselling engagement—and by 'non-directive'

I mean a counselling engagement in which the values and needs of the client are what dictates the direction, the quality of the engagement and how referrals are made out of it. That is a conflict. That is saying, 'I do not believe in abortion, but I put myself in a position where I say, "I'm offering you a service where you are at the centre. You might believe in abortion and you might want one, but I'm conflicted. I can't offer you what I am claiming to offer you."' So I think it is really important that there is the recognition that there are all sorts of conflicts and that those conflicts are not appropriate.

Evidence has been presented about counselling that is offered in abortion clinics, but that is by no means all of the sorts of pro-choice counselling available in this country. As I mentioned before, unfortunately there is not a federally funded, 24-hour pro-choice counselling service, and I think it would be preferable that there were. There are two services, Children By Choice and Bessie Smyth, and both offer pro-choice counselling, all-options counselling, on abortion, but they do not provide abortions, so it is simply factually incorrect to suggest that they have a fiscal conflict of interest.

The third category of people who provide counselling are abortion clinics. The government has made very clear its view that there is a conflict of interest there. I was very interested in this, and I did a lot of exploration of exactly how that might work. I also noticed there was a fair bit of contradiction in the anti-choice concerns about that. On the one hand, there is a lot of criticism of abortion clinics for not offering counselling and that options counselling is not available and that women are being rushed and pushed into decisions that they have not had an adequate chance to discuss. But then, when the counselling is provided, a claim is made that it is a conflict of interest. I find that a curious contradiction in and of itself.

I have spoken to Susie Allanson, who is a trained psychologist and has worked at the Fertility Control Clinic for many years. Susie Allanson is responsible for counselling women who are feeling conflicted about their decision. She does not get any extra money or any extra anything if she assists a woman to come to a decision that results in her deciding that she wants to go through with the termination or if it results in the decision that she wants to adopt or have a child. She does not get paid any differently; there is no financial incentive. Indeed, because of the grey legal status of abortion in this state and in many, but not all, states, it is highly problematic for somebody who is in the position of having to run a number of agendas—again, this is something that the anti-choice criticise but is all the result of their agitation about keeping the law grey—and a number of engagements when they counsel women. They have to fulfil medico-legal requirements. One of the things she has to make sure of is: does this woman qualify for an abortion? If this woman is going to be unhappy about this abortion later, is this going to end up being a problem for her and is this going to end up being a problem for the services we need to provide for other women?

There is no legal, financial or service provision practical incentive to allow a woman who clearly does not want to have a termination to have one. None of that seems to work for me. However, it certainly seems very important that we acknowledge that services that are pro choice offer the same things that pro-life services do, plus one. They offer support and referral for adoption, support and referral for continuation and support and referral for abortion. They do not just offer referral for abortion. That is not the philosophy, and it is a profound

misunderstanding of the philosophy if that is the way it is being understood. The philosophy is that it is not about what we think; it is about what you think and what you believe.

Ms Schaler-Haynes—With respect to financial conflict of interest, it is important to remember that allied health professionals, including physicians, routinely engage in counselling with respect to medical decision making. Oftentimes, that may blatantly include a financial incentive for them. Therapists routinely suggest more therapy. Eye doctors routinely suggest or discuss the possibility of laser eye surgery. Orthopaedic surgeons will suggest another MRI. This is a fact of medicine and a fact of having alternative procedures available. There are specific professional guidelines and laws designed to prevent a conflict of interest being the directive of medical decision making. I think it is important to remember that professionals—counsellors, social workers, psychologists and physicians—are specifically directed by their professional mandates in this context.

Senator BARNETT—I have a quick follow-up question on that last point. Do some abortion providers charge extra for counselling to continue the pregnancy?

Ms Schaler-Haynes—I have never heard of that.

Dr Cannold—Nor have I.

Senator BARNETT—Thank you. Can I draw your attention to a quote from Mrs Marie Coleman, convenor of the Social Policy Committee of the National Foundation for Australian Women, at the Canberra hearing. You have referred to the Canberra hearing a number of times. I would like to read the quote to you and then seek your response to the comment. Mrs Coleman said:

... I think there are good quality termination services that do offer some counselling and I think there are some absolutely shabby ones that we could all be deeply mortified about ...

I am wondering if you agree with that statement. Perhaps Ms Wickham could respond, as well as Dr Igai, and you can advise us if you are aware of the latter and if you are able to identify any of those services.

Dr Cannold—I am not aware of any.

Dr Igai—Nor am I.

Senator BARNETT—Thank you. In the debate earlier, Senator Moore touched on the difference between pre-termination counselling and decision making. Do you accept that there is a difference and in what context are you aware of abortion providers making a clear differentiation between the two?

Dr Cannold—The word 'counselling' in the abortion area in Australia is a very complex term because there are a number of engagements that need to be undertaken before a woman can have a termination legally. There is an informed consent process which needs to go prior to any medical procedure, and this is no different. Termination is no different to any other medical procedure. The doctor must engage with a woman, according to the law, and make sure she understands clearly what the procedure is going to involve and get her consent for it.

There are also, as I said before, medico-legal issues which will differ from state to state. For instance, in the ACT, where abortion is legal, these medico-legal engagements, as I understand it, are not necessary. In states where there are requirements that the doctor, if he is

hauled into court, must be able to stand up and say that he formed a reasonable belief on reasonable grounds that the termination was justified according to the provisions of the law, the doctor or someone in the clinic must go through an engagement and ensure that the woman's reasons conform with the law. That is a requirement, unfortunately, of the grey legal status of abortion in this country. Then there is a third kind of counselling, which is called decisions options. That is the kind of counselling that most people tend to think of when they use the word 'counselling'. That is an engagement where they discuss whether termination or adoption or parenting is the way that you want to resolve this unplanned pregnancy.

Senator BARNETT—Do abortion providers always provide decision-making counselling?

Dr Cannold—I feel that is really outside the bounds of my expertise, I am afraid. I am aware that some of them do. I would not be able to make a statement definitively about the remainder.

Senator BARNETT—Ms Wickham or Dr Igai, would either of you be able to?

Ms Wickham—No.

Dr Igai—I am not able to say either.

Senator BARNETT—On the Canberra hearings, you referred to departmental advice. Senator Stott Despoja has referred to it as well. In answer to a question from Senator Stott Despoja, the department's Deputy Secretary, Ms Murnane, says:

> We are not expecting them to provide specific referrals to specific termination services. We think it would be very difficult for any telephone counselling service to be in a position to do that, and that is not required.

That was in the context of the debate about the definition under section 3 which requires that the service provide referrals to termination of pregnancy services. Do you not support Ms Murnane's thrust or views or do you support her views?

Dr Cannold—I am sorry, I did read the entire hearing, but that is not familiar to me. Can you clarify it a bit more?

Senator BARNETT—This is from the debate on section 3 regarding the requirement that the definition of 'non-directional pregnancy counselling services'—

Dr Cannold—Is Ms Murnane a public servant?

Senator BARNETT—include the termination of pregnancy.

Dr Cannold—Is this about the hotline?

Senator BARNETT—Yes, it is about the use of the hotline.

Senator STOTT DESPOJA—The government hotline.

Senator BARNETT—Yes, it is about the use of the government's hotline.

Dr Cannold—Can you again state what the position was that you were asking whether I agreed or disagreed with?

Senator BARNETT—I was just wondering whether you could understand, acknowledge or agree with her views when she says:

We are not expecting them—

that is, the pregnancy counselling service—

to provide specific referrals to specific termination services. We think it would be very difficult for any telephone counselling service to be in a position to do that, and that is not required.

Dr Cannold—What interests me about that word 'referral'—and, as I said, I see this as part of the quibbling around the words used in the bill—is the idea that 'referral' is such a problematic word because it is a medical word and, in any case, many of these services do not refer at all. As you have said, there is now a suggestion that that would be the practice of the new help line. Yet, in the constitution of the AFPSS, they clearly state that what defines them is that they do not advise, provide or refer directly or indirectly for abortion or abortifacients. So it seems to me that the word 'refer' is in fact something that is very much a part of this debate as defining who does what, particularly, in terms of the specifics of that claim, if the help line is not going to refer, direct or assist women to carry out any of the decisions it assists them to arrive at in a balanced, even-handed, accurate and honest way. Suppose I say to the help line: 'You have really helped me. That counselling was a really fantastic engagement. I have decided that I'm going to choose to adopt my baby out. Can you tell me where I need to go to put that decision into action?' and the help line takes the same attitude as it seems to be taking with regard to abortion, which is to say: 'No, I am sorry. We do not refer. Good luck. Off you go.' Then, I suppose, at least we can say it is even-handed. Do I think that is a proper way for the government help line to conduct its business? No, I do not. I think providing referrals is something that is standard practice and should be done in an even-handed and balanced way for all three options to make real the idea that the help line will in fact be a non-directional all-options service.

Senator BARNETT—I would just make the point that was made earlier today, and also by the department, that there is an understanding that a termination or an abortion is a medical procedure which is, at best, according to that advice, referred to the GP to provide advice rather than to a counselling service.

Dr Cannold—To adopt, one has to have a baby, which is also, presumably, a medical procedure in which a doctor needs to intervene; so I am not quite sure I agree with that separation.

Senator BARNETT—So you would disagree with that; that is fine. Thank you.

Senator ADAMS—Coming back to the Canberra hearing again, the AMA commented that pregnancy counselling services disclosing their particular ideologies up front to potential clients, such as that they do not refer for terminations, may lead to a reduction in the number of late-term abortions. Could you comment on that? The AMA feels that it would help if counselling services were up front right at the start rather than—coming back to what you were saying—if you were fobbed off and not given any sort of advice as to where to go. Will people being left out in the ether delay their making an informed decision? Could you give us your view on that.

Dr Cannold—Obviously, they are the doctors, and I would take their view on board; and my intuition would be to agree. I have been told—but this is second-hand information—that often when, not meaning to, women end up ringing up an anti-choice service they get a range

of false information about the medical costs of abortion and information, perhaps, if it is relevant to them, about how they might go on and have one. The range of information that women are provided with can freeze them—that is what I was told by a counsellor—for a while. I think we heard from Dr Igai's story as well that women can get so disturbed and confused about an engagement they thought and trusted was going to be one sort of engagement, but which ended up being another, that they freeze.

There are time considerations when one is dealing with an unplanned pregnancy. Often we hear a lot of worry about women being rushed or stampeded. Maybe that is a perception that comes from the idea that in a pregnancy time is ticking on and that terminations are safer and easier to access earlier on in a pregnancy. If a woman is frozen for, say, two or three weeks before she can get back on track and trust and go and look for the assistance that she actually wants, that is going to delay her getting a termination, if that is ultimately what she decides, and that is going to lead to more second trimester terminations. That seems to me to be a logical way of thinking it through.

Senator POLLEY—Your emphasis throughout your submission and your evidence today is that people should be factual and objective with their counselling. My understanding is that you represent the organisation Children By Choice.

Dr Cannold—Children By Choice is one of the people in our network.

Senator POLLEY—Would you describe their website, where they describe the Vatican and the Catholic Church as anti women and fundamentalist, as objective?

Dr Cannold—I think Children By Choice are testifying tomorrow, and I suggest that you ask them directly about the contents of their website.

Senator POLLEY—I thought you said that you were speaking on their behalf, so I thought I would take the opportunity today.

Dr Cannold—I will clarify that. I am not speaking on their behalf; I am speaking for Reproductive Choice Australia, and Children By Choice are one of our members.

Senator POLLEY—In relation to the submission, would you like to describe for the benefit of senators your assertions of what fake counselling is?

Dr Cannold—Are you now referring to our submission?

Senator POLLEY—That is right.

Ms Schaler-Haynes—Again, the terminology is one of the quibbles in this situation. In the United States fake counselling centres are called crisis pregnancy centres. I do not think the terminology is what is important. What is referred to by 'fake counselling centres' are those centres which intentionally advertise in a deceptive and misleading way such that they are targeting women who, with full disclosure of whom they are calling, would not call.

Senator POLLEY—In relation to Reproductive Choice Australia, would you be able to provide to the committee the statistics on the number of referrals for continuing the pregnancy, adoption and termination?

Ms Schaler-Haynes—Reproductive Choice Australia is not a service provider itself.

Senator POLLEY—Of the groups you represent here today, can you provide that information for us?

Ms Schaler-Haynes—I advise you, as Dr Cannold just did, to speak directly with Children By Choice to see if they gather their statistics. That is really an individual determination made by the various organisations themselves.

CHAIR—I will follow up that line of questioning by Senator Polley. In your submission you referred to Pregnancy Counselling Australia as one of dozens of fake pregnancy counselling organisations. Can you tell us who some of the others are?

Dr Cannold—In fact, I was going to bring a list but I did not. I can take that question on notice and provide that to the committee. It would be a list of members—27—of the Australian Federation of Pregnancy Support Services.

CHAIR—Does that include services provided by the Catholic Church or associated with the Catholic Church?

Dr Cannold—It would not be targeting any type of organisation other than through its behaviour. So it would be any organisation that does not transparently advertise who it is and that has a philosophical commitment to not providing all options but not disclosing that fact.

CHAIR—I understand that, but does it include services associated with or provided by the Catholic Church?

Dr Cannold—I will take that on notice and get you the list because I do not have it with me.

Senator MOORE—Centacare Family Services is in the *Yellow Pages*. Anyone who knows Catholic services would know that Centacare is linked to the Catholic Church. Would that be one of the ones that you would consider? Is that your line of questioning, Gary?

CHAIR—Yes.

Senator MOORE—That is the kind of answer I am sure you are after. In the *Yellow Pages*, amongst all the others—I would like to tick, tick, tick through them—how is Centacare listed?

Senator WEBBER—It says:

Centacare Catholic Family Services

—Confidential Free Counselling

—Relinquishment Counselling

—Adoption.

Dr Cannold—What I do not know is whether they are part of the AFPSS, and I have not visited their website. I have gone to the websites of all the ones on the list that I can present to the committee, and I have checked out their advertisements. If I had seen that advertisement and had a chance to look at the website, I would be able to say whether that qualified as a service that is problematic because of the way it is not disclosing its particular philosophical beliefs.

CHAIR—Can you list for us today any of the other services that you refer to as being fake counselling services?

Dr Cannold—Pregnancy Counselling Australia is certainly on the list.

CHAIR—Apart from that one. You mentioned that one in the list.

Dr Cannold—Birth Line is on the list. Birth Line is connected to Right To Life Australia. I am sorry; memory is not one of my strong points. I will get that list to the committee, though.

CHAIR—Philosophically, what is the difference between labelling pregnancy counselling services in this way and not labelling, say, doctors who for ethical reasons will not refer patients to abortion services or hospitals associated with particular faiths that do not conduct or facilitate abortions? Is there any difference between them to justify giving one set of services that label and not others?

Dr Cannold—Do I think all of them should disclose this fact? Yes, I do.

CHAIR—Should all of them be subject to legislative provisions like these?

Dr Cannold—It would be preferable if all doctors—and I would even throw pharmacists into that list—who because of their religious or philosophical commitments cannot refer or provide particular sorts of services disclosed that information. For instance, some pharmacies have started the practice of putting on their window, 'We will not provide the contraceptive pill,' or 'We will not do x, y and z.' That is a very good practice for everybody. It enables people to choose other options—where there are any. In the instance of hospitals, in country areas, for instance, sometimes there will not be an alternative choice if the philosophical predisposition of the hospital is not in agreement with yours. But where there is the capacity to make choice, it would be very wise and right for that information to be disclosed in all instances.

CHAIR—So you would say that the legislation should cover those situations as well?

Dr Cannold—We probably need to find another piece of legislation. I am certainly not a legislator, but I suggest that is probably not wise to try to do too much. I certainly would like to see this legislation passed so as to cover a small part of the problem.

Ms Schaler-Haynes—I would also point out that those are heavily regulated industries as it is. The pregnancy counselling situation exists in a loophole of regulation and is unjustly outside the rubric of the Trade Practices Act solely for the reason that no funds are changing hands. In the context of medical professionals in hospitals, those are highly regulated professions and industries. We are talking about what I see as a very unique loophole that exists within medical decision making.

Senator BARNETT—Shouldn't it apply to abortion providers? I thought you said that it should.

Ms Schaler-Haynes—Yes, we think it should apply to everyone.

Dr Cannold—Yes.

Senator BARNETT—Thank you.

Ms Schaler-Haynes—With respect to advertising, physicians are regulated through professional standards. The issue here is that generally a lot of the counsellors who answer the phones in these organisations are volunteers who have no medical training and who exist outside professional regulatory schemes. They are acting in such a way that callers should reasonably expect to be able to rely on advice given. In that context, they need to have some guidance, which is why we are here.

Senator POLLEY—I will just take up a point there. You said that the volunteers do not have any medical experience. Why are you then insisting that they refer people to abortion clinics? Surely that is up to a GP. In my state of Tasmania, you need to have two GPs to make the recommendation to have a termination.

Dr Cannold—My understanding is that at the moment they will not refer for abortion on what I feel are quite specious grounds: that it is a medical procedure. But as I pointed out, if one goes on and continues a pregnancy to keep the child or to adopt out, that is also a medical procedure. One has to have contact with a GP, have ultrasounds, get prenatal care and then give birth. It seems to me to be quite specious to suggest that one is a medical procedure and therefore cannot be referred to when the other two are being referred to and also could be easily seen to constitute medical procedures.

Senator POLLEY—Thank you. I was directing my question in response to—

Dr Cannold—As I am in the same organisation, I was able to answer it for you.

Senator ALLISON—I will follow that point. It is my understanding that in 'referral' we are talking about quite different concepts. If you go to your GP to get referred to a specialist of some sort, a letter is written describing your symptoms, which is put in an envelope and you take it to your specialist. With pregnancy counselling, it is my understanding that it is more a question of information. Someone rings and says: 'I think I'm pregnant. I want to terminate this pregnancy for a range of reasons.' They would just be given the name and phone number to contact rather than there being any exchange of medical, if you like, referral material.

Dr Cannold—As I said, I feel that all this quibbling about the word 'referral' is a way of ducking the main issue. Do we support transparency or do we not? If we do, maybe we can find another word. Andrew Pesce in the Canberra hearings used 'assist women to', if we are going to have such a hard time with the word 'referral'. This is not really a major obstacle to having this bill go into law. It seems to me that if the AMA is saying that one can use 'refer' in a variety of terms—as a medical term and as a more common parlance term—then we can probably take their word on it.

Dr Igai—I also ask what is meant by 'counselling'. If people are ringing up so-called counselling lines and getting argued at, they are not actually receiving a counselling service.

Senator NETTLE—Ms Wickham, you raised some concerns about self-regulation of pregnancy counsellors, in that, currently, organisations that get funded by the federal government provide to the federal government their own information about what kind of service they provide. I wonder whether you or anybody else wants to mention what type of regulation would be appropriate for pregnancy counselling services.

Ms Wickham—I do not really know. Perhaps spot checks, but I really do not know. I think that something needs to happen but—

Dr Cannold—Can I offer something? I think this also came out of the Canberra hearings. Marie Coleman mentioned a range of ways in which quality is assured through other health lines that I think the government funds, but I might be mistaken there. Those are not reactive ones in which one waits for a complaint before one has a look to see if things are going well; rather, it goes in a proactive way. People can be on the line listening. I cannot remember precisely what she said, but there are manners of ensuring that quality is taking place in a more proactive way, and that would certainly be preferable.

Senator WEBBER—I have Senator Moore's latest favourite book here—the *Yellow Pages* from Melbourne, which is probably a transparent commentary on us more than anything else. Ms Wickham, there is an ad here that says: 'Are you pregnant? Alone? Need someone to talk to? Scared? Confused? Needing help?' How would the young women who you deal with in your organisation interpret that?

Ms Wickham—I guess they would interpret that as a safe place, space or phone line to call and that people on the other end of the line can support all of their different worries. I think it is concerning if it is an organisation that does not provide all three options. To me, that reads: 'As a young person, I don't know what to do. I don't know what services are available. I don't have contact with this. This looks like the type of ad that will help me when I don't at all know what I want to do.' I would assume, and I think a lot of young people would assume, that they would help support and explore all options.

Senator WEBBER—So when you ring the Pregnancy Helpline, which is the organisation that has that ad, you would be a bit stunned that you were not given all of the options.

Ms Wickham—I think that is the entire problem that this bill is trying to overcome. The major problem is that a lot of young women do not know what they want and, if it is a provider that is not supporting or helping with all three options, then there is a bias, and I assume that young women would be quite concerned to realise later on that they were not provided with all the options that were available to them.

Senator POLLEY—Are you suggesting that young women would not seek further options of counselling?

Ms Wickham—Not if it is a hugely traumatic experience. I see a lot of women who do not have a lot of family or friends who have gone through the experience, or they may not even tell their network of support or friends because they are deeply concerned about the effect it would have on them and the way that the people they know would look at them. I truly believe—and I have heard stories—that it has turned young women away from seeking further clarification for quite a while or at all. I know it sounds bizarre, but there are a lot of young people for whom it does not mean that they are confident and that they understand what they want just because they are at university.

Senator WEBBER—There is still a lot of stigma about an unplanned pregnancy.

Ms Wickham—Yes.

Senator WEBBER—It is a different stigma these days. The stigma is more about your foolishness in not being able to control your reproductive choices. I compare that ad with the Centacare Catholic Family Services ad which, I have to say, would fall within my definition of transparent. It says that it offers counselling, it is free and it is confidential. They are very good things. But it highlights relinquishment counselling and adoption counselling. If you look at that, it is a lot more transparent, in my view.

Dr Cannold—Can I make a comment about that?

Senator WEBBER—Yes.

Dr Cannold—It is based on an experience that a woman told me about. She had an abortion and she wanted to talk about it with somebody afterwards. She went to the Victorian *White Pages*. She was looking for the term 'post-abortion counselling'. She saw a range of anti-choice agencies which were advertising post-abortion counselling. There were probably also some pro-choice ones, but she stopped at the first one she saw because that was what she was looking for.

The problem with how these ads deceive is that they are capitalising on an unacknowledged wellspring of trust that women have that services use particular words. The Care Net research that I have tabled here shows how that trust is exploited. Women associate certain words: women-centred, options, counselling. Those are feelgood words. They engender in women a feeling that: 'This will be the sort of service that will not judge me, that will tell me the truth about all my options, that will support me to make a decision consistent with my own values.' That trust is being exploited in some of these ads. So even though it might seem clear, if you were aware that there were two sorts of counselling agencies out there, one might think: 'Centacare? Maybe that is religion.'

There are all sorts of filters you might put on it if you knew that you needed to put some filters on. But the problem is that at the moment there is not a lot of awareness out there that there are a range of services that are being offered and they have different slants. Women are very trusting, and it is that trust that is leading them to not apply critical faculties and facilities that they need to and to have a look at these ads in a more critical way. I think the one you listed could still lead a woman to ring, not realising what would not be offered. What were the terms used again?

Senator WEBBER—Relinquishment counselling and adoption.

Dr Cannold—If she wanted, say, to talk about adoption, abortion and parenting, she might think: 'Okay, this is a service for me,' because she would trust that all of the services and options in the book—and we have heard a lot about the trust, particularly of the 24-hour health and help pages—would be available.

Senator WEBBER—Bearing in mind the time, I will leave it at that.

CHAIR—Thank all of you for the evidence you have given today. The submissions you presented and the oral evidence you have given us are very useful.

[12.24 pm]

CRACHI, Mr Marcus, Lawyer, Sensis Pty Ltd

HURST, Mr Thomas Berkeley, Senior Policy Manager, Sensis Pty Ltd

RONCHI, Mr Stephen, Manager, External Communications, Sensis Pty Ltd

CHAIR—Welcome. Information on parliamentary privilege has been provided to you, as has information on the protection of witnesses and evidence. We have the submission that you presented to us. Thank you very much. It is submission No. 34. I now invite you to make a short opening statement before we proceed to questions.

Mr Hurst—Sensis are Australia's leading local content provider. We do this through a number of media, including the print books, online, voice and wireless. We are a fully owned subsidiary of Telstra, and we manage a number of household brands, such as *White Pages* and *Yellow Pages*. About one million Australians use our products every month, and we advertise over 600,000 businesses in our products. I would like to say up front that we support transparent advertising across all advertising media, not specifically for pregnancy counselling services. Sensis' role as a publisher of directories is obviously of prime importance here, as is the sense that that is our expertise, as opposed to definitions of what are appropriate counselling services.

To that end, we believe that pregnancy counselling services are in a better position to determine, firstly, whether or not they refer for abortion and, secondly, whether or not they are non-directive pregnancy counselling services. As a consequence of that, we feel that the bill and the legislation should be aimed squarely at those organisations in order to determine what they are or how it is that they will meet that legislative requirement. We feel therefore that it should be acceptable that we rely on the warranties in our terms and conditions that stipulate that all organisations across all industries must adhere to legislation that is particular to them. To that end, we have difficulties with both clauses 6 and 7, as we have outlined in our submission.

We feel that clause 6 is onerous in its obligations on Sensis and persons or businesses that publish such material to categorise and define what an appropriate pregnancy counselling service is. We feel that clause 6(1) should be narrowed in order to focus specifically on pregnancy counselling services. We also feel that, if that were not to be achievable, the deletion of clause 6(2)(b) would be appropriate, as we feel that clause 6(2)(a), in that we took no part in the determination of the content of that advertising, should be an appropriate defence. In relation to clause 7, which is the clause that talks specifically about the *White Pages* and the 24-hour services listed in the *White Pages*, we again feel that we are not in a position to determine what is an appropriate pregnancy counselling service, and therefore we feel that that clause should be altered. If you like, I can read out what we feel should be altered to.

CHAIR—We have your submission, and I think we have your suggestion from there.

Senator STOTT DESPOJA—Thank you for your submission and for presenting today. I think there are a few things we can work around. I want to acknowledge firstly, and I might

even table for the benefit of the committee, the correspondence that I have engaged in with Sensis over the years. None of the three of you here today have represented Sensis on this issue before. I think Mr David Graham is who I have dealt with previously.

In relation to the bill and its effect on you, I might request through the committee some additional legal advice on clause 6. I can see your concerns about being caught up in it, but the intent is not necessarily to catch you up in it. In fact, the intention is to do as you suggest, and that is ensure that those responsible for notifying or advertising are responsible for the content and whether it is misleading or deceptive—basically the accuracy of their information.

I am a bit reluctant to get rid of 6(2). That is not because I have a problem with the Sensis perspective necessarily; I just think that that is an appropriate defence in the legislation for those people who place an advertisement that could be deemed misleading or deceptive but would like to claim that they were not knowledgeable at the time. They should have that right of a defence if they claim they genuinely were not aware about the material. We can examine that. I am happy to get, as I say, additional legal advice. What happens in the case of Sensis if there is an advertisement that is placed by a professional organisation or a business, for example, that is misleading or deceptive under the Trade Practices Act? What would be your understanding as to what penalties or sanctions they would face?

Mr Hurst—The organisation particularly or Sensis?

Senator STOTT DESPOJA—The organisation and/or Sensis.

Mr Hurst—I suppose that in terms of the organisation it would be between them and whatever body determined to prosecute them under the Trade Practices Act. That is probably outside our expertise or experience.

Senator STOTT DESPOJA—Sure. Then perhaps from Sensis's perspective.

Mr Hurst—From Sensis's perspective, in dealing with the Trade Practices Act it would depend on whether or not we were put on notice as to whether or not the content of the advertisement was false and misleading under the Trade Practices Act. We would initially rely on the publisher's defence under the Trade Practices Act, which, basically outlined, is that, similar to subsection 6(2)(b), we were not knowingly involved in the determination of the content. After taking that on notice we would seek legal advice ourselves to determine the extent to which we were in breach of the Trade Practices Act if that were the case and then we would take steps with both the prosecuting body and the business that was potentially in breach to attempt to amend possible breaches.

Senator STOTT DESPOJA—Can you see that the provisions in section 6 but also in the bill are designed to reflect the Trade Practices Act in that respect—that is, if you knowingly placed an advertisement that was misleading or deceptive, there would be penalties, arguably, in law that you would face if you were dealing with a business that was subject to the TPA? In this case I am wondering, out of curiosity, why you would not expect to face some penalty if you were responsible for placing an advertisement in the case of, say, a pregnancy counselling service, and you knew that that advertisement was misleading and/or deceptive?

Mr Hurst—I think that there would be difficulties in determining what the content was and what type of service the provider provided, and, in relation to all three options, there would be a difficulty in determining what reasonable knowledge was, which we have outlined in our submission. We would probably seek to have those types of items clarified.

Senator STOTT DESPOJA—The intent of the bill is to determine what is misleading and deceptive advertising. There is no intention to leave you or any organisation, for that matter, that may be involved in advertising, in some kind of legal or other vacuum so that you would be in a difficult position because the definitions were unclear. This is not about targeting Sensis. I make that very clear.

I move on to section 7. You said in your opening statement that obviously Sensis does not consider itself, and understandably so, to be an expert in determining what is non-directive counselling and what have you. That is what legislation is for. That is our role as legislators and/or government to determine. That is why I am curious to see you attempt to address section 7 with a rewording. It is almost that there is an onus on a telephone carriage service or Sensis in particular to come up with a definition. I am looking as to what is appropriately advertised. You have removed the word 'non-directive' despite—

Mr Hurst—We have removed them and replaced them at the end.

Senator STOTT DESPOJA—Yes, I know. You have removed the words 'non-directive' and at the end put in 'where they are satisfied that those pregnancy counselling services are non-directive pregnancy counselling services'. How would you establish satisfaction?

Mr Hurst—It would be based on the representations made to us by those organisations. I really do not think there is much more that we can do apart from seeking information from a particular organisation on the determination of the types of services they provide.

Senator STOTT DESPOJA—That sounds very much like a self-regulatory framework as opposed to what we are trying to do here, which is taking that away from self-regulation so there is a clear law, in the same way that, for example, the Trade Practices Act comes up with a very clear definition of what constitutes misleading or deceptive advertising. So the intent of the bill is not to put that onus on you—it is to define in law what is appropriate and what is not. Therefore, it is not up to the organisations per se and it is not really up to you, but it is to make sure that people conform with the law.

Mr Hurst—Sure. I suppose it is not really my intention to imply that it is self-regulating. What I am trying to imply is that the organisations themselves should be responsible for determining it under the legislation, just as for all other organisations and industries there is a requirement to meet their particular legislation or the general legislation that covers all bodies. We are not asking for self-regulation in that respect.

Senator STOTT DESPOJA—Thank you. I want to put on record, Chair, the work that Sensis has done. In particular, I will table the letter from Sensis to my office dated 27 August 2004, in which Sensis outlines the role that they played once the issue was drawn to their attention in 2003 about the listings in relation to Pregnancy Counselling Australia. The initial listing was 'abortion trauma and crisis pregnancy counselling'. They acknowledged that they were not clear representations of the service that Pregnancy Counselling Australia provided to the community. They then changed those listings and they are before you today. I would

suggest that there is still room for us to work on those issues. With your consent, Chair, and the will of the committee, I will table my letter to Sensis and their response, because I think it is illuminating in terms of how Sensis has recognised that there were some outstanding issues and how they have sought to address them. Obviously, I think we need legislation to go further, but I will get that stuff on section 6 because the intent is not to hold you primarily responsible.

Mr Hurst—That is a relief.

Senator STOTT DESPOJA—I can see you walking round asking, 'What is she doing to us?' Thank you.

CHAIR—We accept those documents for tabling. Thank you.

Senator ADAMS—I do not have the Perth phone book in front of me, unfortunately.

Mr Hurst—I did not bring that one, I am sorry.

Senator ADAMS—Something that arose when we were in Sydney doing the—

Mr Hurst—Can you clarify which directory it was—the *Yellow Pages* or the *White Pages*?

Senator ADAMS—It was the *Yellow Pages*. We heard evidence in Sydney on RU486 from the Bessie Smyth Foundation. They had had calls from rural people. The problem was that under one list they had four or five different organisations—and the same thing happens in Perth too—which all lived at the same postal address but all have different names. These people ring through that list and keep going down. By the time they get to the sixth lot, they are absolutely desperate because they just cannot get the advice that they want. They have been given advice that really has been quite hurtful and not what they are looking for, so they are completely and utterly confused. My question is: do you look at the clarity of the advert as an organisation? If these organisations all live at the same box but have different names, is that of any concern to you? How do you work on what is put forward to be placed in your directory?

Mr Hurst—As I said in my statement, we deal with over 600,000 businesses. As a consequence of that we rely on the warranties provided to us by those businesses that they are representing themselves accurately and fairly. Therefore it is their responsibility to determine the content of their advertising, whether it be a compound listing—as the one that you have just suggested—or a singular listing or a display listing. I am not too sure if that helps you answer that question.

Senator ADAMS—No, it is hard because I do not have it in front of me. I should have brought it.

Mr Hurst—I am sure you can imagine the onerous nature of managing well over 600,000.

Senator ADAMS—I certainly could. With the listings as you have them at the moment in your *Yellow Pages* here for Melbourne, could you please explain how you put one into one category and the other into the other category?

Mr Hurst—Yes. I do not know if you want a copy of this book. This is a fairly hefty tome—the *Yellow Pages Advertising Rules*. As part of the advertising contract's terms and conditions all organisations actually sign up to ensure that they adhere to these rules. There is

a particular rule in there for the protection of the taxonomy and the integrity of the directory, to ensure that businesses are actually representing themselves under the appropriate heading. There is a rule which basically states that you must predominately provide the good or service which that heading purports you provide. It is a representation that they make to us that they are providing that service.

Senator ADAMS—If you have a complaint that states that that particular organisation has not adhered to your rules, what process do you use then?

Mr Hurst—We will investigate the specific complaint. If it is a general complaint that refers to all listings under this heading then we will seek further clarity from the complainant to advise us on the specific listings under that heading. Then we will seek to investigate those specific listings in determination of their adherence to our rules and terms and conditions, and take action appropriately should it be required.

Senator ADAMS—Could we have that document tabled, please?

Mr Hurst—Yes.

Senator ADAMS—Thank you.

Senator BARNETT—In regard to your submission, where you refer to clauses 6 and 7 you specifically refer to pregnancy counselling services. In your opening statement you said that you supported truth in advertising and laws relating to misleading and deceptive conduct.

Mr Hurst—And transparent advertising.

Senator BARNETT—Yes, and transparent advertising, which is notable. Do you support the same laws applying to abortion providers as you do for laws relating to pregnancy counselling services?

Mr Hurst—I think that we would support transparency in all advertisers where there is a requirement for that to be done. If there was legislation to be put forward on that then certainly we would support it.

Senator BARNETT—We have a debate or a dichotomy here where we have legislation that relates to pregnancy counselling services. You have referred to it in your submission and you have specifically referred to clauses 6 and 7. I am asking whether the law should apply to them as it would apply to abortion providers as well. Do you think it should be consistent across the board or only relating to pregnancy counselling services?

Mr Hurst—I am not too sure if that is our expertise. I think that that is something for you and this committee to consider and certainly to inform us of the outcome of that consideration. Obviously if some form of legislation were provided we would take it under advisement and certainly take whatever steps or actions that we were required to if that were the case.

Senator BARNETT—Let me phrase another question to you then. In terms of transparency in advertising, do you support the concept?

Mr Hurst—We certainly support it.

Senator BARNETT—And that legal principle across all sectors?

Mr Hurst—Agreed.

Senator BARNETT—Thank you.

Senator MOORE—Mr Hurst, if you actually have the tomes in front of you, you are able to read through lots of pages, and the *Yellow Pages* in itself has, as I said before, the section clearly headed 'Pregnancy counselling and related services' and then the supplementary section, 'Pregnancy termination services'. There are two pages, I think, of advertisements and listings.

Mr Hurst—It is certainly in that direction, although the content would differ from directory to directory.

Senator MOORE—Sure. I am looking at Victoria today and I assure you—

Mr Hurst—The Broken Hill directory might only be half a page, for instance.

Senator MOORE—I have been looking at other places as well, but it is Melbourne we are in today. The *White Pages*, because of the way they are done, lists these services differently, of course. Under 'Pregnancy counselling' there are a number that begin with the letter 'p' and so on. If I rang 12456 or another of those directory assistance numbers not knowing anything and said, 'I want to get a number for counselling on pregnancy', do you know what the process would be for the operator? How would they refer me on?

Mr Hurst—Quite simply, they would refer you to the first agency that was provided to them on the computer screen.

Senator MOORE—And that is how it works? So if you used that system, if you were calling from a phone box and did not know where you wanted to go, you would just get the first one—there would not be time for someone to go through the different services?

Mr Hurst—I suppose it would depend on what type of—

Senator MOORE—On the person, yes.

Mr Hurst—question was asked of Sensis 1234.

Senator MOORE—But the normal process would be whichever one came up first. They key it in, don't they?

Mr Hurst—Yes. If the specific question was, 'I need a pregnancy counselling service in West Melbourne', for instance, they would be read the first number that came up.

Senator MOORE—And that would be through a process of—years ago I knew how this worked—

Mr Hurst—It would be typed in—

Senator MOORE—'P', pregnancy counselling.

Mr Hurst—Pregnancy counselling, yes.

Senator MOORE—When they do that, does that come up in the *Yellow Pages* or the *White Pages*?

Mr Hurst—It is a different database.

Senator MOORE—A different database. And that is purely alphabetical—

Mr Hurst—It does mirror the content that is in both the *White Pages* and the *Yellow Pages*; however, it is a different database.

Senator MOORE—So normally the process would be that they would just get the first one that came up?

Mr Hurst—That is certainly my understanding.

Mr Ronchi—I would just quickly add that, if the caller were to ask for a range of services, they could certainly be provided with more than one number.

Senator MOORE—On that other database, because there are two pages in the *Yellow Pages* for Melbourne and its surrounds, is it feasible that they would give you all of them?

Mr Hurst—It is feasible.

Senator MOORE—It is feasible?

Mr Hurst—Absolutely. It would be quite a costly call, if you called them—

Senator MOORE—I was just thinking that, because it is by the minute. I think that is another area as well, if you are using a telephone service. And the issue of access always comes up: it is one thing to have a book and another thing to be standing and calling. Thank you.

Senator NETTLE—If someone calls up on the 12456 number and asks for pregnancy counselling services, do you know which one they would get?

Mr Hurst—It would depend on the location they were in. It would also depend on whether or not an agency or organisation had purchased to be read out in those areas. It would depend on quite a number of factors, so I could not tell you.

Senator STOTT DESPOJA—Can you find out?

Senator NETTLE—Could you take that on notice?

Mr Hurst—Yes, I think we could. But, honestly, I think you would have to call, because there are so many variables that you could apply to the question. I suggest you would have to call and ask—try it out.

Senator STOTT DESPOJA—All right. We are ready!

Mr Hurst—I apologise. But thank you for calling Sensis!

Senator NETTLE—I think you were here earlier when Dr Cannold was talking about the idea of doing a survey to see what sorts of terms women identified with each of the two different types of pregnancy counselling services available. I think you were here when she was talking about that. I was wondering: how did you come up with the terminology that you use in the Yellow Pages and White Pages?

Mr Hurst—For the Yellow Pages, a sales consultant pretty much deals with the organisation. The organisation determine the content of their ad and provide that to us. Upon signing the advertiser terms and conditions, they guarantee to us that the representations made in that ad are accurate and in adherence with legislation and our rules and policies. In relation to the 24-hour services section at the front of the directories, as Senator Stott Despoja pointed out, we have actually engaged in quite a rigorous amount of work with the organisations

which has culminated in the descriptors that the organisations have chosen to put against their listings. But it has been consultative. It has not relied on definitive terminology, which goes to the fact that we are not experts in this field and we would have difficulty in applying those sorts of definitions, or words to that effect, if that were a requirement of us.

Senator NETTLE—This information might be in the letters that we are getting back—the letters that Senator Stott Despoja tabled. Could you describe for us the history of the process that Sensis has gone through?

Mr Hurst—I am a small element in the history. I have worked for Sensis for only five years but my understanding is that some 30 years of discussion has gone on. I do not have records of that; I found that out from one of the submissions tabled here. We have received, I suppose, feedback from all corners on this issue and it is quite a contentious issue. We have determined the need to work with these organisations to ensure that they rectify what could be considered a lack of clarity in the information that they put in their listings. We have worked with them in a voluntary and consultative manner. The words offered up by them in relation to this requirement for further clarity are the words that we have published. We have also tried to apply a filter on the 24-hour service listings and we have also applied this in the pregnancy counselling services, and that is a banner that suggests that consumers should be aware that there are differing points of view relating to these types of listings and that in choosing to use these organisations they should try to determine what type of information is presented by these types of organisations.

Senator NETTLE—Have you had any difficulty getting organisations to be clear about what types of services they provide so that you can then make it clear in the book?

Mr Hurst—That is a hard question for me to answer. We have a limited expertise in this area. I cannot necessarily say that we have actually made the listings much clearer. We have worked with the organisations and they have represented to us that there is clarity in their listings.

Senator NETTLE—You may need to take this question on notice. Can you tell us the number of complaints you have received with regard to the listings?

Mr Hurst—Yes I can. Probably only a handful of organisations have specifically chosen to write to us over the past five years that I have been working for Sensis. They have written to us often with form letters and the like, which has prompted us to work with these organisations to ensure that they represent themselves as clearly as they possibly can.

Senator NETTLE—Would you be able to provide the committee with the number of complaints that you have received for each of the different listings?

Mr Hurst—I probably could. It is really not a huge number of complaints. I am not too sure we could go down to the specifics of the individual listings but I can certainly give you the numbers of complaints.

Senator NETTLE—Whatever you can provide would be helpful.

Mr Hurst—Certainly.

Senator BARNETT—You said there were rote letters. Can you identify the organisations that are behind the rote letters?

Mr Hurst—Off the top of my head I could not.

Senator BARNETT—Could you do it in your response to Senator Nettle?

Mr Hurst—Yes. It was one of the discussions we had and some of the text in the letters seemed to be quite consistent in terms of the feedback we provided.

Senator BARNETT—If you could elucidate, that would be helpful.

Mr Hurst—Certainly, as part of the response to the question on the number of complaints I will provide information on that.

Senator BARNETT—Thank you.

Senator STOTT DESPOJA—Does Sensis have any legal advice in relation to their interpretation of section 6 of the bill that they would be willing or able to table? I want to make it clear again that the intent of the legislation is not to subject you to greater or different standards than the Trade Practices Act would apply to you.

Mr Hurst—I might rely on my lawyer to answer that question.

Mr Crachi—We have looked at it internally and our view is that the words 'a person that advertises or notifies' would extend to anyone involved in the advertising process. That is where we are coming from.

Senator STOTT DESPOJA—How is that different from the current Trade Practices Act in relation to capturing an organisation like Sensis in the case of someone who may be guilty of misleading or deceptive advertising placing advertising with you? Obviously, I am trying to emulate those standards so that they apply to pregnancy counselling, which is nonprofit, in the same way that they apply to professional organisations that are profitable.

Mr Crachi—This particular bill, especially section 6, focuses on the type of service which the relevant organisation is providing, which is something that objectively we cannot determine. It is something that only the organisation could reasonably determine. That is why we want to make it quite express that we do not fall within that provision—particularly since the wording for section 6 makes it quite clear that that particular section applies specifically to those organisations who provide the particular serves.

Senator STOTT DESPOJA—Okay. I will definitely take it on board. One last question: are you satisfied that the current listings in the 24-hour section of the *White Pages* in relation to pregnancy counselling give a correct and accurate impression of the services that are provided? I am presuming that you do, but I am wondering if the evidence that was presented today perhaps gave you some insight into some of the concerns that have prompted this legislation. I know it is a vexed issue, but I am wondering if Sensis are conscious of the fact that there is room for misinterpretation.

Mr Hurst—To the extent to which we can rely on representations made to us by the organisations—in addition to the other steps that we have taken in the 24-hour services section—we are satisfied with the listings that we have provided.

Senator WEBBER—Just for the information of both the people from Sensis and the committee, I took you up on your suggestion and spoke to a very helpful woman when I rang 12456 and asked to be connected to a pregnancy counselling service in Melbourne. I was

offered Pregnancy Counselling Australia as my first option and Pregnancy Support Service as my second option and then asked whether instead I wanted a more geographically specific referral—so it is 'p' for pregnancy.

CHAIR—Thank you very much for the submission that you provided and for the evidence that you have given to us today. Sensis has had so much free advertising out of this that I am sure that Senator Stott Despoja would expect a campaign donation from you! You have some evidence that you are going to provide to us on notice, and we appreciate that. Thank you again.

Proceedings suspended from 12.58 pm to 1.53 pm

ALLANSON, Dr Susie Janet, Clinical Psychologist, Fertility Control Clinic

TAFT, Dr Angela, National Convenor, Women's Health, Public Health Association of Australia

HARDIMAN, Ms E. Annarella, Manager, Pregnancy Advisory Service, Royal Women's Hospital, Melbourne

OATS, Professor Jeremy, Medical Director, Women's Services, Royal Women's Hospital, Melbourne

CHAIR—Welcome. I declare open this afternoon's proceeding of the inquiry into the Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005. Thank you for being here. We have submissions from all three of the organisations represented at the table. Information on parliamentary privilege has been provided to each of you. Before we proceed to questions, we would be happy for you to make a short statement. Professor Oats, do you wish to start?

Prof. Oats—The Royal Women's Hospital supports the intention of the Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005. We believe that women dealing with unplanned and/or unwanted pregnancy have the right to high-quality and comprehensive counselling, advocacy and support services which are informed by codes of ethics, provided by health professionals, accountable to their peers and professional bodies and supported by research and evidence based practice. This implies that information is provided impartially about all available options for a pregnancy.

Research confirms that few women experience abortion as traumatic, dangerous and difficult as long as certain conditions prevail, such as non-judgmental support, acceptance, respect, advocacy, freedom to choose and factual information. It is also recognised that unplanned pregnancy can be experienced as a crisis by some women, either in relation to the complexity of the decisions about the pregnancy or where pre-existing social or emotional concerns combine to create a potential risk. Therefore it is imperative to recognise the difficulties marginalised or vulnerable women have in accessing professional services and their right to sensitive and comprehensive support encompassing the short-term and the longer term implications of an unplanned or unwanted pregnancy.

The Royal Women's Hospital is interested in this bill because we frequently hear women's experiences of some services which have contributed to their fear, anxiety, misinformation and levels of stress and crisis directly in relation to the lack of support for their wishes and

choices regarding accessing abortion information and services. Rather than deterring women from seeking abortion, this has resulted in delaying women's access to a safe and lawful procedure and increased their emotional distress.

Many women have noted that they would not have contacted such a service if they had been aware of the service's bias against abortion. It is of great concern that some pregnancy counselling services are not transparent about the limitations of their service and are unable to provide impartial, comprehensive services. The availability of a professional response tailored to every woman faced with an unplanned or unwanted pregnancy which can provide a comprehensive risk assessment and offer appropriate responses such as counselling, referral, crisis intervention, advocacy and care is a basic and essential service to which all women have a right.

The Royal Women's Hospital's model ensures that women receive impartial and comprehensive support and counselling separate from clinical, medical and surgical services, which is given prior to offering any appointments for those services. They subsequently receive follow-up support as required, including post-abortion and post-pregnancy loss counselling. The Royal Women's Hospital supports professional practice which requires impartial and non-judgmental service and the transparency of any conflict of interest. It supports services which describe their philosophy up front and it supports regulation which prohibits misleading and deceptive advertising. It is committed to supporting services which improve public health and maintain accepted standards of regulation, qualification, accountability, supervision and training of counsellors. The Women's Hospital would welcome the opportunity to collaborate with government and support initiatives to develop standards of practice and guidelines for all unplanned pregnancy counselling and support services.

Dr Allanson—Thank you for the opportunity of testifying to the committee. Since my written submission supporting the bill to ensure transparency in pregnancy counselling advertising, two additional issues have arisen in other submissions which I would like to take this opportunity to address. One concerns the definition of referral by a pregnancy counselling service. For example, women who wish to continue a pregnancy but contact a service complaining that they lack support should be provided with the opportunity to consider their informal networks, such as family and friends, but also be put in contact with formal networks of support services. In this instance referral really is about linking women into services that they require or request.

In this particular example, depending on her circumstances, the service should be linking her in to or referring her to a local hospital or a local sympathetic doctor in her area. In Victoria, it might be referral to the Royal Women's Hospital Social Work Department or the Royal Women's Hospital Young Mothers Clinic, or it might be suggesting she contact Centrelink to work out what sort of financial assistance she may receive. Similarly, a woman contacting a service who wishes to terminate a pregnancy should be directed to an abortion-providing clinic, to the Royal Women's Hospital Pregnancy Advisory Service or to Family Planning Victoria. A woman who is undecided may need referral to all of those, so that she can receive the information she needs to make an informed decision. I consider refusing to refer a woman to services she requires or requests to be a dereliction of duty of care. It is

failing to provide ethical, professional counselling. In my opinion, the terms 'medical referral' and 'non-directive counselling' have been misused by some submissions to the committee to rationalise not referring women to services that they require or request.

The second issue concerns submissions which have claimed that abortion-providing doctors and services pressure women into having an abortion so that the doctor can make more money. I find this particularly offensive and untrue. I note that no such concerns seem to be raised about doctors or services providing other medical or surgical services, and I am quite perplexed as to why abortion-providing services should be seen as more likely to ignore the various legal, ethical and professional regulations and obligations that any medical and surgical service is expected to abide by.

At the Fertility Control Clinic, we provide women with the opportunity for discussion and information sharing, including around decision making and informed consent. I would like to table some of the written material that is provided to women who attend the Fertility Control Clinic. Included in that is a chapter that I was asked to prepare for a World Health Organisation report on reproductive health and mental health. The chapter concerns elective abortion and mental health. That has not been published as yet but we expect it to be published closer to the end of this year. The reason I am tabling it is that it seems that some services do not want to refer women to abortion-providing services or anything to do with terminating an unplanned or unwanted pregnancy because they consider that abortion harms women. I might also say that, with that logic, neither would they refer them to services which would support them in continuing a pregnancy, because the mental health and physical risks to women of continuing a pregnancy outweigh the risks associated with an early elective abortion.

CHAIR—Do you have any evidence to support your last statement?

Dr Allanson—Yes. I can certainly ensure that the committee gets that.

CHAIR—Just to clarify, did you say that there was a higher risk in continuing the pregnancy than in terminating the pregnancy?

Dr Allanson—There are more health risks for women in continuing a pregnancy than if they have an early elective abortion.

CHAIR—I might come back to that after the other opening statements. Dr Taft, it is your turn.

Dr Taft—The Public Health Association of Australia also supports the intention of this bill. We believe that the primary public health goal for unwanted pregnancy is prevention. The PHA abortion policy states that the health status of women and their children and families is enhanced when safe, reliable methods of fertility control are available. If abortion is chosen, the complication rates are reduced when abortion services are available and can be accessed early in pregnancy. PHA believes Australian women have a right to the provision of impartial pre- and post-abortion counselling services which offer the full range of options: continuing to term, adoption or termination. Such counselling should include a proper history and risk assessment surrounding the woman's decision making that includes the nature of her relationships, her finances, the levels of abuse and violence she may be experiencing, her work situation and her access to child care.

PHA has seen the evidence, and I have analysed a longitudinal large-scale study—although it is yet unpublished—that indicates women seeking termination in Australia are more likely to be socially disadvantaged, which means that they are likely to have a lower education level and income. These women are entitled to the bill's proposed protection from any pregnancy counselling service using misleading advertising, because I am suggesting that they are less able to see that it is misleading. Let me give you an example.

First of all, on behalf of PHA I participated in the Royal Australian and New Zealand College of Obstetrics and Gynaecology comprehensive review of the evidence available on the website to inform and support health professionals in their discussions with women about decision making, information provision and the risks and benefits of different methods of abortion. There are many examples of misleading advertising on the Pregnancy Counselling website. I refer to the kinds of information available on the web for young women who are seeking information on this website about termination.

In the physical effects of abortion section it states that the immediate risk of complication of abortion is one in 100. There are no references, there are no studies cited and, most importantly, there is no distinction between the different methods of termination, such as surgical, medical, curettage or RU486. It is grossly misleading, disproportionate and out by a factor of 10. The website states:

Most studies conducted so far show a significant link between abortion and breast cancer.

I understand you discussed this this morning. This statement is factually wrong. It overlooks the WHO 2000 scientific statement saying that there is no link between breast cancer and abortion and the study published in the *Lancet*, which is a top scientific journal, in 2004 which analysed 53 studies around the world of over 83,000 women and concluded that there is no link between abortion and breast cancer. I am an epidemiologist and I would say there is no link between abortion and breast cancer

There are many more examples on this website of exaggerated, unreliable, unreferenced and misleading comments about incomplete abortion, allergic reaction to drugs, tearing of the cervix and perforation of the uterus. Regarding death, it does not compare the risk of continuing to term with the risk of termination, and I will happily table the *Public Health Perspectives* with the reference in it about carrying to term having a higher risk than terminating. There are many more examples, and most are exaggerated and unreferenced, and I put it to you that they illustrate the reason for this bill.

I also have here a poster and a covering letter which Children by Choice included in their submission. This letter, which is provided to doctors, is a really good example of deception by omission. Nowhere in this letter does it say that this organisation will not provide information or send women to places where they could have a termination. I will leave it to my colleagues here to give examples where, if women are misled, it may lead to late presentation for abortion, which we believe is an unhealthy choice. It increases the risk and it can cause post-abortion distress.

PHA supports scientific, evidence-based information and advice for women, with professional and ethical counselling. We support pregnancy counselling services having accreditation and credentialing for telephone listings—all services. In summary, Australia is a

diverse, largely secular society with multifaith communities. Where pregnancy counselling services are funded by government they must be impartial, transparent and any conflict of interest where faith prevents abortion being offered must be disclosed. All services which provide pregnancy counselling should be subject to these standards. We support the developments that are outlined in the Royal Women's Hospital submission. In conclusion, PHA believes this bill is necessary to provide quality services which in turn will contribute to good public health for families.

CHAIR—Thank you very much for those opening statements. I will kick off with a question to the Royal Women's Hospital. Your submission does not state a view on the bill itself. Do you have a view on it?

Ms Hardiman—We have the view that the intention of the bill is very important and there are some very strong reasons to support the regulation of counselling services to ensure transparency.

CHAIR—So you support the intention but not necessarily the letter of the legislation?

Ms Hardiman—We support the intention of the bill.

CHAIR—You refer in your submission—and, Professor Oats, you made reference in your remarks—to some of the unsatisfactory experiences of pregnancy counselling services not giving women the full picture or providing misleading information to people. I assume you would accept that it is possible and indeed is the experience that services on, if you like, both sides of that divide are capable of providing a poor level of service to women in this country?

Prof. Oats—It certainly is possible, yes.

CHAIR—I will go further than that. Is it the experience that such services can sometimes be of a poor quality on both sides of that divide?

Ms Hardiman—It is possible, and if any—

CHAIR—Just to clarify: I am not asking whether it is possible; I am asking whether it is actually the experience that some women have had poor quality of services and poor advice from services purporting to offer termination services, for example.

Ms Hardiman—If a woman received a service she was unsatisfied with at the Royal Women's Hospital, for instance, she has very clear pathways to make a formal complaint, whether it is through our consumer advocate service or she chooses to go to the Health Services Commission. There are clear pathways for her. Women are informed that that is their right and any feedback is used by the hospital very seriously to evaluate services and to improve services. That would be a fundamental responsibility of any service providing any sort of counselling or clinical services. If there are complaints, we support women to make those complaints in whatever way they feel comfortable making them, whether that is directly to the service provider, via the consumer advocate or via the government organisation.

CHAIR—That is not the question I am asking, with respect. You listed in your submission a number of examples of women in Australia reporting having experienced a sense of disapproval and judgment, increasing psychological distress, misinformation, exaggerated claims, increasing of the emotional risks of abortion et cetera.

Ms Hardiman—Yes.

CHAIR—I am saying that you purport in the submission that those can be features of services that are, reading between the lines, effectively pro life services. Would you not accept that some pro choice services can justifiably suffer from the same kinds of criticisms?

Prof. Oats—We can only comment on the reception we get from people approaching the Royal Women's Hospital. We do not have much experience of that from the nature of the approaches that we receive.

CHAIR—Earlier today the committee's attention was drawn to an article in the *Herald Sun* in September 1998 about a case dealing with a woman called Ellen—I am not sure if that is her real name or not—which was, according to this article, a case about a woman who received poor advice from the Royal Women's Hospital. I assume that you are familiar with that particular case?

Ms Hardiman—I am not sure of the relevance of the point for the discussion about the bill.

CHAIR—Perhaps I can explain. Are you aware of that particular case?

Ms Hardiman—I am not personally aware of the particular case but I am aware that there have been complaints made. As I have described, there are very clear pathways available for women, who all have a right to make a complaint about any service they receive.

CHAIR—This was more than a complaint. This was a case where, according to the article, the Royal Women's Hospital and a gynaecologist were sued by the woman who claimed to have received poor advice, advice that was insensitive to her fragile emotional state, when she sought support and counselling from the hospital. According to the article, she was subsequently paid an undisclosed amount in damages for the poor quality of the services that she received. So I am coming back to this point that it is not merely one side of the debate or one end of the spectrum that delivers poor services. According to this sort of evidence, it is services at both ends of the spectrum.

Ms Hardiman—We have conducted a number of service user evaluations over periods of time at the Pregnancy Advisory Service—last year and one in the late nineties—enabling women to give feedback if they chose to. We have received very positive feedback from women who have been evaluated at those opportunities. We work with many thousands of women, so over those years it would perhaps not be surprising if occasionally an individual might perceive some part of her care with concern. As we said, we have very clear processes to feed back any complaints and any feedback into service provision to ensure increased quality of service provision. In respect of our current services, I can table the written information we provide to all women using the Pregnancy Advisory Service about the philosophy of the service, what they can expect and avenues for feedback.

CHAIR—Again, that is not the question I am asking, but I will leave that question.

Dr Taft—Mr Chairman, may I make a comment?

CHAIR—Yes, please do.

Dr Taft—I would suggest that the principle that comes out of the answer that the Royal Women's Hospital gave is that there is a process for complaints and that these complaints are acted on and reported on. I would recommend therefore—

CHAIR—In the case of the Royal Women's Hospital.

Dr Taft—in the case of any pregnancy counselling service that the intention of the bill is to provide just such feedback. I am unaware of the anti-choice pregnancy counselling services having any such formal mechanism. I would like to see that, for any service—whether it is the Women's Hospital, the clinic, pregnancy counselling or pregnancy support—it is a matter of principle that women who do have a grievance and do have a problem have somewhere stated to go to at which their complaints will be acted on, noted, registered and reported.

CHAIR—I agree with that but I am saying that such a mechanism should provide for complaints across the whole spectrum, not merely at one end of it.

Dr Taft—I am making a point of principle. I quite agree with you in this instance. I think that all services should provide such avenues for complaint, and that should be part of standard accreditation and credentialing.

CHAIR—I put to you a situation which has been suggested to us today in evidence and which would not be entirely fanciful: a woman falls pregnant unexpectedly, faces great emotional pressure from her partner and possibly from her extended family to have an abortion, and goes to an abortion counselling service that provides terminations. It has been suggested to us that in those circumstances what she receives is pre-termination counselling, not general counselling, to help her make a decision about whether to keep, abort or adopt out the child. In those circumstances, the pressures on a woman to make the wrong decision can be very real. Therefore, the need to analyse the kinds of services that those sorts of situations offer to a woman is as real as the sorts of problems that the Women's Hospital submission draws attention to.

Ms Hardiman—There are a number of descriptions of standards of practice for unplanned pregnancy counselling around the world that our work uses as examples. You referred to abortion counselling. We do not refer to what we do as 'abortion counselling'. We provide unplanned pregnancy counselling and support. The word 'counselling' encompasses a whole range of techniques and strategies. It is not just talking and not just nondirective but about all information and opening up options for women. Every woman who contacts our hospital, for instance, has access to a trained counsellor who talks about all of her options. We do not make assumptions about what women want.

We work with many thousands of women each year. Obviously, we do not have enough services for all those women, but every woman has access to that counselling in the first instance of her contact. Those services are provided separately from the clinical and surgical services, so there is not an assumption she wants an abortion. If she does want an abortion—she has made a considered decision—then those options are opened up for her, as are all the other options, whether she wants to consider relinquishing a child for adoption, continuing her pregnancy and raising a child, or organising another care arrangement, if she is a young woman, for instance. So we do not call it 'abortion counselling'; we provide unplanned pregnancy and/or unwanted pregnancy counselling and support.

CHAIR—That is commendable, but I am not sure every service of the kind we are talking about reaches the same standard. That is the point I am making.

Dr Allanson—If I might respond, working with a fertility control clinic where we are an abortion providing service, every woman sees a counsellor initially. We are most concerned about the risk factors and being well educated in being able to pick up any risk factors. Coercion is one of the main risk factors for a woman not coping well after an abortion, so our counsellors are very tuned in to trying to ascertain that. Ambivalence is also a key risk factor. Poor self-efficacy—not feeling optimistic that they will cope well—is also a major risk factor. There are a number of risk factors that we understand from the evidence and from our clinical practice. There are others that are not documented but that we think set off alarm bells. The particular example you gave of coercion can be quite a difficult one. Even where we make a point of seeing a woman on her own, she can sometimes be reluctant to tell us what is actually going on in her life. That can make it quite difficult. That is where it is so important that counselling staff are nonjudgmental, that they are accepting and that in a very short period of time that rapport can be built.

Senator MOORE—Following on from Senator Humphries's questions, we had considerable discussion this morning with a range of providers whose argument was that advertising in any way a pre-established position—such as: we do or do not support referral for termination—somehow devalues the kind of counselling that is provided. The argument is that someone choosing to take up counselling would be pushed away by that kind of access and that the ability of professionals working in such a service to work effectively with a client would be affected by that kind of limitation. I think the general argument that came through the discussion of the difference between judgments or decision counselling and pre-termination counselling was that once a woman has made up her mind that is what she wants. I would be interested in the perspectives from your clinic, where you provide counselling, and also from public health, on whether you think it is a valid argument that having clear information about the type of counselling or services offered would limit access to clients—that they would self-assess whether or not they would go to particular counselling.

Ms Hardiman—Some women contact our service who may be quite clear about wanting to continue their pregnancy; we are able to refer them to the service to support them with that. Similarly, if a woman is clear about seeking an abortion, she usually assumes and would expect, in going to a service that has advertised itself as a specialist service in a particular area in something as serious as unplanned pregnancy, that she is going to have access to all the information available. I think it is more concerning that women's experience of some of those services is that the service they are specifically seeking is blocked to them.

Whether it affects the ability of the counsellor or not, the women's experience of those services is extremely concerning. That is why we have been so concerned about this issue and its impact on women. For instance, a marginalised woman or a young woman who is fearful, not articulate, vulnerable and in crisis, is in a very vulnerable position to be manipulated by an inappropriate use of inappropriate counselling techniques. We would argue that counselling that is not transparent about what is available within that service is inappropriate. Once she is linked into the service she has goodwill and she thinks that the service is professional and impartial. Women do assume that and they want that, and if they want to discuss only one

option—keeping a pregnancy, for example—it is great that they are provided with the support from the service.

Counselling can be a powerful experience and there is a power dynamic where a counsellor is in a more powerful position. We are particularly concerned—as Dr Allanson mentioned—about women who are particularly disadvantaged or at risk, or are vulnerable to that sort of influence, that they will be prevented from accessing the service they want and, rather than just deterring them from what they are wanting, it will prevent them from accessing the service as soon as they should be getting it.

Dr Taft—I would like to make a point about the principle. It seems to me that people are going to advertise the service that they are providing and the service that they are not providing. What that is going to do is give women choice, and an informed choice. I see that as a benefit. If women see a service advertised as a pretermination service—I have not seen any such service; I have only seen the services provided in Victoria by these two very well-run and professionally-run organisations—if it says pretermination or abortion counselling then a woman knows what she is going to. I agree that any termination is not an easy decision no matter how it is painted for any woman. So if it says, 'We do not offer termination services or referrals to abortion,' she knows that if she goes there she is getting pregnancy support.

I have another page on that website that gives more information from Pregnancy Counselling Australia where there is absolutely no such statement and all the further references are for babies and baby support. For example, on support and information links on pregnancy support there is: 'just look', 'reach out', 'bonny babes', 'womb', 'heartbeat', 'paternity angel', 'Bub Hub', 'huggies', 'baby centre', 'maternity clothes'. Frankly, if I were seeking a termination I would not find it very helpful. Nevertheless, if I had an unwanted pregnancy and even in a difficult situation I decided I want to continue, that is helpful. But they should be up front about it. It seems to me that if you do not get that level of clarity in advertising, which is the intention of the bill, then you are going to get more distress and more delay because women are going to have to then go through and find out that it is not the service that they need. This is the reason this bill is important.

Senator MOORE—You don't see a conflict between decision-making counselling and counselling that is helping you to continue with the decision that you have already made?

Dr Taft—I have never seen anything advertised as pretermination counselling. If it is specific, I would be concerned if that were the wording. Women who seek abortions are more likely to be less well educated and therefore those kinds of terms are not really clear to them. I would like to see standards of practice where the wording is simple and at a reading level that is a very average one so women can understand it. If somebody went along to such a service advertised as pretermination and were ambivalent, I would hope that this bill would set standards of practice whereby that kind of a history and counselling and a sensitive analysis of their ambivalence was provided. But I do not see an ambivalence if it is clear, if women understand what they are getting into.

Dr Allanson—You can draw a parallel with other surgical or medical procedures. If someone attends a doctor looking to have heart surgery, for instance, or eye surgery, there are pros and cons to that. They must be well informed. They may go through a period of

ambivalence and they may need assistance in sorting that out, not just with a doctor but perhaps in talking with friends and family. They may even need to be put in contact with other health professionals if someone is looking at something quite serious. I do not see much of a difference there in terms of women attending an abortion-providing clinic.

With our clinic, women know that we are an abortion-providing clinic, so we do not usually see women who are very clear that they are going to continue. They just would not come to us. Roughly 90 per cent of the women we see at their initial consultation have no doubts about their decision to terminate, but that other 10 per cent are the ones we work very hard with to try and help them reach a decision that is right for them. In my submission, I have also indicated that, if a woman remains ambivalent, she is in no way ready to go through theatre. She cannot reach informed consent to a procedure when she remains unsure, and in fact we do see that, for some women, that is the way they make the decision—they remain ambivalent and, by default, it means they are going to continue the pregnancy.

Senator BARNETT—What percentage of your clients who walk in the door have an abortion?

Dr Allanson—I would not be absolutely clear on that, but because 90 per cent of them have no doubts about their decision then it is at least 90 per cent. Out of that other 10 per cent, it might be five out of 10 who would end up having a termination.

Senator BARNETT—What happens to the other five per cent?

Dr Allanson—Some may miscarry prior to having made their decision—that always happens to a small percentage. Some may be beyond the time limit where we are able to assist them—and they will be referred elsewhere—and others will decide to continue.

Senator BARNETT—Where would they be referred to?

Dr Allanson—We may refer to the Royal Women's Hospital, or we may have to refer to somewhere like David Grundmann's clinic, but it depends.

Senator BARNETT—Would you ever refer them to a pregnancy counselling service?

Dr Allanson—I would refer them to the Pregnancy Advisory Service if I felt that they needed more assistance.

Senator BARNETT—At the Royal Women's Hospital?

Dr Allanson—Yes. I have also referred people to private clinical psychologists who I know are excellent in that area.

Senator BARNETT—Of the people who seek your services, do you offer all of them non-directive pregnancy counselling services?

Dr Allanson—I think the meaning of these terms has become a bit of a stumbling block here. We provide women with women-centred, respectful, evidence based and pretty comprehensive counselling, so I would probably stay away from 'nondirective'. It is something I have raised as being something that I am not sure about.

Senator BARNETT—I used the word because it is in the bill, and this is the Senate inquiry looking into the bill.

Dr Allanson—Yes.

Senator BARNETT—Let me rephrase the question. Do you offer every person who walks into your clinic and seeks your services decision-making counselling?

Dr Allanson—They do not all need decision-making counselling in depth.

Senator BARNETT—Can you answer the question?

Dr Allanson—Yes, I think I am. One of the first things that occurs in a counselling session is that we have the pregnancy result, and usually the first thing we say is: 'You are pregnant. Do you want an abortion?' The woman may say, 'I'm not sure,' or 'Yes, I definitely do,' or 'No, I don't.'

Senator BARNETT—In your view, is that decision-making counselling?

Dr Allanson—What comes after that, yes. But a woman might be very clear that that is what she wants, so there is discussion around her circumstances, because with abortion there are of course legal circumstances surrounding that as well.

Senator BARNETT—Sure. It would seem understandable to me that, if somebody walked into your clinic and sought your services because you provide abortion services, they would want to skip the decision-making counselling and go straight to the thrust of having a termination and seek pre-termination counselling. I could understand that, and that is why I am seeking your response to that.

Dr Allanson—I think there is quite a deal of overlap if we want to talk about that. I would prefer to be talking in terms of informed consent as well as woman-centred counselling. The whole issue is that a woman makes a decision that she feels is right for her—not for me or anyone else.

Senator BARNETT—Could I read to you a quote from Mrs Coleman from the National Foundation for Australian Women. At the Canberra hearing, she said:

... I think there are good quality termination services that do offer some counselling and I think there are some absolutely shabby ones that we could all be deeply mortified about ...

Would you agree with that?

Dr Allanson—I can really only speak about our clinic, although I have heard of some women who have talked about a previous abortion where they have felt that they were rushed, where they have felt that they did not get the opportunity for any real counselling. I guess the whole issue here is that women have a right to make a decision that is right for them. With any sort of operation people can feel vulnerable, but ultimately they have a right to make the decision that is right for them. But that also implies that they have a right to make a mistake. Very, very occasionally women may feel afterwards that they have made the wrong choice, and that is part of—

Senator BARNETT—I am just asking you, based on your experience—you are in the industry, as it were and I would assume that you are familiar with the other providers in Victoria and perhaps elsewhere—

Dr Allanson—Yes.

Senator BARNETT—whether you agree with Mrs Coleman or whether you have had that experience with other providers.

Dr Allanson—I think it is very difficult to know, because sometimes after someone has been to a particular service they may look back on things and actually forget what a crisis they were in, and thus see things in a very different way.

Senator BARNETT—You are focusing on the woman. I am asking you about your familiarity with other providers.

Dr Allanson—I do not know that I know of providers who are shoddy. We refer women and have links with other providers that we feel provide a good service.

Senator BARNETT—Okay, thank you. Dr Taft, we had a discussion earlier about the quote that early elective abortion is a better health option or has less health risks than—

Dr Taft—It carries less risk of mortality—less risk of death.

Senator BARNETT—I heard the words 'health risk'.

Dr Taft—I am clarifying that for you, Senator Barnett. I am saying a mortality risk. It has less risk of death than carrying a baby to term.

Senator BARNETT—Okay. Let's deal with both questions then: the risk of death, and then we will get to the health risk question. In terms of the risk of death, at what point does the risk of death get worse in terms of continuing the pregnancy compared to having an abortion? Is it 12 weeks, 18 weeks, 20 weeks, 28 weeks? Can you give me a definition or a point in time?

Dr Taft—What I can tell you is that global statistics to date consider that the risk of dying from a termination—globally—is less than the risk of dying from childbirth. You have to consider, Senator Barnett, that the conditions for birthing and the conditions for termination vary widely across the globe, so I am not going to be as specific as I think you are wanting. I can refer you to the evidence, and I am happy to provide it.

Senator BARNETT—Dr Taft, you have used the words 'early elective abortion'. What is your definition of 'early elective abortion'?

Dr Taft—Prior to 12 weeks is the ideal, and that is what most people—and certainly public health professionals—would argue is what we would aim for when there are unwanted pregnancies that women want to terminate.

Senator BARNETT—Sure, but you would be fully aware that there are second trimester abortions and late-term abortions—

Dr Taft—I am fully aware of that, yes.

Senator BARNETT—and they are included in the document that you have tabled before our committee. Can you share your views about second-term and late-term abortions as to whether you think they have a lower health risk to the mother compared to continuing with the pregnancy?

Dr Taft—Can I clarify how that question relates to the transparency of advertising and pregnancy counselling services, Senator Barnett?

Senator BARNETT—You brought it up earlier, Dr Taft. I am seeking a response from your earlier advice.

Dr Taft—I was only responding to a question that you raised. In terms of transparency of counselling and the pregnancy counselling services, I am seeking to make sure that these services are of a high standard and that they are clear about what they provide, so that if there are risks and benefits then any provider is able to give those with good evidence and that it is not misleading. That is my goal, and that is the goal of PHA.

Dr Allanson—I might address some of the concerns about mental health following abortion and early termination compared with continuing pregnancy to term. Some very simple stats are that approximately 80 per cent of women after delivery go through the 'baby blues'. Thirteen per cent to 20 per cent of women experience postnatal depression, which is a very serious illness. That compares with only about 10 cent of women who experience some distress after an abortion, and that can vary from really quite minor distress—more like the 'baby blues'—to that which is more extreme. So that is quite a difference in terms of mental health morbidity.

Senator BARNETT—I was just trying to ascertain your view on whether it is 12 weeks, 16 weeks or 20 weeks, and whether you agree that we are talking about death or health risks. But I realise that may be a difficult question, so I am happy to pass to Senator Stott Despoja.

Senator STOTT DESPOJA—I want to get back to the bill and clarify a couple of things in relation to its provisions. First of all, I thank you all for providing submissions and for giving evidence to the committee today. Ms Hardiman, I thank you for your supportive comments. I do not want you to feel trapped by the question of whether you support the bill or the intent of the bill; I am happy if it is the bill's intent, as I am sure any legislator would be if you were to say that in a committee inquiry.

But I think you might have some suggestions that would help me to refine the bill. This legislation is not perfect; I have yet to see a bill that is perfect on its first drafting. Based on your support for its intent, could you give me your perspective on some of the definitional or terminological issues that we are dealing with, particularly in relation to the definition of 'non-directive'. As I am sure all of you know, that is the terminology used by the department; that is, of course, the reason I use that terminology in the bill. Obviously, I consulted widely to come up with that definition, but I think it could be changed. I do not want any group, particularly those in the pro-life pregnancy counselling environment, to feel that I am talking about closing down services, because the bill does not do that, as you know. Is there a form of words that you think might achieve the non-directive definition?

Ms Hardiman—Yes. I would like to suggest that there are many interpretations of what 'counselling' means. Within counselling, I would understand 'counselling' to mean a whole range of strategies and techniques that a skilled, trained counsellor can provide to support a woman. For instance, if she is decision making then counselling is more than nondirective. 'Nondirective' certainly implies that you do not lead someone down a path they do not want to go. Referring back to my comments about the power dynamic in a counselling session, it is a very powerful thing, so there are things within a counselling session that include

nondirection, but they include problem solving and problem exploration, which imply providing information to assist women in problem solving.

'Pregnancy counselling' as a broad term should also refer to advocacy and referral. Not everyone wants counselling. Many women will use the resources, knowledge, skills and supports that they already have in their lives to make a decision. When they go to a counsellor, it is more about going to a service to assist them in working through the decision and taking action. So, within the counselling strategies that are used, non-directive is one, but so is information provision.

All those techniques should be underpinned by a set of ethics, a set of principles. Whether you refer to the AMA code of ethics or the social work profession code of ethics or the psychology or psychiatry codes of ethics, they all refer to a set of principles about being impartial. And if you cannot be impartial then you need to say that you are not able to provide a certain service or that you have a conflict of interest, and provide something else that will resolve things for that person. That should be up front. Principles and ethics—ethics that include the respect for people's self-determination and an understanding of women's right to choose and their independence of decision—should also underpin the actual counselling techniques. The ethics should underpin all of the work that is offered to women.

In fronting up to any sort of service, women would rightly expect that sort of service. If it is not available they should know about it straightaway. For instance, in our service, we inform women in their first contact with us what we are, what we do and the philosophy we work from, which is about supporting and respecting women's choice about their reproductive lives. They are the principles that should underpin it. The non-directive part is one of those things, but so are impartiality and the acknowledgment of the vulnerability of women.

As I mentioned, we work with a significant group of women who are marginalised and disadvantaged, where the unplanned pregnancy may pose a great risk to that woman—for instance, a mental health risk or a social risk. A service that is professional and comprehensive should be able to undertake a risk assessment, as has been mentioned, to pre-empt the additional damage that could be caused to women. We know that the vast majority of women who have an abortion experience relatively few negative effects, but there are those who do. A lot of that can be predicted in a good professional risk assessment where the conditions exist—for instance, coercion or lack of information or violence and risk to the woman and also her perception of what she is doing and the perception around her. If she is made to feel guilty, ashamed and disrespected for her decision and if she is made confused and scared about it by poor information, that is going to increase the risk to her mental health. So the role of any service should be to assist her with positive supports for her situation and positive, comprehensive information.

Senator STOTT DESPOJA—I think impartiality is clearly the core of what you are saying there to me in terms of reworking a definition. Obviously, in the bill, certainly my definition of the provision of non-directive service involves information, support and, indeed, referrals on the three options. I am not suggesting that every service has to provide that, lest anyone misunderstand the bill. I was surprised to hear that some witnesses today thought that maybe this was closing down services that did not necessarily provide information on all three options. Clearly, that is not the case from a reading of the bill.

If a service is partial—that is, they have a particular philosophical, religious or other persuasion; and I am not talking about a particular perspective but any one of a spectrum—what is so wrong with that counselling service explaining in their advertising material that they either have that perspective, or do or do not provide options or information on the three options? I open that question to any of the four witnesses. I am almost at a loss today to work this out. We can resolve definitional and other terms. This is not about standards. It seems that a lot of witnesses today are prepared to work with the government to come up with a regulatory framework, and I am really excited by that. This is simply about misleading and deceptive advertising. What is wrong with making the services that provide abortion and those that do not provide it be up front about that?

Dr Taft—One of the things I think is implicit in what you are saying is that, if you actually do require by law that people are not misleading, I think there is a level of concern about poor service provision, be it on one side or the other. I think PHA is perfectly willing to accept that, in any profession, whether it is the medical profession, the counselling profession or otherwise, there are going to be good and bad providers. That is just life, frankly.

What one wants to see, if you are asking people not to be misleading, is recourse that women and any consumers have afterwards if you do have a complaint to have that complaint heard by somebody who is impartial as well, and to have that complaint not only recorded but also acted on so that it becomes a cycle of organisational improvement and evaluation. I think that should be the standard that goes along with this bill in its implementation for any service of whatever persuasion. So, if any woman finds herself forced into termination or provided with misleading information, or even being told post-abortion that she has committed a crime, and that is distressing to that person, she has recourse, she has a way of having her grievances heard and recorded. That service would then be asked to respond and tell the government why it should continue to be funded.

I think it is right across the board. I think that what you are asking is enormously important from a public health point of view. We want to see the full range of options for women so they make good fertility choices that suit their finances, their situation, their relationship and their access to child care. If it goes wrong and they are distressed, they have recourse and that recourse is noted. If it becomes damaging to the health of any person from either side then the government does not fund it.

Dr Allanson—I would like to say that I consider misleading advertising a very serious issue, and I think that the bill is a way of ensuring that women know before they contact a service what sort of service they are contacting and whether it is an abortion provider or an organisation that puts the rights of the embryo and foetus ahead of the rights of the woman. There may be woman who have that philosophy too and want to speak with someone of a similar mind; whereas, for other women, that is the last sort of person they would want to speak to. I think it is crucial that the misleading nature of the current situation, where there is misleading advertising, is changed so that women can choose the service and get the service that they want.

Prof. Oats—I think that—because of the very nature of the situation that we are dealing with, which has limited time—getting timely access is very important. We have talked about other analogies and advice—for example, in cardiac surgery—where time certainly may be

critical. But it is particularly critical in this instance that it is very clear right from the word go so that women are not prevented, as we have discussed in our submission and a little bit today. If a person does eventually decide that the course of action she wishes to take is a termination of pregnancy, it should not be delayed unnecessarily. We have talked about it being so much safer at up to 12 weeks, and not pushing into the later pregnancy. I think that is something that we all wish to avoid.

Senator STOTT DESPOJA—I have one last question, and I am happy for anyone to take it. It relates to section 7 of the legislation, which is the section dealing with telephone service providers and a requirement to list a non-directive pregnancy counselling service. Obviously the non-directive issue arises again. I am wondering: is it of concern to your organisations and professions that, in that crucial *White Pages* 24-hour emergency section, there is no advertisement or listing of a pregnancy counselling service that deals with issues such as referral for termination?

Dr Allanson—I have been most concerned about that because, especially in the 24-hour emergency section, people assume that all the organisations are very reputable and that they are accredited. In fact, because of our concern, the clinic ended up in the last year putting a listing in there as well, so that women at least had an option. We were very clear that we do provide abortions. What I would like to see is a service such as the Pregnancy Advisory Service from the Royal Women's Hospital, Family Planning Victoria or SHine in South Australia, which are very reputable services which can provide women with really solid professional counselling.

Ms Hardiman—It is a great concern because some women have access to the internet, endless phone calls and lots of resources, but some women do not. If a 15-year-old Sudanese refugee who has just arrived from a refugee camp, pregnant after a sexual assault, and who has half an hour during her school lunch break to make a call on a borrowed mobile phone goes there for her support and does not get the service she wants, she does not have a lot of options.

Some women do not have many options; they do not have access to options and information. If their first port of call is something that does not help them, that also sets up a sense of distrust and dissatisfaction. We are working with a lot of young people—not all who have unplanned pregnancies or who seek abortion are young, but many are—and women report to us frequently that they have been extremely angry and distressed about the services they have received. That has created less trust of services and it lessens the likelihood of them approaching services for good sexual and reproductive health information and advice later on in their lives. Some women are very disadvantaged by the fact that the information provided at their first port of call is not clear for them. Many women describe to us, when they eventually have contact with our service, that it has disadvantaged them quite significantly.

Dr Allanson—As Annarella mentioned, it is not just young women in extreme situations. In my submission I have given examples of mature women leading very productive and well-functioning lives—they may have children—who find, perhaps because of the stigma around unplanned pregnancy and the stigma and taboo around abortion, that the information out there is not very good and that the information about where to go for information is not very good. Even quite well educated women who are functioning well can end up phoning a service that

does not provide them with what they want, to the extent that they are very distressed by their contact with that service.

Senator POLLEY—We have had evidence today and in Canberra that some organisations that provide pregnancy counselling refer a woman to her GP if she says she does not want to adopt the child out or go full term with the pregnancy. What is wrong with that type of referral? Also, can you explain to me how this legislation ensures good counselling for women in a situation where they are unsure about the options available to them?

Dr Allanson—Professor Oats commented about delay. That is one reason it may not be appropriate to send a woman back. I do not know, if it is an anti-choice organisation, whether they would be suggesting the woman go back to her local GP or whether they would be recommending one of the GPs who has a similar anti-choice philosophy. If a woman is referred on to a GP who does not think abortion is an option then that can further delay that woman receiving the abortion she wants.

Senator POLLEY—I would have thought it would be in the interests of all women who found themselves pregnant to go to a doctor.

Ms Hardiman—Some women choose not to use their own GP for the very reasons Dr Allanson has referred to—they may be aware that that family GP may have anti-choice views or it may be a very small community. They seek service elsewhere because of either their GP's attitude or the issue of confidentiality. Referral should be much broader than just one or two choices of a GP. For instance, if I make a referral to a service, I make it my business to be aware of what sort of service it is and whether it is going to be useful and professional and provide what the woman—the service user—is seeking. I do not just refer to some unknown service that may create another block in her way.

Dr Taft—I will respond by saying that I do not think it is the intention of this bill to try to seek the provision of quality services. As I understand it, the intent of the bill is around advertising and making advertising clear.

Senator POLLEY—That is quite correct.

Dr Taft—The further question of the quality of services is a big one, and I think that we all share a concern to increase the standard and quality of pregnancy counselling services. But, as I understand the bill, its purpose is to get transparent advertising and notification of the services. I think the increased transparency is going to contribute inevitably to an improvement in the quality of services by making it clear what the services provide and, hopefully, to a complaints mechanism if they are not providing what they should be providing. That is the only intent I can see of this bill—and I am sure Senator Stott Despoja can clarify that that is the intent of the bill—and that is what we are fully supporting. Certainly, PHA sees the transparency issue and the issue of complaints when transparency is breached as being an improvement in the quality of what is currently on offer.

Prof. Oats—I would like to make one comment. Approximately 40 per cent of the women attending the Royal Women's Hospital do not have an established relationship with a family doctor. These are often the most disadvantaged groups—refugees and recent immigrants. I would have concerns that if that were the direction of referral this would seriously disadvantage a very substantial number of people who need the service.

Senator POLLEY—Dr Taft, you made a disparaging reference to a particular website. I would also like to draw your attention to the website of Children by Choice. On that website they describe the Vatican and the Catholic Church as being anti women and fundamentalist. If you are going to have legislation, surely it should bind everybody to give correct and accurate information.

Dr Taft—I cannot speak for Children by Choice but, in terms of applying the intent of this bill to all services, we fully agree that that should be the case.

Senator POLLEY—I go back to Senator Humphries's initial question and that is that we have had evidence—and I can give you anecdotal evidence—of people who have not received the best counselling. Some women have gone to abortion clinics and have been counselled the same day as they have had the abortion. That is not in their interests. When you talk about having complaints, we should keep foremost in our minds that once you abort you are not only affecting the woman but it is a bit late to do anything for that unborn child.

Dr Taft—PHA would certainly be concerned about any service provided to a woman that was inadequate or poor. If the service was advertised as otherwise we would be concerned about that. We would want to see that that woman had recourse to complaint. It goes right across the board that if any pregnancy counselling service provides misleading or poor quality information there should be recourse to a process that is appropriate, and that would be a complaints process. I do not think anyone at this table would argue that in any service you are going to find poor quality service. I do take your point—you are arguing that it is too late—so we need to look at making the advertising clear. I do not want to comment on anything else, other than that.

Senator POLLEY—Would you like to see this legislation go further than just transparency in pregnancy counselling to have transparency in advertising for the entire medical field?

Dr Taft—I have not given that enough thought. I think I will limit my comments to this particular bill. I commend Senator Stott Despoja for bringing it forward, because it will improve the information provided to women who are in very difficult circumstances.

Senator POLLEY—Could we have provided to the committee from Dr Allanson and the Royal Women's Hospital the statistics on the number of abortions and terminations that your areas conduct?

Dr Allanson—I think the Department of Human Services has access to all the statistics in Victoria.

CHAIR—Do they have them by facility or service?

Dr Allanson—I do not know whether they are by facility. All I know is that as part of our accreditation we feed a lot of stats into the Department of Human Services.

CHAIR—If those statistics cannot be provided by the department then presumably you are in the best position to provide that information.

Dr Taft—What would you like those statistics for, in relation to this bill?

Senator POLLEY—I think all information before us helps us in our deliberations.

Dr Allanson—I am not one of the medical directors of the clinic, so I would need to discuss that with them.

Senator POLLEY—If you could take that on notice, I would appreciate it.

Dr Allanson—Okay.

Senator ADAMS—Dr Taft, you probably realise that we had quite a discussion on breast cancer issues before. I am very pleased to see that you have read the same information that I have. I am quite relieved about that because I was quite concerned this morning with the misinformation that was being given. That leads me to a question that is for anyone really: do you consider it appropriate for pregnancy counsellors who are not trained medical practitioners to provide information on potential health risks and dangers associated with termination? We have had some fairly scary evidence. It really does worry me—I am a health professional myself—as to just what is going on in some of these counselling services.

Dr Taft—I do not think I would want to see it restricted to just medical professionals. I think what PHA likes to see is the best available evidence that is scientifically accurate. I do not think this bill can actually address that issue except in advertising and, say, misleading advertising. The statements that I read out to you from the website that I cited had no references, had no way in which anybody could check that information. I think that we in PHA would argue that, if they are going to make statements, any good evidence based professional would always cite their references. I am very concerned that these are entirely misleading, alarmist and exaggerated. In advertising perhaps there could be a consideration, Senator Stott Despoja, in the drafting of the bill of exactly what 'misleading' means and how it could be checked, going into those sorts of details. References would be one of those things.

Prof. Oats—I do not think it should be restricted to medical practitioners; it should be done by well-informed and trained health professionals working in that area.

Dr Allanson—I concur with that.

Ms Hardiman—A good practice standard model is to have a team of health professionals who bring specific expertise to the services being provided. Decision-making counselling—about the actual decision about that woman's life—is one part of that, and then medical information to assist her in an informed decision would come from a medical practitioner. So any decent service will ensure that the woman has access to the whole range of professionals, who all bring their own expertise, so she makes her informed decision.

Senator NETTLE—Thank you for your submissions. I want to ask a question of the Royal Women's Hospital and the Fertility Control Clinic. We have had some discussion about codes and standards by which pregnancy counselling can operate. From what you were saying before to Senator Stott Despoja, you seem to be supporting a code, but do you support a code instead of the transparency or a code as well as the transparency component?

Ms Hardiman—There are a couple of issues that come out of it. We certainly support the bill, to ensure that any service is transparent and clear about what it provides, but this deliberation is also a good opportunity to support the development of codes of practice and codes of ethics and standards of practice. For instance, in Victoria there is no one standard of practice for unplanned pregnancy support. There is a range of service providers, as you know,

in the public and private spheres. Some of us tend to refer to some other established standards of practice. We would like to see the development of standards of practice for all services. As we have discussed this afternoon, occasionally there are problems or complaints. It would be a great outcome to develop high-quality standards of practice to which the staff and the services are accountable.

Dr Allanson—That is what section 7 seems to lead on to, in terms of the 24-hour emergency section—having a reputable accredited service there. In the bill it is termed 'non-directive pregnancy counselling', but ultimately that especially is an area where you would want to see a really well accredited and solid counselling service.

Senator NETTLE—I want to thank you both for the examples that you gave as well—it is really helpful for us to have those examples. I was interested in the legal example from the Royal Women's Hospital. I had not seen that one before. I was going to ask you a question in relation to the police that you talked about in one of your examples. Were you able to inform the police more broadly than just about that particular one? I wondered if it was a practice of the police to refer to that particular service across the state or whether it was just—

Dr Allanson—I think it may have just been that particular police station. Again, the rural and regional areas seem to be more susceptible. They do not have as many resources available. But perhaps I should check whether the police here are aware of the family planning and action centre in the Royal Women's Hospital. I would think that the services are more available here.

Senator WEBBER—I think earlier, when Senator Barnett was asking you a question you said—and I do not want to misquote you—that about 90 per cent of the women that come into your clinic end up having a termination. I will not hold you to that figure. It seems to me, reading the trusty Yellow Pages—

Senator MOORE—My Yellow Pages.

Senator WEBBER—Yes, Claire's Yellow Pages. It seems to me that that is an example of what is right and good about this bill because I look at the ad for your centre in the Yellow Pages and the first thing it says is 'confidential abortion and counselling'. So the women who approach your clinic approach it knowing that that is the option. It is transparent and open.

Dr Allanson—That is right.

Senator WEBBER—It is up there in lights and people know what they are getting.

Dr Allanson—Yes, it is.

Senator WEBBER—I just want to put that on the record. In earlier evidence today we were told—I am paraphrasing—that counsellors should not really have to outline which options they would rule in and which they would rule out when dealing with people because after all we do not require that of GPs and counselling services should not have to be any different than any other medical service. I was wondering if I could get any of you to comment on that. Now Senator Polley is reading the Yellow Pages. I knew it would catch on eventually!

Dr Allanson—In terms of providing a woman centred service, as I said earlier, even given that advertising we do not assume that every woman who comes to see us is absolutely clear

about her decision, and roughly 10 per cent of them are not. In those instances or in instances where you see that there may be some risk factors or other factors that they have not really considered, it is important that you raise the option of continuing the pregnancy. The women who are referred on to me are those women for whom it is a more complicated decision and they are more likely to be ambivalent. I routinely give them homework to go and contact the Council of Single Mothers and Their Children, to phone up Centrelink, to talk with relatives and friends who may be able to support them to continue a pregnancy and to be very creative about how they can continue that pregnancy rather than terminate the pregnancy. It is really dictated by the woman and her needs.

Ms Hardiman—It is not our role as professionals to rule in or rule out anything. We should respect that anyone who presents to a service has capacity and agency and is able to make their own decisions. Our role is to facilitate decision making, not to rule anything in or out. With any specialist service there is an assumption that they are there to enable that decision-making process, and in an area such as this—a very specific area of women's health—those women who are unclear, undecided, distressed or in crisis are the ones who do approach services. In our experience the majority of women are clear, informed, decided and do not require counselling, but they have made a decision. Those who may not be clear, who may be ambivalent, in crisis or requiring options approach services for that very reason—to have facilitation of the decision making. If they have made a decision to continue a pregnancy then knowing that the service they approach can support them with that is an excellent thing. But, if they need access to all their options, they need to know who they are approaching in order to facilitate that.

Dr Taft—Senator Webber, I would like to take up your point. I will just give us an example. I do a lot of work with general practice, and I work with a general practice department. I have an honorary position there. I have been to practices where a GP has actually had up 'I do not provide contraception or refer for abortions.' I actually think that is a very commendable position, and I think that, if any medical or other health professional were to be advertising on common places that they provide pregnancy counselling, this bill should refer to them. It would be a good thing in professional standards. I think PHA would support GPs and other providers actually making that clear, because I think there are fairly good examples, and I am aware in other work that I do of GPs refusing services, much to the distress of the women and, as Professor Oats pointed out, causing a delay in terminations. That is a real issue. I do not think it can be covered by this bill because I think this bill is talking about transparent advertising. But should a health professional be advertising? I think that they should be subject to this bill.

Senator BARNETT—Dr Allanson, I have a follow-up question to what you said in terms of same-day abortions. Do you provide same-day abortions?

Dr Allanson—Yes, we do.

Senator BARNETT—What percentage of your—

Dr Allanson—It would be about half.

Senator BARNETT—Ms Hardiman, you mentioned in your last comment that, for some of your clients and people you provide services for, you do not require counselling. Can you elaborate on that, please?

Ms Hardiman—It relates back to the skill and training of the health professional to make a mutual assessment with the woman about her needs, her situation and her ability to give informed consent. So if she presents to our service, for instance, well informed, well supported, clear in her decision, having thought it through for some period of time and clearly stating that in her interests she is requesting an appointment to discuss an abortion with a medical practitioner then for us to impose in-depth counselling on her, separate to the initial phone contact, would be disrespectful of that decision. However, an assessment is made within that initial contact and, if she was unclear, ambivalent, being coerced, depressed or dealing with other crises, an appointment would not be offered to her straightaway. A range of other services would be provided.

Senator BARNETT—I understand. What proportion of your clients would receive no counselling?

Ms Hardiman—As I previously referred to, the concept of counselling does not just mean sitting face to face with someone for an hour. It also includes information provision, discussion about the situation and risk assessment. All women receive that at their first contact.

Senator BARNETT—And what proportion then proceed immediately, as you have outlined, to an abortion?

Ms Hardiman—Around 75 to 80 per cent of women can, after they have indicated they are clear in the decision and they do not require further in-depth counselling. If we have appointments available, they will be offered a medical consultation appointment.

Dr Allanson—We also see women who, as well as speaking with friends and family, have also been to Family Planning Victoria and had a comprehensive counselling session with a counsellor there, and by the time they have come to us they are either very clear or they are referred to me because they have remained unclear.

Senator BARNETT—Sure. Ms Hardiman, do you offer same-day abortion services?

Ms Hardiman—No. Generally there is a delay. Purely through the demand on the service there is a delay between the contact with our service and the opportunity to have a medical consultation. There is never an opportunity to have an abortion the day a woman contacts our service.

Senator BARNETT—How quickly can it be obtained?

Ms Hardiman—It is usually at least a week before her medical consultation. It is not planned that she should have to wait a week. It is purely about demand and the arrangement of appointments.

Senator BARNETT—Did you want to say something, Professor?

Professor Oats—No. I was going to clarify along those lines.

CHAIR—I want to clarify one more thing. I think Dr Allanson was saying how at the moment there are no 24-hour, non-directive health services which are funded in Australia that would qualify to appear in the phone book under the 24-hour health—

Dr Allanson—I think that is correct.

CHAIR—If that is the case and this legislation were to be passed and ban any directive pregnancy counselling services, we could have a situation where there are no pregnancy counselling services available in that part of the phone book. Do you think that is a very desirable result?

Dr Allanson—I would prefer that to women accessing a service that they think is going to assist them and then finding out that the agenda is that they must continue the pregnancy.

CHAIR—Wouldn't it better to allow both sorts of services in, as long as they are properly labelled?

Dr Allanson—If they are properly labelled, yes. I think that is the purpose of the bill.

CHAIR—Actually, it is not. The bill says, as it is presently drafted, that non-directive services cannot appear in that part of the phone book, irrespective of whether they are labelled or not. This is a problem that I think Senator Stott Despoja has cast her mind to.

Senator STOTT DESPOJA—It sounds like there might be consensus breaking out on this side.

CHAIR—We will see. Thank you very much for your evidence here today and for the submissions which you provided to the committee. We are appreciative of the time that you have spent before the committee today.

Proceedings suspended from 3.21 pm to 3.42 pm

DENNIS, Mrs Helen Mary, Volunteer Counsellor and Secretary, Pregnancy Counselling Australia

WELLS, Mrs Sheila Joan, Coordinator, Pregnancy Counselling Australia

TIGHE, Mrs Margaret Mary, President, Right to Life Australia Inc.

CHAIR—Welcome. Thank you all for being here. I think that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. We have your submissions, Nos 26 and 18 respectively. The committee would like to ask you some questions about your submissions but, first of all, I invite each of you to make an opening statement.

Mrs Tighe—I do not do pregnancy counselling, but our organisation funds Pregnancy Counselling Australia. I have to say at the outset that we decided, because of the donations of our members and purely from their support, that we should see that an organisation like Pregnancy Counselling Australia was established. I was particularly impressed with the work I saw done in New Zealand with a similar organisation there. That is why we decided some time ago to fund Pregnancy Counselling Australia. In fact for many years we have always funded pregnancy counselling. Another reason why we have done this is that we believe there should be a three-pronged attack on the current culture of abortion in which we live today—political action, education action and social action. We would certainly be criticised if we were not using any of our hard-earned funds for this work.

The aim of this legislation is quite clear. It is designed to prevent the operation of pregnancy counselling services established by organisations that rightly perceive that abortion makes two victims: one dead, the other wounded. The services are run by volunteer women who have been appropriately trained to listen without judgment and to care enough to try to help, and Sheila and Helen will speak for themselves. Callers faced with an unplanned pregnancy are offered crisis counselling support, and contact is facilitated with sources of ongoing help in the community.

Ever since our organisation was established, in 1973, it was considered that it was an essential part of our work to foster this type of work in the community. As I said earlier, we would be criticised if we did not use some of our hard-earned funds for this work. Although Pregnancy Counselling Australia is funded by Right to Life Australia, it is run by a separate board of management and is supported by a large team of well-trained volunteers. Those who are involved with the work of Pregnancy Counselling Australia are not involved with the work of Right to Life Australia.

The sponsor of this legislation, which is called the Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005, Senator Stott Despoja, and others of like mind, of whom there seem to be quite a few here today, seem determined to prevent any avenue of support for pregnant women that does not include abortion. I feel very strongly about this attempt to stifle any avenue that can be open for a woman who, in many instances, is ambivalent about what to do when she is facing a crisis pregnancy. They want to put the lid on any voice that might say, ‘Look, there is another way.’

We live in a country where there is literally wall-to-wall access to government funded abortions, with an approximate rate of one for every three live births. I think that is to our great shame, living in a country like this. As we all know, abortions are carried out in most hospitals, with the exception of those that are philosophically opposed to abortion, as is Pregnancy Counselling Australia. Privately owned clinics operate brazenly and openly, unashamedly seeking customers through expensive ads in *Yellow Pages* telephone directories. And, in fact, for those people saying, 'How will women know where to go for an abortion?', there is a special section in the *Yellow Pages* on pregnancy terminations; that might make them feel a lot more comfortable. The main aim of those clinics is to sell an abortion. Women telephoning for an appointment are instructed, No. 1, to bring sufficient money and their Medicare card, and to come fasting and to bring an appropriate change of clothing. The so-called counselling is scant.

As a matter of fact, I well recall evidence given by Dr Geoffrey Brody, who runs some abortion clinics in Sydney, one in particular being at Randwick. The evidence was given against protesters, at the Castlereagh Street Magistrate's Court in Sydney several years ago. Dr Brody was under oath. He was asked: what percentage of women attending your clinic would go away with an abortion? Dr Brody ummed and ahed and was reminded that he was under oath; he finally, grudgingly, said, 'Ninety-eight to 99 per cent.' So much for the counselling.

I want to know if there is any government scrutiny of the practices of these abortuaries, given the millions of dollars of taxpayers' money, in the form of health-care dollars which should be used to promote good health care, provided for the termination of unborn children's lives. Is there any scrutiny of these practices, which are funded through Medicare? It is Medicare that props them up. Pregnancy Counselling Australia is quite open in indicating that they do not advocate abortion as a way of dealing with an unplanned pregnancy. Their entry in the emergency section of the *White Pages* telephone directory is quite clear. It says: Pregnancy Counselling Australia—alternatives to abortion and post-abortion counselling. It receives not one cent of government funding, so the section in the legislation relating to the use of government funds does not apply to Pregnancy Counselling Australia.

I might ask in passing, in defence of those services that do receive government funding, such as Pregnancy Help Australia—and I only know of their work; I do not know them personally: why should they be denied funding? Does this principle apply to the funding, for example, of Catholic hospitals and related agencies that do not provide abortions? Are they to be denied funding because of a firmly held principle regarding the sanctity of human life? Is the work that they do in health care, which has benefited millions of Australians over the years, to be jeopardised because of a firmly held principle? I think not.

Protagonists of this legislation, I believe, have absolutely no idea of the whole culture of women out there suffering because of their Medicare funded abortions. Is there to be no help for them? They will not find it at the clinic which killed their child, and indeed they do not want to go back to that clinic if they are grieving following that abortion. I use the expression 'pro-abortion'. I resolutely refuse to use that dishonest expression 'pro-choice', as we are all pro choice. We all like to make our own choices in relation to lots of aspects of our lives. But to use that dishonest expression when you are talking about killing is reprehensible. Members

of the pro-abortion lobby emphatically deny that abortion causes any after effects such as grief, depression et cetera. Over the years I have been involved in this cause I have taken a number of phone calls from time to time from women who have been grieving following their abortions. This usually occurred when there was quite a dispute in the media about some aspect of abortion. It was very sad to listen to those women, some of whom got pregnant again. They wanted to have a child to replace the one that they had lost.

Some women may say: 'Having an abortion did not affect me. I feel a sense of relief.' It may be that they are able to suppress those feelings. Nonetheless, there are a significant number of women who are badly affected and carry that with them for life. Are these women to be denied access to a compassionate listening ear? That is a most important aspect of what we are talking about today.

Now that there are advertisements in the *White Pages* section of the telephone directory from a couple of post-abortion counselling services I rarely get phone calls from a post-abortion woman. But over the years prior to these advertisements being prominent in this telephone directory I did receive calls. You might wonder at that and ask, 'Why would they ring an anti-abortionist?' Believe you me, they did and, believe you me, I shed a tear with them too.

This is very significant. During debate in the Western Australian parliament in 1998 on the legislation which legalised abortion, Dr Kim Hames, who was then the member for Yokine, and who himself referred women for abortions, said:

> People whom I have referred for terminations have said to me years later that they wished they had not gone ahead with the termination and still regret it. They said that I had a blase approach and did not care; in my determination to provide an unbiased view and to give alternatives, I should have given a much stronger point of view against terminations. Some of those women said that, had I done that, they would have made different decisions. I sincerely regret that is the case. If many doctors were aware of that and could go back to the time they were giving referrals for abortions, they would provide much better counselling than they have.

There are those who suggest that the trauma suffered by some women following abortion is caused by the very existence of a movement such as ours and our public utterances. Yet it was interesting watching the TV film about the life of Marilyn Monroe, which was called *Blonde*. It was very illustrative of post-abortion trauma. She had recurring nightmares of hearing a baby crying following her first abortion. Yet there was no pro-life movement in those days. Tragically, she went on to live a life of ups and downs, with more abortions, substance abuse and allegedly suicide. Other aspects of her life no doubt contributed to that. But the thing that struck me when I saw that film was that here she was suffering these nightmares because of that first abortion.

The rationale behind this piece of legislation is nothing short of outrageous in my opinion. It is clearly designed to close the door on any service that is available for those women who are facing an unplanned pregnancy and who are ambivalent about abortion or women who may well be suffering following an abortion and who do not want to go down that path again. Government moneys are used in the millions to prop up the abortion industry. Either no money or a comparatively small amount of government funds are used to assist pro-life

pregnancy counselling services that perform a most useful service. This legislation should be rejected.

In conclusion, I would like to point out that the legislation is described as 'A bill for an act to prohibit misleading or deceptive advertising or notification of pregnancy counselling services, and for related purposes', and yet, when somebody complained to the Australian Competition and Consumer Commission about the activities of Pregnancy Counselling Australia, they replied:

For your information, the complaint you refer to was received and responded to by our Canberra office. As no charge is made for counselling provided by PCA and other similar providers, the provision of such services does not constitute an activity undertaken in the course of trading or commercial activities.

So much for misleading advertising. The letter goes on to say:

The complainant was advised the matter did not raise any issues for consideration under the act, and the claim that PCA may be engaging in misleading or deceptive conduct does not need to be assessed.

CHAIR—Thank you, Mrs Tighe. Mrs Dennis or Mrs Wells, would you like to make a statement as well?

Mrs Wells—Mr Chairman, Senators, thank you for this invitation to speak. I have three aspects of our submission to address. First, I want to give you a brief overview of our trained volunteers. Our women are dedicated, generous and nonjudgmental. They come from backgrounds including teaching, nursing, journalism, being a housewife, music, psychology and business. Many have given long service. Nine have given 23 years service. More than 25 have given more than 10 years service. One volunteer, by her own accounting, has taken 2,016 calls in 13 years. She is typical of many. The volunteers have a wide knowledge of pregnancy crisis related matters and post-abortion syndrome. Some have done extensive study with Professor Philip Ney, who is a psychiatrist and world expert on post-abortion trauma. One travelled fairly recently to Canada to do extensive study with him. All our women have hearts and minds to help women in crisis, both pre abortion and post abortion.

I really must elaborate on our policy of nonreferral for abortion. We have a duty of care to first do no harm. That means that we are dedicated to helping the caller achieve an outcome free from psychological and physical harm for any of those implicated. To give you an idea of the damage that can occur, I will give you a few examples—I have many—from my own personal experiences as a volunteer.

A young executive called us. She had been successful in the area of finance and was due for an international posting. She had been, she said, a confident, outgoing and productive person, with a fiance and wide interests in sport and the arts. She became pregnant, despite conscientious contraceptive practices, and decided to abort the pregnancy. She believed allowing the pregnancy to continue would have thwarted her flourishing career, put a strain on her fiance and upset her parents. She said that, after the initial relief that she felt after the abortion, she became depressed and lost her self-confidence, to the extent that she left her job. Her fiance ended the engagement because he was unable to accept the changes in his fiancee, although he had promised to support her and had in fact encouraged the abortion. He had not anticipated the depth and the type of support that he would be called upon to show. She felt

bitter and unworthy of her previous success. She gave up her work because she felt she could not make financial decisions when she had made such a bad decision for her own life. At the time of the call, she was not able to support herself. The property that she and her fiance were buying had to be sold. It seemed that, through the abortion, she had lost what she had hoped to retain.

The second example I will give you is typical of the sorts of cases that we have. A woman in her 20s and studying one of the health sciences called us. She was in a state of despair and crying when she began her story. She had had an abortion at the beginning of her tertiary studies, believing that it would resolve her problem of unwanted pregnancy. She was initially relieved, and seemed to pursue her studies with no significant after-effects for some months. When her course introduced her to intensive study of anatomy and physiology, she became aware of what was involved in her abortion. She looked at what happened in foetal development. She sought information regarding the surgical procedure.

As a result, she became despondent and fell behind in her studies to the point where she could no longer continue her course. She was unable to keep her part-time job. Her finances depleted, she fell back on her now ex-boyfriend's mother for accommodation and care. That lady had encouraged her to have the abortion. The caller said there was very little discussion. The boyfriend, his mother and she decided very easily that abortion would meet their needs. The mother believed that it was for the best. The caller felt that she had destroyed her future and was drowning in grief.

She said that her pre-abortion interview was very brief and gave no indication of possible outcomes. She remembers being asked: 'Are you sure you want an abortion?' And that was it. This question came about two days after she confirmed that she was pregnant and three days before the abortion. We were able to refer this girl to ongoing post-abortion counselling, but she was not hopeful of an outcome that would be good. She did not think she would be able to recover from her despair. So the personal cost to the community with these young, talented women is not possible to estimate.

I have another short example. A father called to say that his much-loved teenage daughter had turned against him and regaled him with violent language following her abortion. He had made the decision for her to have her abortion on the understanding that she would be able to resume her life. He honestly believed that it would be a quick and easy resolution to her situation and had been given no warning of possible risks. Indeed, he had not sought this type of information beyond matters of the time taken, cost and recovery. He was shocked and confused that this 'only sensible way'—as he had thought of it—had brought such a devastating result to his daughter.

Another father called us. He was sad and worried that his daughter, who was 19, had been showing signs of mental anguish for three years. She had taken to using drugs occasionally and alcohol often. It had recently been revealed to this father that his daughter had had an abortion three years ago. He had been kept in the dark by his wife and daughter, as had other family members. The exposure of this truth, while explaining the daughter's behaviour, brought some bitterness and resentment between him and his wife. This troubled family sought help from several areas, especially post abortion.

With ultrasound imaging comes another source of post-abortion anguish—

Senator STOTT DESPOJA—Chair, I think given the short time frame, we need to—

Mrs Wells—May I continue?

CHAIR—Senator Stott Despoja is raising the question of whether this is—

Mrs Wells—I am addressing this for a purpose, Senator Stott Despoja. There is some purpose.

CHAIR—Opening statements have tended to cover the issues that the person making the submission wishes to cover. We have questions to ask, but I am sure you are aware of that, so we will let you finish the statement.

Mrs Wells—I guess that gives you a pretty good idea of what can occur. I have dozens of them and an infinite variety, of course, but this is a typical example, covering aspects of calls that our volunteers are constantly encountering. You can see from these examples and you must be able to appreciate that we cannot possibly be implicated in abortion referral.

My third point, and this is a short one, is about our value to the community. First of all, with the post-abortion calls, we believe that women are entitled to recovery and help in reclaiming their lives after the unresolved grief following abortion. We can give them help and direction to experts in this field. With those in crisis relating to pregnancy, mostly we do not know the outcome of our work. However, most thank us at the end of the call.

I will quote some comments we hear regularly: 'It is good to talk to someone who understands', 'Thank you for listening', 'You have given me a lot to think about', 'I feel stronger from talking to you', 'Thank you for not judging me', 'You have helped me understand my own needs', 'I now have some hope', 'I don't feel so alone now', 'Today you have saved my baby's life', 'I need all the information you have given me.'

Occasionally, we do hear from those who continue their pregnancies. We may get a photo or a thankyou. We have never heard from anyone who is glad about their abortion. Thank you for your attention. I would be happy to answer any questions to the best of my ability.

CHAIR—Thank you. Ms Dennis, do you wish to make a statement?

Mrs Dennis—Yes, I do. I am grateful for the opportunity to speak to our submission. I would like to give a brief overview and elaborate on a few points. Our submission explains who we are; our funding, advertising and training; our role as a crisis pregnancy counselling service; and our duty of care statements. We hold the view that life begins at conception and that pregnancy is a natural process that should not be interrupted. We believe that pregnant women should be protected and supported. We understand that abortion destroys a unique individual, deeply damages a woman and has profound and long-term consequences that affect many people. We have included reports of actual calls to give some insight into the dilemma a woman faces when confronted with an unintended pregnancy. We believe there is a real need for independent services where a woman can discuss her doubts and fears in a safe environment.

I would like to elaborate briefly on the types of calls we receive and how we manage them. PCA receives approximately 4,000 calls a year and an average of 10 or 11 calls a day. The

calls range from medical queries to relationship problems and post-abortion distress. The majority of our calls are from women who find themselves pregnant unexpectedly. Some are confused and wanting to discuss their situation. Others are considering abortion but are open to exploring their options. The caller who has made up her mind to abort is often determined to go through with it. She disregards any attempt to explore her situation and feelings. After we explain our duty of care, she usually ends the call.

For our callers seeking counselling, we aim to engage the caller in a warm and friendly manner and endeavour to keep the lines of communication open. We validate her feelings and invite her to discuss her worries and concerns surrounding the pregnancy. We listen for the things that may need to be further explored. We talk about the effects of pregnancy and the baby's development. We recommend appropriate support services where necessary. If the caller is considering abortion, we offer information about the possible physical risks to their reproductive health and the often long-term emotional consequences of grief, regret, guilt and anger which can impact on her personality, relationships and behaviours. We do not make judgments, give advice or provide solutions. We hope that the caller has enough information to make an informed decision. For post-abortion callers who are distressed, we listen with compassion and understanding to their experience of loss. There are usually many issues and conflicts to resolve. Abortion is a complicated grief, and healing is a process. We do not provide ongoing post-abortion counselling, so we offer specialist counsellors as part of our service, if necessary.

The sad reality is that many women in a crisis pregnancy situation feel powerless and are vulnerable to pressure. In her panic and confusion, a woman often makes an impulsive decision or she loses confidence and lets others decide for her. Often she denies her own instincts and aborts her child either to please or protect someone else. I will give you an example to illustrate this. I recently spoke to a woman in her 40s. She was upset following an abortion that morning. She had rung our counselling line a week earlier, and at that time was going to proceed with her pregnancy. She had had a daughter when she was 15, whom she never saw. That child was taken from her at birth and placed for adoption. She felt this pregnancy was the last opportunity to have a child; however, her partner decided that he did not want any children, and threatened to leave the country to avoid paying child support. Because of her fear of rejection and abandonment, she ignored her desires and feelings and had the abortion. She went to the clinic alone that morning, and was now waiting anxiously for the partner to return her call.

The Elliott Institute, a post-abortion education and advocacy organisation in America, has published many studies on the detrimental effects of abortion. One study found that 64 per cent of women felt pressured by others to choose abortion. Other studies have shown a link between abortion and depression, substance abuse and suicide.

PCA is an independent organisation. We have never received government funding, and we do not wish to apply for funds. We are funded by ordinary Australians who support our work. We trust that the committee will allow us to continue our work with women in crisis.

CHAIR—Thank you very much to all three of you for your submissions and the opening statements given today. I invite Senator Moore to ask questions.

Senator MOORE—Thank you very much. Can you tell us where in the draft legislation your services are being threatened?

Mrs Tighe—That is a good question, Senator. I believe they are not, actually, because of the response from the ACCC. But the fact is that in some of Senator Stott Despoja's writings she certainly made ample reference to Pregnancy Counselling Australia. I have read the articles in the newspapers.

Senator STOTT DESPOJA—But there is nothing in the bill designed to target or close down the organisation.

Mrs Tighe—Well, you have been critical of organisations like Pregnancy Counselling Australia, suggesting that they are behaving in a misleading and deceptive fashion. I believe that is very unjust. I believe it is important that we stand up against this type of legislation, which, really, is only aimed, I believe, at closing all avenues for those women who are ambivalent about whether or not they have an abortion. Believe you me, there are a lot of them out there, Senator Moore.

Senator MOORE—But where in the legislation is your work being threatened?

Mrs Wells—In the legislation, I cannot see anything in particular. However, Senator Natasha Stott Despoja has been very outspoken about the matter of our not referring for abortions. She wants a situation where everybody needs to do that. I have explained to the committee why that is impossible for us. Senator Stott Despoja has spoken loud and long about this, and she has directed articles in the paper at us, which I have responded to, about what she calls inappropriate or dishonest information on our website; I think she was referring to the abortion and breast cancer link. We are very sensitive about criticism of our work, and perhaps fearful that our 25 years of community service could be thwarted.

Senator MOORE—I am sure Senator Stott Despoja will take up some of those issues.

Mrs Wells—I hope so.

Senator MOORE—In terms of the work of the committee, what we have before us is a draft piece of legislation and its full intent is to ensure transparency of advertising. From what I have seen from all of you, you are very clear about the work you do, the importance of the work you do and the links the organisation has to widespread support for Right to Life services, and that is respected.

Mrs Tighe—That is good news, Senator Moore.

Senator MOORE—Absolutely, Mrs Tighe. It has always been respected. But what we are saying in this legislation is that, if I am opening the *Yellow Pages*—which I treasure—or any other form of advertising and I am seeking information, I will be able to find out what the kinds of services are and what the background of those services is. I only have the *Yellow Pages* from Victoria in front of me, but I am interested to find out what the problem would be if, in the *Yellow Pages* under 'Pregnancy Counselling Australia'—which has a long history and a website—there were something in the advertisement that said: 'We do not refer for termination'?

Mrs Wells—No problem at all.

Senator MOORE—No problem at all?

Mrs Wells—No.

Mrs Dennis—If I could show the Senator our latest advertisement, which will be going in the 2007 *Yellow Pages*.

Senator POLLEY—Can we have that tabled?

Senator MOORE—Can we have a look at that, Mrs Dennis? That is the core issue, because the differences of opinion about people choosing to have abortion or not will always separate people. But what we are trying to achieve through this discussion is that someone who is thinking about what they are going to do would be able to seek support and advice from someone that they feel safe going to. So, if a woman or her family is seeking information and they choose to go to Pregnancy Counselling Australia, then they would know that the kind of work you do, as you have described, would be completely opposed to anything to do with referral to abortion, and they would know that before they went to you.

Mrs Tighe—It is quite clear in that entry in the emergency section of the *White Pages*. But we have had several attempts to try and remove us from there. And yet the reality is that the Fertility Control Clinic, which is Melbourne's biggest abortion clinic—making big bucks out of killing babies and harming women—also have an entry in there and they are a business. It is supposed to be for non-profit organisations. So it is quite clear—I do not take calls; I am not involved with that—that if somebody does ring and think they might have an abortion they will soon find out that they will not have an abortion at Pregnancy Counselling Australia.

But at the same time, as I understand it from what I have been told about the calls that they receive, many women start off talking about that, and then it is revealed that they have already had an abortion—or they have had two abortions or three—and they do not want to go down that path again. Helen made the comment to me recently that there are more than 100,000 abortions each year in Australia and Pregnancy Counselling Australia takes about 4,000 calls. What a pity they cannot take more. It is a jolly shame, isn't it? I see and know children and grown-ups whose mothers could have had abortions, and for whom it was very tough being a single mother in the beginning. I have 26 nieces and nephews and I have four nieces who have been single mothers. I do not want you to think they are all running around making a practice of this.

Senator MOORE—I would never think that, Mrs Tighe.

Mrs Tighe—All I am saying is: I think it is important to focus on each and every one of those people who are very, very valued citizens of this country. I will just give you an example. The first one is a principal of a primary school. Her daughter is in second year at Melbourne university. She got a very high score for her VCE. The next one became pregnant and had the baby out of wedlock. It was tough for her but she had the support of her family. Then she thought, 'I think I will go and do primary teaching.' She went back to university and did that course with a small child. She is now a very sought-after teacher working at one of Melbourne's big private girls' school, and has the most beautiful daughter, who is good at sport, good at academic work and is a beautiful natured child. Where would she be without her? Where would Australia be without her? And the third one, her son is now 16 years of

age. Once again, he is good at sport and smart academically. His mother has been told he is a leader at school.

I think of those people, and then I think of the older people who are adoptees, because adoption was more common in those days. Once again, there are three of those in my large extended family. Two of them have met their relinquishing mothers, who are very pleased they are alive. I think: isn't it high time we stopped and thought about these children who are just been carelessly discarded and thought about the harm? I compare those mothers with those women whom I have spoken to over the years who are suffering because of their abortions. There is no comparison when it comes to who is the happiest, and Australia is richer for the existence of those people.

Senator MOORE—I have now got a copy of the advertisement and I think that that is quite clear. People might have different views. If someone is looking at making a choice and they do not know where they want to go, it is clear from that advertisement the kind of work that Pregnancy Counselling offers. I think that that would fit the requirements that we have.

Mrs Wells—The 'community 24-hour-services' section at the front of the *White Pages* that we have here lists 'alternatives to abortion' and 'post-abortion counselling'. Do you need it to be more subtle than that?

Senator MOORE—Whilst we will have differing views on a whole lot of issues, is there anything in the draft legislation to which you object?

Mrs Tighe—Because there have been references to Pregnancy Counselling Australia and to all pro-life pregnancy counselling organisations—and there have been, in Senator Stott Despoja's speeches and also some articles that have been published in the newspapers—can you blame us for being uptight?

Senator MOORE—I think that it is good that we have the discussion, Mrs Tighe, but for my own peace of mind I just want to know whether in the other parts of the legislation there is anything specifically to which you object, apart from feeling discomfort and being uptight, so that we can pursue this as a committee.

Mrs Tighe—We have got these sections here about promoting transparency and full choice—they have taken care of that—and improving public health. I think they are doing more to improve public health, but it is only a drop in the bucket compared with what is going on in the whole country. Another object of the bill is to 'minimise the difficulties associated with obtaining advice to deal with unplanned pregnancy'. Wouldn't it be great if they were given a lot of money and they had a bigger service? They could be doing a lot better than they are doing at the moment.

Mrs Wells—I have here a letter from Senator Stott Despoja, who says:

While I understand that you do not require a referral for a termination, providing accurate information for women wishing to contact such clinics should be an essential component for any non-directive pregnancy counselling service.

She goes on to say that the Australian Democrats:

... vehemently recognise the need to provide women with a safe and secure environment in which they can make an educated decision based on impartial advice.

It is a bit of a contradiction in terms—impartial advice and information that is provided to them. We do not want to refer for abortion and never will.

CHAIR—Thank you. Just for the record I note that there are other services that have given evidence to the committee that provide pregnancy counselling services and do object to some of the terms of this legislation. I might direct you to have a look at what they say in their submissions. Mrs Tighe, you have been working in this area for a very long time and I think that you are very familiar with legislation in Australia in this area and I think also overseas. Are you aware of any precedent for this sort of legislation that outlaws a particular kind of advertising of services of this kind?

Mrs Tighe—As a matter of fact there have been a number of attempts made in the United States through some of the state legislatures and even in the local government in New York City at one stage or another. They have always managed to ward them off. But more recently there has been a bill introduced into congress, which is very similar to this legislation. I guess there might have been a bit of communication going on. It would lead me to suspect that. I do not know where the legislation will go. I would say that it will not go anywhere in the US congress.

I think it is tragic that we are living in a world where we are surrounded by ready access to abortion. Just look at those *Yellow Pages* ads. It is hard to believe that people are advertising killing babies. They are allowed to put the ads in the *Yellow Pages*. It is monstrous really. Yet there are groups that are trying to do their best in a voluntary capacity, giving all of their time. All I can say is that I know who are the happiest when I compare the women I have spoken to who have had abortions and the women for whom it may have been the easy way out but who did not have abortions. I think they are so much better off in the long run.

CHAIR—Okay. So you are not aware of any legislation that has been passed anywhere else in the world along these lines?

Mrs Tighe—No, there is nothing in England, because I would know about that, or Canada or New Zealand. But there have always been attempts to, as they say, try to expose these pro-life counselling services. Over the years we have had letters come to us from the Department of Human Services here in Victoria complaining, saying, 'You people don't refer for abortion and it's not fair for women who go to your services.' There have always been these attempts and this sniping at us.

But on the other hand too, with regard to the legality of abortion in Australia, I would like to point out that strictly speaking all of those abortions that are carried out in Queensland, New South Wales and Victoria, or the vast majority of them, are still illegal. In Western Australia and South Australia there still are some restrictions that are supposed to be adhered to, but I do not think they are much. When you consider it, strictly speaking, the way that most of those abortions are carried out, in that they are yours for the asking, would be considered to be illegal.

Senator ADAMS—Just on that last comment: I come from Western Australia—

Mrs Tighe—Yes, I know that.

Senator ADAMS—What evidence do you have about them being carried out? I am very interested in that.

Mrs Tighe—I guess it is my cynicism, because I know how easy it is for people to get around these so-called restrictions and regulations. There is much anecdotal evidence. Forgive me if I am repeating myself here—I think I might have said this at that inquiry into RU486—but I have not forgotten the woman who rang me grieving over her abortion. She finished up winning big damages, as a matter of fact, from a senior obstetrician and gynaecologist at the women's hospital here and from the hospital itself. That was the beginning of it. She had seen the foetal remains in her toilet. What I am leading up to saying is that, when she presented at the hospital with her husband seeking this abortion, she was earnestly telling this senior obstetrician and gynaecologist why they were taking this radical step. It was because of the sickness of another child. He said: 'You don't have to tell me all of that. You're pregnant and you don't want the baby. That's it.' From the anecdotal evidence I get from Western Australia, I believe that to be the case also. However, forgive me if I am wrong.

Senator ADAMS—I would like some evidence of that because I am sure that our shadow spokesperson for women's health would be very happy to pursue it on your behalf.

Mrs Tighe—Thank you. I will speak to my colleagues in Western Australia.

Senator ADAMS—I certainly would like that evidence. With your organisation, Right to Life, you are saying that it is an essential part of your work to provide help for women facing unplanned pregnancy. What do you do as far as provision of help? Secondly, once they have their baby does your organisation follow them up and still help them?

Mrs Tighe—To start with, we are essentially a lobby group. What I was explaining to you and to the committee earlier was that this is part of the work of social action, so to speak, of running a pregnancy counselling service in much the same way as we have Lifeline and those other telephone services. Naturally, we cannot be distributing largesse to people, because we do not have it to distribute.

But the most important thing initially is to have that listening ear, to be given reassurance and some compassion at the end of the line, and to be directed to places where you will be able to obtain help. There have been instances where somebody was really up against it and we have said, 'We'll have to try to help this person,' and money has been given to them to help them. But, by and large, you have to understand that we simply would not have those resources. We struggle to keep going as it is, and to keep working against people like you in the parliament—sorry about that, but it is part of our job.

Mrs Wells—To shine another light on your question, Senator Adams: Pregnancy Counselling Australia is a crisis counselling service—we are a turning point. Mostly, we get to speak to the person, the caller, once. I think Helen might have explained this, but we have a whole lot of referrals which we have to keep updated in areas that could be helpful to the women, no matter what their situation is, whether it is housing or clothing problems. But, apart from that, although it is not part of our service, because we are a crisis service, many of our women happen to take on particular women who have continued their pregnancies and give them personal support for the time of the pregnancy, the delivery and afterwards—for as

long as they need to build relationships with them. But that is not our prime purpose, which is crisis. Does that explain things?

Senator ADAMS—Well, yes, but I was speaking about Right to Life, as one organisation; you are telling me about yours. I am fully aware you are two different organisations. I wonder where the continuity is for that person who has rung up in a crisis situation. They might be four, eight or 12 weeks pregnant and still have a long way to go. And then they have to go on and raise the child, perhaps as a single woman. What is the length of time involved, on the crisis or Right to Life side of it, when you say that you are there to provide help to the woman during and after pregnancy? What is the process, going through?

Mrs Wells—There are referrals to appropriate, approved organisations that can help those women. They are given a choice of places that they may go to for help in continuing their pregnancy.

Mrs Tighe—That is in keeping with the work of Lifeline. Many years ago, before I got involved in this, I was a telephone counsellor for Lifeline. Our work was mainly the listening ear—they were mainly psychiatric calls, of course, but there could be other problems and referrals; we had a whole file of places to which we could refer. And there have been instances where they have sought financial help for a specific person.

If I could make a suggestion—and I do not know if it is within your powers to look into this—there have been instances where young women travelling through the country working as backpackers have become pregnant. And do you know that they cannot access a public hospital, because they do not have a Medicare card? It can cost them big bucks to have a baby. I think that is very hard, and there should be some steps taken to rectify that situation. You might say: 'Well, who are they? They are not Australian citizens. They are just moving through the country.' I believe that Helen had a case like this recently with a couple from Colombia. It is devastating for them. I do not know whether there can be a fund set up by the government. They may be passing through but, nonetheless, some of them are here working for a while and it costs them a fortune.

Mrs Dennis—If we do have Melbourne callers, we offer them a baby basket. We have those on hand, if required.

Senator BARNETT—I want to put to you, firstly, the proposition that was put earlier with regard to the risk of death to women, saying there was a higher risk of death to pregnant women than to those who have early elective abortions and, secondly, the risk of adverse health consequences of one compared to the other. What is your response to those allegations?

Mrs Tighe—I do not quite understand.

Senator BARNETT—The proposition was that the risk of death is much higher for a pregnant woman—

Mrs Tighe—If she goes ahead and has the baby?

Senator BARNETT—Yes, compared to if she had an early elective abortion, plus the health risks of one compared to the other. What is your response to that proposition?

Mrs Tighe—I am afraid I would go with nature every time, Senator Barnett. It is natural to have babies. We have very good maternal health care in this country and a very low maternal

death rate. I cannot produce figures for you, but I think it is just a big furphy. I cannot believe that it would be safer to go and have an abortion than to go and have your baby. The medically necessary abortion went out with button-up boots. It went out years ago.

Senator BARNETT—Sure. The only thing that they omit to discuss is the health of the child. Of course, in the case of a termination or an abortion, it is the death of the child.

Mrs Tighe—Exactly.

Senator BARNETT—This morning Dr Tonti-Filippini, in his submission to us, referred to the fact that under this legislation a proposal was set out where there would be one law that would apply to one service provider—for example, the pregnancy counselling services like the ones that you provide—and there would be another law that would apply to other service providers. Have you looked at the draft bill enough to concur with Dr Tonti-Filippini or are you not able to make any observations on the bill at all?

Mrs Tighe—We did refer it to a QC. He did not make any such observations. It was to see if it was in any way contrary to the Constitution. He said that is not the case.

Senator BARNETT—You put that the truth in advertising and transparency in advertising should apply to not just pregnancy counselling services but all the services that are provided under this gamut, including services that GPs provide. Do you have a view as to whether that concept should cover across the board or only apply to pregnancy counselling services?

Mrs Tighe—As the ACCC pointed out, it could not apply to services such as PCA because there is no money that changes hands, whereas GPs charge for their services. It is only right that they be subject to scrutiny when money is changing hands.

Senator POLLEY—I thank you for your submissions and your evidence today. One of the concerns that have been raised during these hearings is that in crisis, for women seeking a contact point through Sensis, the first option is the services you provide. Therefore, women seeking abortions are not given any referral. I would have thought that for women seeking advice—and there has been enough evidence in the *Yellow Pages* that everyone has referred to today—it is very clear where you go for an abortion and where you go for pregnancy counselling. There has also been reference to the website—that some of the information there has not been referenced. Do you have a view in relation to ensuring that all websites have accurate information? Do you want to comment and put your view on some of the concerns that have been raised today?

Mrs Wells—Accuracy and honesty are, of course, absolutely vital. Maybe you are referring to the abortion-breast cancer link. Were you referring to that?

Senator POLLEY—They were saying that your website does not provide any reference for any of the statements that you have made. Throughout the day I have also questioned Children by Choice. They made some derogatory statements in relation to the Vatican and the Catholic Church. I wonder if you agree that there should be transparency and honesty in all websites and whether you want to clarify what is on your website.

Mrs Wells—I support that completely. If any lack of transparency in any of our work is pointed out to us, we will treat it with great concern and address it as best we could. What have we got to hide?

Mrs Tighe—I say that there should be a lot more transparency regarding the abortion clinics. They help you to kill your child. They would not put that in the *Yellow Pages*, would they? They use nice euphemistic language. They are the ones who need to be more transparent.

Senator POLLEY—I asked some of the medical fraternity, including representatives of the women's hospital, whether they thought that this sort of legislation should also be relevant to the medical fraternity. There have been assertions made that some abortion clinics may actually derive a profit from counselling people to have an abortion as opposed to counselling people to continue their pregnancy or adopt out. Some comments were made that that was not a practice within the medical fraternity and they could not believe that anyone would do that. But I think that we ought to put it on the record that overservicing within the medical fraternity is in fact something that we have heard about before in our committees. Do you have any comment in relation to whether or not you believe that there could be instances of overservicing and about the type of counselling that is available?

Mrs Tighe—For sure. In fact, some years ago I received a telephone call from a guy who ran a pathology business in Sydney alerting me to the fact that one of the abortion clinic doctors here was getting kickbacks from the pathology services because she referred her pathology work to this service. That was illegal. In relation to the abortion clinics, there is no doubt that they are in the business of selling abortions. If you make a phone call, they will say, 'Bring so much money, bring your Medicare card, start fasting et cetera.' You just have to look at the advertisements in the Sydney telephone directory: 'Walk in, walk out, same day.' Really, what are we talking about? What about the evidence given under oath by Dr Geoffrey Brody in the Castlereagh Street Magistrates Court? He was asked a question about what percentage of women who went to his clinic left with an abortion. The answer was dragged out of him: 98 per cent to 99 per cent. It is obvious that he was doing well at selling abortions.

Senator POLLEY—It would be fair to say that a lot of those people who have put in submissions and who have given evidence would support a form of accreditation for those people who give counselling to ensure that their counselling is appropriate. That accreditation would also be part of the advertising. Do you think that that would go a long way towards meeting some of the concerns that this legislation was trying to overcome?

Mrs Tighe—Are you saying that there should be certain restrictions placed on the so-called counselling at abortion clinics? Is that what you are talking about?

Senator POLLEY—I am talking about counselling services, whether they are pregnancy counselling services or counselling provided in termination clinics. Those people should be accredited. For comparison, in the building industry, you look in the phone book and you know which builders have been accredited. Would having accreditation surpass the need for this type of legislation?

Mrs Tighe—It probably would help. But I have to say that I am fairly cynical because I am aware of what goes on. For example, I phoned a late-term abortion clinic here in Melbourne and pretended to seek an abortion. I was a bit long in the tooth to be looking for an abortion but nonetheless I got away with it. I made out that I was ambivalent about it and said, 'What sort of counselling is there?' She said, 'Yes, there will be counselling.' I said, 'Who does

that?' She said, 'Our DON.' I said, 'What's DON stand for?' She replied, 'Our director of nursing.' I said, 'What's her name?' The reply was, 'Melissa Grundman.' She is the former wife of Dr Grundman, who does the abortions. I could not help but feel cynical about that.

I could get you a transcript of a court case that took place in Sydney some years ago. One of the counsellors subpoenaed to go before the court was asked about her training and where she had received it. She had received it at pre-term in Sydney's biggest abortion clinic. So it might help, but I still feel very cynical because I think they get around it. Consider what we are talking about. We are not talking about dealing with mental illness or things like that but about a procedure that purposefully terminates a human life.

Senator STOTT DESPOJA—In the time remaining I have a couple of comments to make and questions to direct to Pregnancy Counselling Australia. Mrs Wells, you have seen me nodding. I do not want to cause you more distress by telling you how much I agree with what you have said today. The last thing I want to do is to cause you, Mrs Wells and Mrs Dennis, or your organisation any angst. It is pretty evident that we do not agree on a number of things. Obviously, I can cite your website or discussions had in relation to breast cancer and abortion. As you would have heard today from comments of the panel and other witnesses, people have differing views on those subjects. However, I want to make a couple of things clear about this bill.

First of all, thank you for being up front about the fact that you do not refer women for abortions. You have that right and neither this legislation nor I seek to take that right away from you. Secondly, you have been up front with the committee about the fact that you do not receive government or public funding; nor do you seek such funding. Whether you do so in the future is up to you, but you gave the impression that you would not necessarily do so. Therefore, you are in no way covered under this legislation. Even if you were seeking government or public funding, you would still have the right not to refer women for terminations, but the legislation would request that you be up front about it.

What I may need to do, along with my colleagues here, is to look into the legislation to see that it makes it very clear that, whether you are pro life, pro choice or whatever we want to call a counselling provider, everyone in the debate has to be up front. It does not matter who you are, where you come from, whether you advertise or whether you have brochures, you should be up front about the services you provide. Mrs Wells, when you were asked that question by Senator Moore, you were absolutely up front. You said with alacrity, 'Yes, we're happy to do that.' You are probably among the few people here who have been prepared to say, 'Look, we won't provide referrals for terminations and we never will'—to use your language—'and we're happy to be up front about that.' I respect that and I do not want the legislation to take that right away from you. I just want to make that particularly clear, when there has been some debate about closure of services.

Chair, I will not get on to the issue of whether I am seeking to prevent women from accessing other services. Obviously, some references in the submissions have been unnecessarily misrepresentative on a personal level. But that is okay, because this is an opportunity for people to respond. But I just want to make this clear, Mrs Wells: do you understand that my intention is to get people to be up front about the services they provide?

Mrs Wells—I do, yes.

Senator STOTT DESPOJA—As you have seen, I am aware that you have engaged with me and my office. In one of your letters, dated 4 July, you make it very clear that, in reference to abortion, your policy is 'to do no harm'. You say that you 'cannot give information which could lead to harmful outcomes for both mother and child'. You also say that you 'hear from approximately 2,000 women each year who are suffering in varying degrees from post-abortion trauma'. While I acknowledge your point in that regard, what about other issues like postnatal depression? We know that, roughly, one in seven women experience that trauma. That is a harm that obviously can come when you have a baby.

Mrs Wells—Yes.

Senator STOTT DESPOJA—You say that your policies do no harm. How wide ranging would your advice be on issues other than what you perceive to be the harmful effects of abortion? What about other harm factors?

Mrs Wells—Postnatal depression is one factor. We do hear from people who have postnatal depression and we refer them to an organisation called PANDA, because it really is not our area. We just stick to the matters that I have talked about.

Senator STOTT DESPOJA—You have raised an important point there, which is one that we have debated on the committee, with good reason—the issue of referring. Some people consider the term 'referral' to be a medical term—you know, a GP refers you to a specialist. I use the definition of 'non-directive', although obviously I talk about referrals for terminations. You may not necessarily agree with that, but that is the definition that I have used. But you do refer to other organisations. I have seen that you refer to Caroline Chisholm, for example. So you will refer women who, say, ask for information on adoption? Where would you refer those women? You give women additional information, do you not?

Mrs Wells—Yes.

Senator STOTT DESPOJA—Except on abortion, and we acknowledge that.

Mrs Wells—Yes, we do.

Senator STOTT DESPOJA—So for adoption—

Mrs Wells—Centacare or any agencies that we can. We are constantly trying to increase our base of referrals, because we get calls from all over the country—from Darwin, Perth, Hobart. It is a concern for us to always be looking for people to whom we can refer the women for further help, bearing in mind always that we are a crisis service.

Senator STOTT DESPOJA—Bearing in mind that you have been very up front, very transparent, in the fact that you do not refer for terminations, what happens in that crisis capacity, if you like, when a woman does ring up? Mrs Dennis, you did mention this, I know, in your submission, but I would like to clarify it again. When a woman rings up and requests information about an abortion, I think you said, 'Obviously they will hang up and go elsewhere.' You do not in any way provide access to other services where they may find more information? I understand that is not necessarily within your ambit. I just want to know what would happen in that circumstance.

Mrs Dennis—We would invite them to share their situation. As with any caller, we would try to engage them. We would perhaps say to them: 'Obviously this is a distressing time for you. Do you think it would help to talk about your situation for a little bit?' If they insist that they want an abortion, then we normally say, 'We do not recommend any procedure that may cause physical or psychological harm, so we do not refer for abortion.' We do say that to quite a lot of our callers. Some of them accept that and still want to keep on talking and discuss what is happening, but a lot of them just say sorry and hang up.

Mrs Wells—With some who say they want an abortion, if we can engage with them, we find that really they might not. It might be that their boyfriend wants them to have an abortion, or a friend or somebody thinks it is a great idea. Very early on, our volunteers are trained—and we affirm this, I think, in just about every piece of ongoing training—in what to say, as soon as they possibly can, to a woman who is looking for an abortion. We do not say it as directly as: 'We do not refer for abortion. Goodbye.' We say: 'You have probably called the wrong person. It is not our area to refer for abortion, because we have a duty of care. But perhaps you would like to talk.' We just give the woman an opportunity in case. Helen, you may have mentioned this earlier, but the Elliot Institute seems to think there is a very high percentage of women that succumb to pressure from other people and do not get support to address their own heart's feelings. They are very vulnerable and sometimes they are speaking from a position of high crisis. They have just found out that they are pregnant. Anyone in high crisis is emotionally and mentally disabled to the point that they really could not choose between a chocolate and a vanilla ice cream. You cannot make a choice when you are in high crisis, can you? I cannot, I know. We often ask them, 'How long since you found out you were pregnant?' If it is yesterday, we say: 'Time, time, time—give yourself a little bit of time. You might want to discuss it.' Sometimes, because of what Margaret said—the culture of abortion—unfortunately they think: 'I'm pregnant. The solution? Abortion.' But for every problem there are probably 10 solutions. Abortion might not be the one for them.

Mrs Tighe—It does seem like the end of the world when they find out they are pregnant and had not planned to be. But, as the late—

Senator STOTT DESPOJA—I do not have questions for Right to Life.

Mrs Tighe—She was a member of parliament here and a member of the Labor Party. What was her name? Pauline Toner. I do not know if you remember her. Late one night we were up at Parliament House. She had had a few drinks, as it was just before Christmas. She said: 'You want to remember this, Margaret. An unwanted pregnancy is not necessarily an unwanted child. My last two pregnancies were unplanned and unwanted and, my word, I would not be without those daughters now.' She is no longer with us.

Senator STOTT DESPOJA—My question is to Pregnancy Counselling Australia. When you said, 'Ten solutions'—I would like to think that there are 10 solutions to everything, Mrs Wells, but I think there may be three solutions in this case! Or there are three options, whether or not we agree with all three. On that point, there are times where we may not always like each others' positions and we will have to agree to disagree on some things. But I have to say that there are some points that you have made today that are very helpful in the consideration of this bill and there have been similar from across the spectrum. I have one final point. I am not sure if this is something that Mrs Dennis and Mrs Wells are comfortable with, but do you

have a funding agreement with Right to Life that you would be prepared to table or, indeed—given the debate about standards, particularly Senator Polley's point—is there a standards or guide of counselling that your counsellors use and that you would like us to be aware of? We have asked that of some of the other organisations.

Mrs Wells—I am not quite sure what you mean.

Senator STOTT DESPOJA—I am talking in terms of the training your counsellors receive or the guidelines or standards that you like them to maintain. I am happy for you to take that on notice if there is any further information that you would like to give the committee. I am happy for you to provide us with the further information that you were reading out earlier; I was just very conscious of the time at that point and preferred to ask questions. Perhaps there is something else like that that you would like to take on notice or table for us—

Mrs Tighe—Under the supervision of highly trained psychologists, it always has been the case.

Senator STOTT DESPOJA—Perhaps you could table that guideline. That would be appreciated—

Mrs Tighe—Before it became more solely a telephone counselling service—

Senator STOTT DESPOJA—Chair, I am happy for that to be tabled. I do not have questions for Right to Life.

Mrs Tighe—there was a psychologist, now deceased, who used to supervise the training and supervise the training manual. Now they have another woman psychologist who does that, supervises that and helps with the training. I would like to add, in relation to the funding, we just pay the bills. They get very big telephone bills, and we pay the bills.

Senator STOTT DESPOJA—Anything that you would like to table on that—

Mrs Tighe—We do not question them about it. At this stage, we are planning to see if we could have the funds separated so that there could be tax exempt status of the funding for Pregnancy Counselling Australia. We are currently dealing with a lawyer in relation to that. We have to submit that to the income tax department. We would have to separate it from our funds. But, at this stage, we just pay their bills. They are pretty big phone bills and advertising bills, too.

Mrs Wells—We do the work; they pay the bills. It is very nice!

CHAIR—Sounds like a good arrangement to me. If I could find someone to do that for me, I would be very happy. Do you have any questions, Senator Webber?

Senator WEBBER—In light of the time, I do not. Senator Moore has covered the issue I would want to cover. I want to place on the record that I think your proposed ad certainly is transparent. It is very clear. Thank you.

CHAIR—I think that draws the session to the close. I thank the three of you for your time today and for the work that has gone into your submissions.

Mrs Wells—Thank you.

Mrs Tighe—Thank you to the committee members. I am glad that there was not too much rapid fire across the table.

Mrs Wells—Thank you for hearing us and for the invitation.

CHAIR—We always believe in that sort of exchange. It is a very important part of the process.

Committee adjourned at 4.59 pm