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Committee Secretary
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
George St. BRISBANE QLD 4000
By Email: health@parliament.qld.gov.au

Wednesday 5th September 2018

Dear Committee members,

Re: TERMINATION OF PREGNANCY BILL 2018

Thank you for the opportunity to comment on this landmark Bill.

I have no legal training, but my experience may be helpful in the Committee's deliberations. I was a clinical psychologist for 35 years before retiring last year. Twenty-six of those years I worked as the clinical psychologist at the Victorian abortion providing clinic, The Fertility Control Clinic. Related to safe access, both The Victorian Human Rights Law Centre (VHRLC) and Maurice Blackburn Lawyers represented the Fertility Control Clinic in a Supreme Court action, and Maurice Blackburn is representing the Fertility Control Clinic as amicus curiae in the High Court challenge to Victoria's 2015 Safe Access Zone legislation. Both HRLC and Maurice Blackburn Lawyers are expert in safe access zone legislation, and I respectfully recommend their submissions to The Committee.

In Victoria I was actively involved in research, advocacy and advice around the abortion decriminalisation (2008) and the safe access zone (2015) legislations. I am still involved with the High Court challenge to the Victorian (and Tasmanian) safe access zone legislation. On behalf of The Fertility Control Clinic I prepared submissions to abortion decriminalisation and safe access zone legislation in Victoria, Tasmania, and the ACT. On behalf of the Australian Clinical Psychologist Association (ACPA), I prepared a submission in response to 2016 Queensland Law Reform questions about abortion decriminalisation.

I have been a member of various Victorian abortion advisory, reference and working groups with various organizations including: Abortion Law Reform Association; Women's Health Victoria Abortion Working group; The Women's Hospital Pregnancy Advisory Service; University of Melbourne Key Centre for Women's Health in Society; University of Melbourne Centre for Excellence in Rural Sexual Health; and the Department of Health & Human Services. I was a Board member of Family Planning Victoria, an honorary clinical fellow of the University of Melbourne, and supervised Masters and Doctorate students, psychologists and other counsellors in abortion-related counselling and research at The Fertility Control Clinic, The Women's Hospital, Family Planning Victoria and elsewhere.

My 1999 PhD investigated psychological and emotional variables associated with women's abortion decision making and outcomes. I have spoken widely about

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abortion. I have numerous abortion related articles in peer reviewed and other journals (included as Appendix A), including a chapter on abortion in the 2009 World Health Organisation publication, *Mental Health Aspects of Women's Reproductive Health: A Global Review of the Literature*.

I congratulate all those who have worked to produce the Termination of Pregnancy Bill 2018. The Bill is underpinned by a recognition of: abortion as an essential part of women's reproductive health care; respect for women's decision-making capacity throughout pregnancy; confidence in registered health professionals and their existing legal, ethical and professional health care guidelines; the importance of ensuring that when accessing abortion women's wellbeing and safety are protected, and their dignity and privacy respected, and; related legislative lessons and progress in other Australian states. I do wish to bring to your attention several points:

Part 2, 5 - 10 is sensible, generally supports women as decision makers about their own health and bodies within a doctor-patient relationship, and supports the legal, professional and ethical obligations of registered health professionals. The Bill recognises the reality that women: do not plan, or wish, to become pregnant under circumstances where ultimately they decide on abortion; when a problem pregnancy does occur, women prefer to reach a decision in the early stages of pregnancy (approximately 95% of pregnancy terminations are before 12 weeks gestation), and; improving abortion access does not result in a rise in pregnancy terminations, but rather, results in earlier and better health care and outcomes for women including improved reproductive health, mental health and future contraception.

6 - 9 are generally respectful and realistic about the sad complexities for women undergoing a pregnancy termination performed by a medical practitioner after 22 weeks gestation. Such terminations represent a fraction of 1% of pregnancy terminations overall and are described as "rare" by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

6(3), 23(1), 23(3): I respectfully recommend that the Bill deletes the term "unborn child" and instead uses the correct medical term, that is, "embryo or fetus". The term "unborn child" has a long history of use by people intent on preventing women's access to safe, timely and affordable abortion and contraception. It is a term used to prioritise the continuation of a pregnancy over the health needs and wishes of a pregnant woman, and to endow and prioritise "personhood" of a pregnancy/embryo/ fetus over the obvious personhood of a pregnant woman. For a minority of women, "unborn child" will reflect that woman's view of her pregnancy, and that then needs to be respected within the patient-health professional relationship. But this important Bill should not use this non-medical term.

8 provides conscientious objection obligations which are crucial to minimise harmful shaming, discrimination and healthcare delays for women requesting abortion.

Part 4, Safe Access Zones (of 150 metres) is to be welcomed as it seeks to ensure that women can enact a variety of human rights (to which international declarations Australia is a signatory) and access abortion providing services without being impeded, harassed or shamed, and with dignity, privacy and safety.

15 (1) (c): I am concerned however about the phrase 'reasonably likely to deter'. I do not know the legal definition of 'deter', but as I discuss below, I am concerned that it may undermine the Safe Access Zone legislation fulfilling its purpose.

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One of the most important benefits of Safe Access Zone legislation (in addition to its obvious aim to prevent harm to women and staff) is that court proceedings against someone who breaches the zone do not require a patient to testify. Rather, the prohibited behaviours are clearly drawn. The Court can also draw on expert testimony and a ready body of evidence.

The term 'deter' is not one usually sighted in the body of research into the deleterious impact on a woman of anti-abortion activists outside a health service she wishes to access. Safe Access Zone legislation is predicated on a considerable history of anti-abortion harassment of women and its harmful impact documented in rigorous and anecdotal research both in Australia and overseas. While anti-abortion protesters describe themselves as 'helping' women, rigorous research (Astbury & Allanson, 2009; Humphries, 2011; Major & O'Brien, 2005) indicates that women perceive their behaviour as intimidating and distressing, during what is often already a difficult time. Robust psychological measures have indicated increased anxiety and other negative emotions for women faced with an anti-abortion presence. I refer you to the ACPA submission emphasising harassment, intimidation and shaming of women by anti-abortion activists as a form of violence against women with documented harm for women's physical and emotional well-being. Appendix B is a summary of Alexandra Humphries (2011) research carried out at the Fertility Control Clinic.

The Committee will be well aware that the impact of anti-abortion behaviour outside abortion providers can be especially harmful to women who are suffering, or have suffered, physical or sexual abuse, mental ill health, disability, or a range of other personally difficult circumstances. In trying to avoid the anti-abortion protesters, a minority of women have faced delays in their health care, or have not returned for important follow up appointments. However, despite the distressing barrier of the protesters, women are determined to attend the Fertility Control Clinic for abortion and other reproductive health services. Abortion's dark history of backyard abortion speaks to women's desperation to access abortion no matter the various barriers, their distress or the appalling prospect of death.

As part of the Fertility Control Clinic's Supreme Court action against Melbourne City Council for its refusal to deal with the noxious nuisance of anti-abortion harassment, in July 2014 Consultant Psychiatrist, Dr Gregory White, examined four staff members, including me. Dr White's report was accepted into evidence by the Supreme Court and was not disputed by Melbourne City Council. Dr White's summary includes the following:

> "The four employees of the Fertility Control Clinic assessed by this examiner have each described in detail their experiences in relation to reported activities of protestors, namely members of the Helpers of God's Precious Infants (HOGPI) outside the Fertility Control Clinic six days a week.
> …there were marked similarities in terms of their perceptions regarding bullying, harassment and threatening behaviours towards patients and staff at the Fertility Control Clinic….common themes include symptoms of heightened physiological arousal, as well as frustration, and periods of significant emotional distress and/or anxiety.
> Despite appearing to be professionally dedicated and to hold strong beliefs about their roles in caring for and providing a safe and supportive environment for their patients, as reflected in the longevity of their tenures at the FCC, they report having experienced strong feelings of powerlessness in relation to the HOGPI protestors' activities.

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> Their fear and hypervigilance has particularly been relevant, in so far as three of the individuals were employed at the Fertility Control Clinic at the time of the traumatic murder of a security guard eleven years ago by an anti-abortion activist…."

At the Fertility Control Clinic, Police convictions against anti-abortion protesters have included assault, obscenity, threat to kill, and murder. But none of this police action made any difference to women being harassed, intimidated and impeded by displays, praying, comments, threats, misinformation, being photographed, blocked or stalked outside the Fertility Control Clinic.

The enforcement by police of Victoria's Safe Access Zone legislation in May 2016, however, was like a switch being flicked. Apart from the one person who challenged the law to the point of conviction, appeal, conviction and now a High Court challenge, there has been no further harassment of patients and staff. Safe Access Zones work.

The phrase 'reasonably likely to deter' may undermine the intent of the Queensland legislation. I appreciate that much thought has gone into the wording of the legislation, but I respectfully urge the Committee to pay particular attention to any advice about this particular matter contained in the submissions from the Human Rights Law Centre and Maurice Blackburn Lawyers, and to consider the wording of prohibited conduct in the Victorian legislation.

14 provides the option for the Minister to recommend to the Governor in Council the making of a regulation to increase or reduce the 150m safe access zone, having regard to the purpose of the safe access zone. I understand that neither international nor other Australian states' safe access legislation specifies an ongoing role for the Minister of the day. I remain concerned about the possible untested and unexpected adverse consequences, particularly with the long history of abortion stigma and the apparent growth of political factions holding more extreme religious views. Again, submissions from the Human Rights Law Centre and Maurice Blackburn Lawyers may be most helpful here.

In conclusion I congratulate those who worked towards the Bill, and hope that my comments may contribute to enacting robust and effective legislation.

I am happy to clarify any aspects of my submission.

Yours sincerely,

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APPENDIX A

Publications

Allanson, S. (2008) Watch your language: Abortion, stigma and murder. *Health Issues*, *91,* Journal of the Health Issues Centre, 21-24.

Allanson, S. (2007) The abortion decision and ambivalence: Insights via an abortion decision balance sheet. *Clinical Psychologist, 11*(2), 50-60.

Allanson, S. (2007) Pregnancy/Abortion counselling: False providers, mandatory counselling, ultrasound & "cooling off". *Women Against Violence, 19,* 5-9.

Allanson, S. (2006) *Murder On His Mind*. Melbourne: Wilkinson Publishing.

Allanson, S (1997) Women's abortion decision making and adjustment: New perspectives. *Proceedings of Abortion Providers of Australasia/Royal Women's Hospital Conference: Sex. Lies & Dilemmas.* October 11-12, Melbourne

Allanson, S. (1999) *The abortion decision: fantasy, attachment and outcomes*. Melbourne: University of Melbourne (unpublished PhD dissertation).

Allanson, S. (1994) De-bunking the myths of abortion recipients, *Proceedings of Abortion Providers of Australasia/Preterm Foundation Conference*, November 12-13, 27-35, Sydney.

Allanson, S. (1994) Debunking myths about abortion recipients: The Therapeutic value of informing the patient. *Proceedings of The Australian Society for Psychosomatic Obstetrics & Gynaecology 21st Annual Congress*, October 21-23, Sydney.

Allanson, S. & Astbury, J. (2001) Attachment style and broken attachments: Violence, pregnancy and abortion. *Australian Journal of Psychology*, *53*(3)

Allanson, S. & Astbury, J. (1996). The abortion decision: Fantasy processes. *Journal of Psychosomatic Obstetrics & Gynaecology, 17*, 158-167.

Allanson, S. & Astbury, J. (1995). The abortion decision: Reasons and ambivalence. *Journal of Psychosomatic Obstetrics & Gynaecology, 16(3*), 123-136.

Astbury, J., & Allanson S. (2009) Psychosocial aspects of fertility regulation. In World Health Organization & United Nations Population Fund (Eds) *Mental Health Aspects of Women's Reproductive Health: A Global Review of the Literature*. Geneva: WHO, pp 44-66.

Dean, R. E. & Allanson, S. J.(2004) Abortion in Australia: Access versus protest Law & Medicine, 11(4), 510-515.

Sample of Conference Presentations:

Decentralising Abortion Services. A case study of collaboration in rural Victoria. Presented to National STI conference November 2016 by K Stephens. Stephens K[1], Hardiman A[2], Allanson S[3], Steele A[4], P Moore[21] (Centre for Excellence in Rural Sexual Health, The University of Melbourne; [2]The Royal Women's Hospital, Melbourne; [3] Fertility Control Clinic, Melbourne, [4] Family Planning Victoria.)

Abortion access versus anti-choice nuisance: Supreme Court action update. *Second National Sexual & Reproductive Health Conference*, PHAA, November 2014

Reproduction and women's mental health: Abortion. *3rd International Congress on Women's Mental Health*, March 19, 2008, Melbourne.

Violence, attachment style and the decision to terminate a pregnancy. *Paper presented at the Biennial meeting of the Marce Society*, June 24-28, 1998, Iowa City, USA. Presented by Jill Astbury on behalf of J. Astbury & S. Allanson.

Women's abortion decision making and adjustment: New perspectives. *Abortion Providers of Australasia/Royal Women's Hospital Conference: Sex. Lies & Dilemmas.* October 11-12, 1997, Melbourne.

Unplanned pregnancies: Debunking the myths. *A hard Choice: Services for Women dealing with unplanned pregnancies, The Royal Women's Hospital,* November 21, 1995, Melbourne.

Debunking myths about abortion recipients: The Therapeutic value of informing the patient. *Abortion Providers' Federation of Australasia/Preterm Foundation Conference,* November 12-13, 1994, Sydney & *The Australian Society for Psychosomatic Obstetrics & Gynaecology 21st Annual Congress*, October 21-23, 1994, Sydney.

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APPENDIX B

PICKETERS ADVERSE IMPACTON WOMEN ATTENDING FFC IN 2010

This summary prepared by Susie Allanson 2011 of Findings from: Humphries, A (2011) *Stigma, Secrecy and Anxiety in Women Attending for an Early Abortion.* Masters Thesis, University of Melbourne

Participants were 158 pregnant women who attended the Fertility Control Clinic in East Melbourne in 2010 for an early (less than 12 weeks) pregnancy termination for psychosocial reasons. Participants ranged in age from 18 to 42 years with a mean age of 26.25 years.The five to ten minute suction-curettage abortion was performed under general anesthetic on the same day following their initial consultations. Of the 158 participants, **135 were exposed to the picketers** (while the others avoided the picketers by entering through the FCC staff entrance at the rear).

Using tick box categories (devised by the researcher) of women's exposure to protesters, 14.6% of the 158 women (*n* = 23) reported having no exposure to the picketers. **85.4% (*n* = 135) reported having seen the picketers** outside the front of the clinic, **55.1% (*n* = 87) reported that the picketers had said things to them**, **74.7% (*n* = 118) reported that they had seen anti-abortion displays** such as posters and props, **60.1% (*n* = 95) of women reported that the picketers had tried to hand them anti-abortion information**, and **20.3% (*n* = 32) of women reported that the picketers had attempted to block their entry into the clinic**. Of the 135 women who reported having been exposed to the picketers, 132 women reported experiencing **two or more forms of exposure.**

131 of the women exposed to the picketers correctly completed the Positive and Negative Affect Scale (PANAS) to indicate how they felt when they were confronted by the picketers. The PANAS consists of 10 positive affect words (eg. strong, proud, determined) and 10 negative affect words (eg. upset, guilty, scared). Following the statement, *when I was confronted with anti-abortion protestors today I felt….,* participants were instructed to rate each feeling word on a 5-point Likert scale ranging from (1) very slightly or not at all, to (5) extremely.

The mean score for the PANAS-negative affect indicated considerable distress in participants when exposed to the picketers. The mean score was more than two standard deviations higher than the mean negative affect rated for present moment experience in normative samples, and was comparable to psychiatric samples (Crawford & Henry, 2004; Watson et al., 1988). The mean score for PANAS-positive affect experienced in women when confronted with the picketers was well below the midpoint of the scale in this sample, and was less than half the mean score for present moment positive affect in normative samples (Crawford & Henry, 2004; Watson et al., 1988).

Higher levels of pre-abortion anxiety were associated with having more exposure to the anti-abortion picketers.

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Higher levels of pre-abortion anxiety were associated with experiencing more negative affect in response to the anti-abortion picketers (such as higher levels of guilt, shame, and hostility).

When asked whether participants felt personally stigmatized by their decision to have an abortion, 14.6% (*n* = 23) responded 'very much so', 24.7% (*n* = 39) responded 'moderately so', 31.6% (*n* = 50) responded 'somewhat', and 29.1% (*n* = 46) responded 'not at all'.

Women were asked to indicate how much they believe having an abortion is stigmatized by various selected options. The results are presented below in table 4.

Table 1
Percentage Statistics for Sources of Perceived Abortion Stigma

Is abortion stigmatized by:	Very Much So (%)	Moderately So (%)	Somewhat (%)	Not At All (%)
The picketers	**77.8**	**3.8**	**5.1**	**13.3**
Allowing protesting at the clinic	**70.9**	**10.8**	**10.1**	**8.2**
Religious groups	53.8	19.6	12	14.6
Society	21.5	29.1	32.9	16.5
The media	11.4	33.5	36.7	18.4
Your family	20.9	18.4	29.7	31
The partner in the pregnancy	5.1	10.1	24.7	60.1
Your friends	5.7	17.1	39.2	38
The healthcare system	5.1	17.1	32.9	44.9

% of *n* = 158

Table 1 indicates that participants **perceived the greatest amount of stigma related to having an abortion to come from the picketers, and from the picketers being allowed to protest outside the front of the clinic**. Women reported feeling the least stigmatized by the partner in the pregnancy, their friends, and by the healthcare system.

Higher overall ratings of perceived abortion stigma were associated with having more secrecy and disclosure concerns about having an abortion (ie women feeling that they could not tell anybody about their pregnancy or abortion), **which in turn was found to undermine women's well being.**

The findings supported the validity of considering the **anti-abortion picketers as a form of enacted abortion stigma.** Enacted stigma may function in opposition to the protective qualities of social support, by leading women to feel the need to keep their abortion secret. In addition, concerns about disclosing to others that one is planning an abortion and engaging in secrecy behaviour may lead to an increase in intrusive thoughts related to having an abortion and consequently, an increase in attempts to suppress the intrusions. The more one attempts to suppress the intrusions the more they may increase in frequency and in turn lead to heightened anxiety.