Australian College of Midwives

ACM: For midwives. With women. For the future.

Inquiry into the health impacts of alcohol and other drugs in Australia (re-referred)

ACM Submission

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Inquiry into the health impacts of alcohol and other drugs in Australia

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are 34,347 midwives in Australia and 1,506 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address terms of reference a) and b) in relation to maternity services in Australia.

a) Assess whether current services across the alcohol and other drugs sector is delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society.
b) Examine the effectiveness of current programs and initiatives across all jurisdictions to improve prevention and reduction of alcohol and other drug-related health, social and economic harms, including in relation to identified priority populations and ensuring equity of access for all Australians to relevant treatment and prevention services.

Background

Consumption of alcohol and other drugs while pregnant are harmful to the mother and the developing fetus[2]. While some women have substance addictions, other women use and consume while trying to conceive or before they are aware they are pregnant. Some women are unaware of the dangers of using alcohol and other substances during pregnancy and breastfeeding[3].

There are multiple national and jurisdictional initiatives and services for perinatal women with substance addiction. It is beyond the scope of this submission to list and analyse all national and jurisdictional programs that target alcohol and other drug use in pregnancy and breastfeeding. ACM is aware of many jurisdictional Government and not-for-profit programs providing support and education to priority populations. This submission will discuss alcohol and other drug use during pregnancy and breastfeeding, screening, education and initiatives related to substance use, and models of maternity care.

The priority opportunities for ACM include:

1. Ensure Midwifery Continuity of Care is available for all women in all settings.
2. Upscale Birthing on Country / Birthing in our Community models of care for First Nations families.
3. Introduce a Medicare general consult item available for endorsed midwives to access.
4. Ensure Midwifery Continuity of Care for incarcerated pregnant and breastfeeding women.
5. Action the recommendations of the Midwifery Futures Report to urgently increase and strengthen the midwifery workforce.
6. Prioritise a National Midwifery Workforce Strategy to address midwifery workforce crisis.

7. Strengthen universal screening of pre-conception, pregnant and breastfeeding women in relation to consumption of alcohol and other drugs.
8. Increase pre-registration and continuing professional development education for healthcare providers related to universal screening, available services, counselling and referral of women who disclose substance use.
9. Increase healthcare provider pre-registration and continuing professional development education about FASD and alcohol consumption pre-conception and while pregnant or breastfeeding.
10. Introduce education about alcohol and drug use pre-conception and during pregnancy and breastfeeding into the secondary school curriculum.
11. Include opportunistic pre-conception counselling in sexual and reproductive healthcare.
12. Fund research to strengthen evidence around the risks of any levels of alcohol consumption during pregnancy.
13. Provide ongoing funding for the successful Every Moment Matters campaign.
14. Increase perinatal mental health mother and baby units nationwide.

Substance use during pregnancy and breastfeeding, screening, education and initiatives

Alcohol use during pregnancy

Twenty-eight percent of Australian women report consuming alcohol while pregnant[4]. This is considerably higher than the global average of 9.8%[5]. While many women do stop or reduce their alcohol consumption once they are aware of the pregnancy[4], the percentage of women continuing to drink is concerning given the risks of Fetal Alcohol Syndrome Disorder (FASD) and other negative effects on mothers and babies. Approximately one in every 13 women who consume alcohol during pregnancy will give birth to a child with FASD[3]. FASD is a lifelong disability caused by prenatal alcohol exposure and is estimated to incur a lifetime cost of one million dollars[5], aside from the individual and family psychosocial burden. Other outcomes associated with drinking during periconception and pregnancy include increased risk of miscarriage, small for gestational age baby, and preterm birth[6]. To reduce the risk of FASD and other negative outcomes, the National Health and Medical Research Council recommends that pregnant and breastfeeding women abstain from consuming any alcohol[7]. In line with the National Health and Medical Research Council recommendation, the National Fetal Alcohol Spectrum Disorder Strategic Action Plan advocates for complete abstinence from alcohol during pregnancy and when breastfeeding, due to lack of a known safe level of consumption. Likewise, the Australian Pregnancy Care Guidelines recommend advising women to abstain from alcohol around the time of conception and during pregnancy (accessed 25/10/24).

There are many reasons why women continue to drink while pregnant. Social pressure and acceptance of drinking while pregnant are important factors driving the rates of alcohol consumption during pregnancy[3]. Misunderstanding of the risk is also an important contributor. Many women believe that only large amounts or particular types of alcohol are harmful to the developing fetus, with some women even believing that certain amounts and / or types of alcohol are beneficial to maternal or fetal health and development[3].

Substance use during pregnancy

According to the National Drug Strategy Household Survey, in 2013 2.4% of women used illicit substances before they knew they were pregnant, and 1.6% used them after they were aware of the pregnancy[8]. Use of illicit substances during pregnancy increases a wide range of risks for both mother and baby, including stillbirth and maternal death[9]. The Australian Pregnancy Care Guidelines recommends screening for drug use more than once during pregnancy, non-judgemental counselling, and continuity of care throughout the perinatal period.

Smoking and vaping during pregnancy

Smoking tobacco while pregnant increases the risk of multiple complications, including low birth weight and stillbirth[10]. Smoking rates are higher in some populations, including adolescent women, First Nations women, women with a lower socioeconomic status, and women living in more remote locations[10]. Rates of vaping are rapidly increasing, with many women believing this is a safer alternative to smoking, however vaping during pregnancy also increases the likelihood of adverse perinatal outcomes[11]. Healthcare providers are significantly less likely to ask women about vaping and use of chewing tobacco than about smoking[12], despite the risks associated with this type of use. Smoking cessation interventions during pregnancy are effective at reducing smoking rates and adverse outcomes[10], however there are barriers to intervention, including the length of antenatal appointments[13].

Education and messaging about alcohol and other drugs during pregnancy and breastfeeding

Universal screening of pregnant women for drug and alcohol use is recommended, but screening is inconsistent, with tobacco the most frequently screened for[14]. Women often underreport current and past substance use[14]. Barriers to disclosure include fear of losing child custody, shame and stigma, and a perception of limited treatment options[15]. When substance use is identified in pregnancy, the most common intervention is written resources, which are commonly declined[14]. A systematic review identified 13 interventions which demonstrated effectiveness in reducing alcohol consumption during pregnancy[2]. Unfortunately, no effective interventions were identified by this review for reducing illicit drug use[2].

Women identify a lack of awareness or clear guidance about the effects of alcohol consumption in pregnancy, and confusion over whether there is a safe threshold for drinking during pregnancy, with some women receiving conflicting advice from healthcare providers, books and guidelines [3]. Less than half of all pregnant and breastfeeding women report receiving advice not to consume any alcohol from a healthcare provider[4]. Some healthcare professionals endorse or even advocate for moderate alcohol consumption during pregnancy, and alongside a lack of high-quality evidence about the effects of low levels of consumption, many women are confused about the accuracy of abstinence messaging[16]. Among the general population, 12.7% of people believe that occasional moderate consumption of alcohol while pregnant will not harm the baby, and 17.1% of people are not sure[4]. Public messaging about alcohol in pregnancy can be inconsistent. For instance, alcohol industry-funded organisations inaccurately represent the risks of consumption of alcohol during pregnancy[17]. There is clearly a considerable lack of effective public health campaigns and direct messaging from healthcare providers in relation to the risks of alcohol consumption while pregnant and breastfeeding. The National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028 notes the high percentage of women who are unaware of the dangers of drinking alcohol during pregnancy, and includes objectives to increase community awareness and to improve screening and support as priorities. The Strategic Plan also recommends that 'all health and human service education at under-graduate and post-graduate levels and in continuing professional

development courses include core competencies in the prevention, screening, diagnosis and management of FASD.' (page 36).

While it is important for education about the risks of drinking and consuming other substances to be provided during pregnancy, this is too late for this information to be provided for the first time. The preconception period is an important window of time, when the quality of the developing oocyte can be impacted by substance consumption. In addition, drinking and taking drugs during this time may result in drinking and drug taking in early pregnancy, before the pregnancy is confirmed. Very few women abstain from alcohol while trying to conceive[6]. In one study 85.3% of women who were actively trying to conceive reported consumption of alcohol, and 56.3% reported excessive consumption[18]. Two opportunities identified for education regarding preconception and pregnancy care are during appointments for sexual and reproductive healthcare, and as part of the secondary school curriculum[6].

Recommendations

- Increase pre-registration and continuing professional development education about FASD and alcohol consumption pre-conception and while pregnant or breastfeeding for healthcare providers.
- Introduce education about alcohol and drug use pre-conception and during pregnancy and breastfeeding into the secondary school curriculum.
- Include opportunistic pre-conception counselling in sexual and reproductive healthcare.
- Fund research to strengthen evidence around the risks of low levels of alcohol consumption during pregnancy.

Australian Government initiatives

The Australian Government's National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018-2028 (the Action Plan) provides an evidence-based roadmap for the prevention of FASD and support for individuals diagnosed with FASD, including targeted actions for priority populations such as First Nations communities and individuals in the criminal justice system. Recommended priority activities include public education campaigns. Given the continued concerning percentage of the population who do not understand the risks of drinking alcohol during pregnancy, this priority has not been effectively realised in the first six years of the Action Plan. The Action Plan also advocates for universal screening of pregnant women for alcohol use, yet less than half of pregnant women report receiving any advice in relation to drinking alcohol[4].

Australian Government initiatives include the Every Moment Matters and Strong Born campaigns, along with the associated health professional education. These programs have showed strong results on evaluation, with 67.2% of the Every Moment Matters campaign target audience recognising the campaign[19]. Over three years there were more than a million visits to the website, with an increase in understanding that there is no safe amount of alcohol during pregnancy among the general population, and 75% of respondents agreeing that the ads motivated them to abstain from alcohol when trying to conceive and when pregnant[19]. Health professional education had a positive impact on understanding and attitudes towards alcohol consumption during pregnancy, as well as intention to provide routine education to women[19]. The Strong Born campaign was similarly well received, with campaign materials translated into eight local languages, and increased staff and community awareness[19]. There were an estimated 2,002 fewer cases of FASD in 2023 as a result of the campaign[19]. Social return on investment for these campaigns is estimated to be $9 for every $1 invested[19].

The FASD Research Australia Centre of Research Excellence includes information for parents, educators, health professionals and researchers. It includes a services directory, events, and research. This is an important national resource and can be utilised to identify research gaps and ensure research is aligned with priorities.

Recommendations

- Provide ongoing funding for the successful Every Moment Matters campaign.

Midwifery Continuity of Care

Midwifery Continuity of Care (MCoC) is a maternity care model where women see the same midwife or small team of midwives throughout their perinatal experience. MCoC provides evidence-based, high quality, high value maternity care[20]. Women and babies experience reduced interventions and better outcomes, both physically and psychosocially[21-23]. MCoC improves satisfaction with the birthing experience and can reduce birth trauma[24]. Midwives are also more satisfied working in MCoC models[25, 26], with lower levels of burnout and psychological distress[27]. In addition, MCoC costs the healthcare system 22% less than other models of care [28]. Midwives provide MCoC in publicly funded models and in private practice. In remote areas where there is genuinely not a safe referral pathway for women experiencing intrapartum complications, an adapted MCoC model which excludes intrapartum care is an option which provides effective primary maternity care during the antenatal and postnatal period. This model of care, known as Maternal and Postnatal Service (MAPS), has demonstrated positive outcomes, is well received by women[20]. It is the ACMs position that the majority of women in Australia should be cared for in a full MCoC model, and we recommend all women for whom this service is not available should be offered care in a MAPS model. The ACM cautions against health services assuming MAPS is an acceptable replacement for full MCoC and defaulting to MAPS models of care due to assumptions about midwives' preferences or challenges setting up MCoC models.

As a relationship-based model of care, MCoC has the potential to reduce FASD and other substance use ill-effects, as women are more likely to disclose and seek support for substance use during pregnancy to a trusted caregiver[29]. In addition, education and advice are more likely to be consistent in a continuity model of care, and there is less risk of discussion topics being missed.

Endorsed midwives

Endorsed Midwives are midwives who have met the requirements of the Nursing and Midwifery Board of Australia to qualify to prescribe scheduled medicines. This means that they can provide primary maternity care services which meet all the perinatal needs of a well woman and baby. They can also provide care outside of the perinatal continuum, for instance in sexual and reproductive healthcare. Endorsed Midwives practice in public and private health services, in group practices, in General Practice clinics, and in private practice. Currently, there is no Medicare item claimable by endorsed midwives which can be accessed outside of maternity care. This is needed to enable midwives working in preconception care and other areas of sexual and reproductive healthcare.

Recommendations

- Ensure Midwifery Continuity of Care is available for all women in all settings.
- Introduce a Medicare general consult item available for endorsed midwives to access.

First Nations families - Birthing on Country / Birthing in our Community models

For First Nations women and babies, intrapartum care in their community is culturally important. Deep spiritual connection to their homeland is a part of their heritage, and ensuring their babies spiritual connection to the land by Birthing on Country is deeply significant[30]. In addition, Indigenous women often experience racism from health professionals, and travel to distant urban hospitals does not allow for inclusion of family support[30].

First Nations babies are twice as likely to be born preterm as non-Indigenous babies, which leads to increased morbidity and mortality rates[31] and Indigenous mothers are 2-3 times more likely to die in childbirth[32]. In the Birthing in Our Community model, designed by Mater Hospital, women are cared for by a midwife in a continuity of care relationship alongside a First Nations Family Support Worker. Care in this model has shown a 5.34% to 14.3% reduction in preterm births, along with a saving to the health care system of $4810 per mother-baby pair (in a 2023 study)[31].

First Nations women are more likely to smoke, drink alcohol and use other drugs while pregnant[33]. For example, 43% of First Nations mothers smoke during pregnancy, compared to 7.5% of non-Indigenous women[33]. A study exploring Aboriginal and Torres Strait Islander women's experience of receiving antenatal advice regarding alcohol consumption identified that they would prefer continuity of care models[34].

Case study: A 42-year-old woman with a history of ice and heroin use for over 15 years and in her current pregnancy was cared for by BiOC North. During her pregnancy, with the support of BiOC, she reduced her use and changed to suboxone. A healthy baby was born at term, and she is currently on suboxone treatment and not using illicit drugs.

Recommendations

- Upscale Birthing on Country / Birthing in our Community models of care for First Nations families

Jurisdictional perspectives

ACM state and territory branches provided feedback on local services and issues. Some jurisdictional examples are below.

Queensland

- Jurisdictional pockets of effective drug and alcohol support services exist in Queensland.
- There are limited inpatient detox services for pregnant individuals keen to access these services.
- Private options are available in QLD - these services are financially marginalising and unattainable without private health insurance.
- Some hospitals offer a MAPS or antenatal service tailored for women with substance-use issues, eg. CHAMP Clinic | Mater Mothers and Women's Alcohol & Drug Service (WADS) | The Royal Women's Hospital (thewomens.org.au)
- Very limited First Nations specific drug and alcohol services are available.
- Birthing in Our Community, a First Nations led service offers MCoC and wrap-around support for the first 2000 days to First Nations families. They support women experiencing drug and alcohol dependence and have demonstrated positive outcomes.

South Australia

- Screening of pregnant women for drug and alcohol use is inconsistent[14].
- Internal research shows that midwives do not feel equipped to ask the right questions about drug and alcohol use, or to provide the appropriate follow-up and referral regarding the information women share.
- Lack of sufficient knowledge is a major barrier to midwives referring women to services.
- Case note audit showed midwives rarely revisited smoking after the first visit, and there was rarely anything documented about other substances[14].

Western Australia

- There are specific services for women with drug and alcohol addiction, such as King Edward Memorial Hospital - Women and Newborn Drug and Alcohol Service (WANDAS) (health.wa.gov.au)
- The biggest issue in WA is it is very difficult to access these services due to the limited places in the services.

New South Wales

- Waminda, which supports First Nations families, has 20% of women using alcohol or other drugs in pregnancy. Successful smoking and vaping reduction and cessation rates.
- Challenges accessing mental health services when drug and alcohol use are also present.
- Women need to be admitted to access psychiatric review and many women decline admission.
- Lack of local psychiatric support leads to delays and missed intervention opportunities.

Recommendations

- Strengthen universal screening of pre-conception, pregnant and breastfeeding women in relation to consumption of alcohol and other drugs.
- Increase pre-registration and continuing professional development education for healthcare providers related to universal screening, available services, counselling and referral of women who disclose substance use.

Other considerations

Alcohol and drug use during pregnancy contributes to patient acuity and increases need for maternity care staffing. For instance, newborns of mothers who used substances during pregnancy require monitoring for withdrawal symptoms and may be admitted to special care units. Appropriate counselling and provision of interventions for mothers also require additional time. The recent Midwifery Futures Report found that the midwifery workforce is in crisis, and immediate change is needed. Under the current pressured workforce conditions, midwives do not always have the time to devote to psychosocial support and appropriate referral.

Many women with alcohol and / or other drug addictions also experience mental health challenges. Perinatal mental health units around the country are inadequate to meet demand. This can lead to delays in treatment and separation of mothers and babies.

Women who are incarcerated may be pregnant or breastfeeding, and may require access to perinatal healthcare and drug and alcohol support[35]. Babies of incarcerated pregnant women experience a significantly higher rate of adverse outcomes such as preterm birth[36]. Women in prison deserve equitable access to midwifery care and alcohol and other drug services, and should be cared for in an MCoC model.

Recommendations

- Increase perinatal mental health mother and baby units nationwide.
- Action the recommendations of the Midwifery Futures Report to urgently increase and strengthen the midwifery workforce.
- Prioritise a National Midwifery Workforce Strategy to address midwifery workforce crisis.
- Ensure MCoC for incarcerated pregnant and breastfeeding women.

Conclusion

Use of alcohol and other drugs while pregnant and breastfeeding is associated with adverse outcomes for both mothers and babies. Midwifery Continuity of Care is a priority for all Australian women, and especially for First Nations women and other priority populations. Increased education for both healthcare providers and women and families is vital to combat misinformation and ensure consistent messaging, especially about alcohol consumption. Actioning ACM's recommendations will improve support for women and families and reduce rates of alcohol and other drug use during pregnancy and breastfeeding.

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Consent to publish

ACM consents to this submission being published in its entirety, including names.

Consent to provide further information

ACM is available to provide further expert opinion and advice if required.

References

1. Nursing and Midwifery Board of Australia A. Nurse aand Midwife - Registration Data Table - June 2025 2025. Available from: https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx.
2. Fergie L, Campbell KA, Coleman-Haynes T, Ussher M, Cooper S, Coleman T. Identifying effective behavior change techniques for alcohol and illicit substance use during pregnancy: a systematic review. Annals of Behavioral Medicine. 2019;53(8):769-81.
3. Popova S, Dozet D, Akhand Laboni S, Brower K, Temple V. Why do women consume alcohol during pregnancy or while breastfeeding? Drug and alcohol review. 2022;41(4):759-77.
4. Welfare AIoHa. Pregnant and breastfeeding women's use of alcohol and other drugs 2024. Available from: https://www.aihw.gov.au/reports/alcohol/pregnant-breastfeeding-women-alcohol-drugs#Alcohol-consumption.
5. Popova S, Lange S, Shield K, Burd L, Rehm J. Prevalence of fetal alcohol spectrum disorder among special subpopulations: a systematic review and meta-analysis. Addiction. 2019;114(7):1150-72.
6. Smith L, Hilton A, Walker J, Alfred L, Ahankari A, Schölin L. Prevention of alcohol related harm though preconception care: A scoping review of barriers and enablers. Dialogues in Health. 2022;1:100040.
7. Conigrave KM, Ali RL, Armstrong R, Chikritzhs TN, d'Abbs P, Harris MF, et al. Revision of the Australian guidelines to reduce health risks from drinking alcohol. Medical Journal of Australia. 2021;215(11):518-24.
8. Government A. National Drug Strategy Household Survey detailed report. 2013.
9. Guidelines APC. 6.5 Substance Use 2024. Available from: https://app.magicapp.org/#/guideline/jm83RE/section/nyqyKx.
10. Guidelines APC. 6.2 Tobacco Smoking 2024. Available from: https://app.magicapp.org/#/guideline/jm83RE/section/nyqyKx.
11. Nagpal TS, Green CR, Cook JL. Vaping During Pregnancy: What Are the Potential Health Outcomes and Perceptions Pregnant Women Have? Journal of Obstetrics and Gynaecology Canada. 2021;43(2):219-26.
12. Gould GS, Zeev YB, Tywman L, Oldmeadow C, Chiu S, Clarke M, et al. Do clinicians ask pregnant women about exposures to tobacco and cannabis smoking, second-hand-smoke and e-cigarettes? An Australian national cross-sectional survey. International Journal of Environmental Research and Public Health. 2017;14(12):1585.
13. Salisbury J, Gibson I, Woldring A. Moving Preventive Health in Midwifery forward: Supporting antenatal teams to implement the" Reducing the effects of smoking and vaping on pregnancy and newborn outcomes" policy directive across NSW. Women and Birth. 2024;37.
14. Stevens MW, Cooper M, Cusack L, Ali RL, Holmwood C, Briley AL. Screening and early intervention for substance use during pregnancy: A retrospective case note review of antenatal care records. Drug and Alcohol Review. 2024;43(7):1817-28.
15. Oni HT, Drake JA, Dietze P, Higgs P, Islam MM. Barriers to women's disclosure of and treatment for substance use during pregnancy: A qualitative study. Women and Birth. 2022;35(6):576-81.
16. Lyall V, Wolfson L, Reid N, Poole N, Moritz KM, Egert S, et al. " The Problem Is that We Hear a Bit of Everything horizontal ellipsis": A Qualitative Systematic Review of Factors Associated with Alcohol Use, Reduction, and Abstinence in Pregnancy. INTERNATIONAL JOURNAL OF ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH. 2021;18(7).
17. Lim AW, Van Schalkwyk MC, Maani Hessari N, Petticrew MP. Pregnancy, fertility, breastfeeding, and alcohol consumption: an analysis of framing and completeness of information disseminated by alcohol industry–funded organizations. Journal of studies on alcohol and drugs. 2019;80(5):524-33.
18. Chivers BR, Boyle JA, Lang AY, Teede HJ, Moran LJ, Harrison CL. Preconception health and lifestyle behaviours of women planning a pregnancy: a cross-sectional study. Journal of clinical medicine. 2020;9(6):1701.
19. Education FfARa. Evaluation Summary Report: National Awareness Campaign on Alcohol, Pregnancy, Breastfeeding and Fetal Alcohol Spectrum Disorder. 2024.
20. Cummins A, Griew K, Devonport C, Ebbett W, Catling C, Baird K. Exploring the value and acceptability of an antenatal and postnatal midwifery continuity of care model to women and midwives, using the Quality Maternal Newborn Care Framework. Women and Birth. 2022;35(1):59-69.
21. Sandall J, Sandall J, Fernandez Turienzo C, Devane D, Soltani H, Gillespie P, et al. Midwife continuity of care models versus other models of care for childbearing women. Cochrane database of systematic reviews. 2024;2024(5):CD004667-CD.
22. Gamble J, Browne J, Creedy DK. Hospital accreditation: Driving best outcomes through continuity of midwifery care? A scoping review. Women and Birth. 2021;34(2):113-21.
23. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane database of systematic reviews. 2016(4).
24. Tafe A, Cummins A, Catling C. Exploring women's experiences in a midwifery continuity of care model following a traumatic birth. Women and Birth. 2023;36(4):e421-e7.
25. Pace CA, Crowther S, Lau A. Midwife experiences of providing continuity of carer: A qualitative systematic review. Women and Birth. 2022;35(3):e221-e32.

26. Dawson K, Newton M, Forster D, McLachlan H. Comparing caseload and non-caseload midwives' burnout levels and professional attitudes: a national, cross-sectional survey of Australian midwives working in the public maternity system. Midwifery. 2018;63:60-7.
27. Fenwick J, Sidebotham M, Gamble J, Creedy DK. The emotional and professional wellbeing of Australian midwives: a comparison between those providing continuity of midwifery care and those not providing continuity. Women and Birth. 2018;31(1):38-43.
28. Callander EJ, Slavin V, Gamble J, Creedy DK, Brittain H. Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery. International Journal for Quality in Health Care. 2021;33(2):mzab084.
29. Reid N, Gamble J, Creedy DK, Finlay-Jones A. Benefits of caseload midwifery to prevent fetal alcohol spectrum disorder: A discussion paper. Women and Birth. 2019;32(1):3-5.
30. Buzzacott C. Birthing on country report. Australian Midwifery News. 2019;19(1):11-2.
31. Gao Y, Roe Y, Hickey S, Chadha A, Kruske S, Nelson C, et al. Birthing on country service compared to standard care for First Nations Australians: a cost-effectiveness analysis from a health system perspective. The Lancet Regional Health–Western Pacific. 2023;34.
32. Government A. Birthing healthy and strong babies on Country. Australian Government Department of Health and Aged Care; 2023.
33. Welfare AIoHa. Aboriginal and Torres Strait Islander mothers and babies 2023. Available from: https://www.aihw.gov.au/reports/mothers-babies/indigenous-mothers-babies/contents/antenatal-period/risk-factors.
34. Brett K, Doherty E, Riley N, Nean A, Kingsland M, Wiggers J, et al. Antenatal care assessing and addressing alcohol consumption during pregnancy: A qualitative study of Aboriginal women's experiences and strategies for culturally appropriate care in an Australian local health district. First Nations Health and Wellbeing-The Lowitja Journal. 2024;2:100022.