

Guidelines for Professional Standards of Practice Infertility Counselling

AUSTRALIA AND NEW ZEALAND INFERTILITY COUNSELLORS ASSOCIATION [ANZICA]

**A Sub-committee of the
Fertility Society of Australia**

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SECTION 1 COUNSELLING & INFERTILITY TREATMENT

PREAMBLE: The laws, and regulations, relating to the treatment of infertility differ for each Australian state/territory and New Zealand. It is the responsibility of individual infertility counsellors to be fully aware of the laws and regulations of their jurisdiction.

Mission Statement

ANZICA (Australia and New Zealand Infertility Counsellors Association) is the peak professional Australian and New Zealand counselling organisation dedicated to promoting the psychological and social wellbeing of individuals and couples undergoing fertility treatment. Consideration of the best interests of the child to be born from all ART techniques, is paramount and a fundamental principle guiding both counselling practice and process.

1.1 GENERAL PARAMETERS

Infertility counselling is a specialist form of counselling. Infertility counsellors are tertiary trained with a primary qualification in social work, psychology, or psychiatry. They should be eligible for full membership of their appropriate professional association and/or registered to practice within their state (or equivalent jurisdiction). ANZICA (Australian and New Zealand Infertility Counsellors Association) is the professional association for infertility counsellors practising in Australia and New Zealand. It is incumbent on all infertility counsellors to have and maintain a comprehensive knowledge of the contemporary human reproductive technologies, the legislative frameworks within which the technologies are practised, and the emotional/ psychological experiences and needs of infertility patients and other relevant third parties. It is strongly recommended that all counsellors have access to regular individual, group or peer supervision. Where possible, this should be with someone with experience or knowledge of this field.

Assisted Reproductive Treatment (ART) clinics are required to engage the services of at least one suitably qualified, accredited and affiliated infertility counsellor. (The National Health and Medical Research Council (NHMRC) Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research and the FSA (Fertility Society of Australia) through RTAC COP (Reproductive Technology Accreditation Committee Code of Practice – revised October 2017). The RTAC COP requires the senior counsellor to meet full requirements for membership of ANZICA. Infertility counsellors may be employed by the Assisted Reproductive Treatment unit or may be engaged on a sessional/ contractual basis. In addition to being eligible for membership of ANZICA, in some states, (e.g. at the time of writing - WA) legislation requires all counsellors undertaking fertility counselling to have specific approval for use of the title “Approved Counsellor” under the Human Reproductive Technology Act WA (1991).

Infertility counsellors may also practise independently in the community as private practitioners, through generic medical practices, or attached to other specialist services. Regulatory provisions and legislation in most states require that all persons requiring assisted reproductive treatment have access to counselling support with a counsellor and at a time which best suits their needs. For example, the NHMRC Guidelines specify that, *‘Clinics must provide readily accessible services from accredited counsellors to support participants in making decisions about their treatment, before, during and after the procedures’*.

It is a requirement of the RTAC COP that all parties involved in third party reproduction have counselling prior to commencing treatment. For known donation, RTAC requires an additional joint session involving all parties must be undertaken prior to the signing of consents.

In order to make infertility counselling accessible to all who require it, it is important that it is available in various modalities (singularly or in combination). These include face-to-face counselling, Skype, telephone counselling, and support groups (professionally facilitated). Counsellors also use resources such as written and video presentations and e-mail. Counselling may be with an individual or a couple. Group counselling may be considered as an additional service but not replace counselling with individuals/couples.

Whilst a mandate for assessment for suitability for treatment per se does not exist, counsellors in the course of their work may identify significant ‘risk factors’ e.g. serious mental health issues, cognitive impairment or family violence. In such circumstances and based on standards of good professional practice, these risk factors may require a counsellor to assess the risks and make a clinical judgement regarding suitability for treatment at this particular point in time. This should be done in collaboration with relevant clinic staff wherever possible.

The NHMRC guidelines state:

‘Assisted reproductive technology (ART) procedures must be conducted in a way that is respectful of all involved. Clinical decisions must respect, primarily, the interests and welfare of the persons who may be born, as well as the long term health and psychological welfare of all participants including gamete donors’

1.2 TYPES OF COUNSELLING

It is generally understood that there are different forms of counselling that can be provided in conjunction with infertility treatment. These are: psychoeducational counselling; implications counselling; decision making counselling; supportive counselling; crisis counselling and therapeutic counselling.

1.2.1 PSYCHOEDUCATIONAL/IMPLICATIONS COUNSELLING

Implications counselling prior to the commencement of ART treatment is primarily ‘psychoeducational’. This is an opportunity to ensure that the patient(s) understand the possible consequences of the

proposed treatment for themselves, their relationships, family and any child born as a result of treatment. It is important that patients' concerns/questions are addressed, in addition to the counsellor providing relevant information. In the case of third party reproduction, the counselling focuses on the implications of this treatment and its outcomes for all parties (see SECTION 2).

Specifically, the counsellors' tasks are to:

- acknowledge the impact and meaning of a diagnosis of infertility and the need for assisted reproductive treatment for the patient(s)
- establish rapport if further counselling is necessary
- assist with the clarification of the potential impact of the proposed treatment (particularly psychosocial)
- identify the more demanding aspects of treatment
- address any concerns the patient/s may have
- identify any risk factors for the patients e.g. mental health history
- provide supplementary information and resources as appropriate
- encourage patients to develop realistic expectations about the outcome of treatment
- promote discussion about appropriate coping strategies
- support and enhance the patients' capacity for decision making in relation to treatment
- assist patients to understand the legal framework and limitations within which fertility treatment is available
- provide information regarding lifestyle factors impacting on fertility
- describe the role and availability of the counsellor in the clinic
- provide referral as appropriate.

1.2.2 DECISION MAKING COUNSELLING

Counselling should be available to patients at significant points in their decision making regarding management of ART treatment. The counsellor's role is to enhance the patients' capacity for informed decision making in relation to treatment and in particular to reflect on the short and long-term psychological implications of the decision.

Points for decision making counselling might include:

- consideration of undertaking treatment involving third parties to the treatment (see Section 2),
- deciding when to end treatment.
- decision-making regarding unused embryos.

1.2.3 SUPPORTIVE COUNSELLING

Supportive counselling can be provided at any phase of the treatment process. The primary purpose is to provide emotional/ psychological support to assist patients to better deal with the experience and/or consequences of their treatment. Support counselling may be brief or longer term. During these sessions the counsellor will assist the patient(s) to mobilise their own resources. Common support provided includes:

- assistance with coping with non-pregnancy cycles/treatment failure

- facilitating cognitive and affective shifts so that patients can better manage the emotional and physical demands of treatment
- (e.g. balancing failure, fear and hope; regaining a positive attitude)
- reviewing and developing stress management/coping skills and self-care strategies
- preparing for childbirth.

1.2.4 CRISIS COUNSELLING

Counselling must be available to patients who experience a crisis or adverse outcome whilst undertaking ART treatment. Common reasons for seeking crisis counselling are:

- unexpected outcome of treatment e.g. no fertilisation, cycle cancellation, biochemical pregnancy
- pregnancy loss -miscarriage/ stillbirth
- relationship issues e.g. relationship breakdown, family violence, partner refuses to continue treatment
- mental health crisis

1.2.5 THERAPEUTIC COUNSELLING

Therapeutic counselling is most often concerned with the more pervasive, disturbing and distressing consequences of both infertility and fertility treatment. Therapeutic counselling assists patients to address their distress and facilitate movement toward adjustment, resolution and/or acceptance.

Common antecedents for seeking therapeutic counselling are:

- clinical disorders such as depression, anxiety and panic states
- marital/ relationship difficulties, including sexual difficulties and dysfunction
- grief and loss issues related to infertility, pregnancy loss, repeated treatment failure
- preparing for and adjusting to ceasing treatment and planning for the future
- preparing for and adjusting to parenthood after a long period of infertility. This may include adjusting to parenting a child conceived with donor gametes.

A range of models have been applied to Therapeutic Counselling for infertility patients. These have been shaped by a variety of theoretical frameworks including cognitive behavioural techniques, problem solving approaches, experiential grief counselling, brief therapy and solution focussed models, crisis intervention, relationship/ marital therapies and more psychodynamically oriented psychotherapy.

1.3 PARTICULAR ISSUES

1.3.1 CONCLUDING TREATMENT, WITHOUT ACHIEVING PREGNANCY

The decision to conclude treatment where the patient(s) have not been successful in achieving a pregnancy is usually a very difficult and may be a protracted decision-making process. Issues which may need to be addressed are:

- Ending treatment despite the continuing availability of treatment which could offer the chance of a pregnancy
- Exploring the meaning of the loss/end of a significant life goal. Facilitating the patient(s)' emotional responses to this loss and their movement toward alternative life goals
- Addressing any differences between partners readiness to conclude treatment
- Assisting patients to explore other options to achieve parenthood or exit treatment.

1.3.2 FERTILITY TREATMENT & PREGNANCY LOSS

The emotional experiences and needs of infertility patients who lose a pregnancy that they achieved through fertility treatment are often intense and complex. Issues to be addressed in counselling may include:

- The need for patients to actively grieve their loss, adopt effective self-care strategies, elicit appropriate support and make decisions re future treatment
- Variable responses between partners to their loss; this can lead to experiences of being misunderstood by the other, a perceived lack of support by one partner and a loss of intimacy.

1.3.3 PREGNANCY AFTER TREATMENT

Some patients may struggle to make the transition to pregnancy, especially after a difficult and lengthy period of treatment. Examples of the type of issues that they may need to address are:

- Dealing with the multiplicity of emotions, in the early stages after the patient(s) first learn of the pregnancy (e.g. joy and excitement, disbelief and ambivalence, apprehension and fear, "infertile" now pregnant)
- Facilitating role transitions and managing/adjusting to the different demands and experiences of the different roles (e.g. no longer attending the fertility clinic and accessing the supports available in that context)
- Addressing relationship issues that may have arisen as a result of treatment
- Addressing concerns about the patient(s) future ability to parent
- If the patient is single, implications of being a solo mother
- If a donor has been used the implications of using a donor often start to really sink in including issues such as parenting a child who is not genetically connected, how to talk to the child, possible contact with the donor and telling others (see Section 2).

1.3.4 MULTIPLE PREGNANCY

Multiple pregnancy rates have significantly reduced with single embryo transfers. However, when they occur, patients vary in their responses to the news of a multiple pregnancy. Patients who are distressed and experiencing difficulties adjusting to the reality of a multiple pregnancy may present for counselling. Typical issues for this patient group include:

- Adjusting to the medical realities of a "high risk" pregnancy, the ante natal and post-natal implications, for the mother and the babies
- Preparing for parenting children of the same age and the emotional, practical, physical and financial implications for the couple/parent
- Preparing emotionally for a 'high risk" pregnancy

- Gauging history of significant mental health concerns as a risk factor for pregnancy and postnatal experiences.

1.3.5 PGD & PGS

Patients at clinics may have Preimplantation Genetic Screening/Testing/Diagnosis as a part of their IVF cycle. In some cases, this will be the primary reason for the IVF, in others it will be to maximise the efficacy of treatment. Examples of the type of issues that they may need to address are:

- Reason for genetic screening and background to treatment
- Diagnosis
- Reactions: Opportunities to explore impact of diagnosis.
- Losses associated with medical condition
- Support system regarding proposed treatment
- Intention to tell others, anticipated reactions
- Understanding and expectations of testing and its limitations.

1.3.6 FERTILITY PRESERVATION

Patients may preserve gametes due to a medical diagnosis (e.g. cancer, transgender preservation) or for elective reasons. It is important to discuss:

- Reason and motivation for preservation
- Possible outcomes of treatment
- Manage expectations of preservation
- Treatment alternatives e.g. donor sperm treatment
- Awareness of statutory limitations to storage and eligibility for use of gametes
- Consideration of advanced directions for disposition procedures in event of death.

SECTION 2: DONATION OF GAMETES & EMBRYOS

2.1 GENERAL PARAMETERS

It is a critical criterion of the RTAC Donor and Surrogacy Arrangements that all donors and recipients and partners (if applicable) must have counselling prior to treatment.

It is also a requirement of the NHMRC Guidelines that clinics 'must provide readily accessible services from accredited counsellors to support participants in making decisions about their treatment, before, during and after the procedures'.

Counselling prior to the commencement of treatment utilising donated gametes will include implications counselling and decision-making counselling. The other forms of counselling: supportive, crisis and therapeutic counselling should also be available.

Counselling must be provided prior to the signing of (informed) consent and donation/treatment commencing.

It is recommended that at least two sessions of counselling per party is conducted. For known donations a joint session involving all parties should be undertaken prior to proceeding with signing of consent forms and can be included as part of the two sessions. Recipients and donors must have at least one separate session.

Further sessions should be made available for any party wanting this or at the discretion of the Counsellor where issues may still require addressing.

A “cooling off” period may be helpful for all parties before signing consent and proceeding to treatment to allow thorough consideration of the issues raised in counselling. In some jurisdictions this is a legislative requirement as is post cooling off period final counselling review.

The concept of “in the best interests of the child” should be reflected in policies and procedures of clinics and infertility counsellors. Donors and recipients need to be educated regarding this concept, particularly in relation to the right of an individual to information about their genetic origins.

2.1.1 THERAPEUTIC COUNSELLING

Therapeutic counselling for the recipients will assist them to address their adjustment, resolution and decision to use donated material. In particular:

- grief and loss issues associated with not using their own gametes
- impact on self-esteem and identity
- impact on their relationship, including sexual relationship.
- development of amended self -concept and plans re conception.

2.1.2 DECISION MAKING/IMPLICATIONS COUNSELLING

Counselling patients in relation to the donation/ receipt of donated gametes and embryos must include discussion of:

- Decision-making re whether to use a known or identity-release (clinic recruited) donor.
- motivations of the donor and recipients in the context of their family and social history
- recipients’ and donors’ feelings about non-genetic parenting
- examination of the risks and benefits of donation
- short and long-term consequences for all parties concerned, including that the donation may result in an adverse outcome
- exploration of expectations of all parties (if known donation) regarding relationship between recipient(s) and donor and donor conceived child and donor
- exploration of the acknowledged importance that donor information be accessible for any donor conceived person and the future availability of donors for information about identity
- attitudes to telling others, plans to disclose donor conception to children and how to do this
- the donor-conceived child’s potential interest in knowing more about the donor and potentially having contact
- relevant federal and state legislation and RTAC/NHMRC guidelines.

2.2 CONTENT OF SESSIONS – ALL DONORS & THEIR PARTNER (if applicable)

This section highlights issues to be included in counselling for a donor (and their partner). Through exploration of themes such as the donor's motivation, social situation, understanding of the implications of treatment including legal and procedural issues, expectations of being a donor, attitude to disclosure and considerations related to the donor conceived person and the potential of future contact.

2.2.1 MOTIVATION

- Catalyst for presenting for donation
- Donor's knowledge and experience of infertility (including social infertility) on a personal, familial and social level
- Length of time they have considered decision to become a donor
- Comfort with donation e.g. by discussion with others.

2.2.2 SOCIAL SITUATION

- Current family situation and the implications of donation for significant others
- Partner's attitude to donation and implications of donation for possible future partners
- Donor's reproductive status. Does the donor have their own children or have plans for future children? If they do not have children; it is important to explore the implications of another person having a child if they are unable to in the future. Any issues related to age, custody, gender, past reproductive losses
- How might donating gametes/ embryos impact on existing and future children, or future fertility? Have they told any existing children, do they plan to tell them/ any future children?
- Any relevant social, psychological, psychiatric history (e.g. adoption experiences, depression)?
- Relevant family of origin issues
- Support systems
- Cultural, religious and moral issues to be addressed
- Level of understanding of their role and boundaries as a donor as distinguished from a parental role, concern for donor conceived person, risk of grieving the loss of perceived potential child?

2.2.3 LEGAL ISSUES

- Extent of donor's/recipients right to change their mind/withdraw consent
- Implications of confidentiality of medical records
- " Legal parentage of donor conceived person
- Disposition of remaining embryos.
- Potential for more than one child
- Donor-conceived persons' legal entitlements for information including information to be kept with the ART unit, Donor Register or voluntary register if applicable
- Possibility of future legislative changes and potential contact with offspring.

2.2.4 PROCEDURAL ISSUES

- Understanding of the process in becoming a donor and procedures involved when donating including likely time commitment and impact on own family
- Understanding of the implications of pre-screening tests for themselves and their extended families
- Whether they want to limit how many people can access their donation?

For egg donors:

- Realistic expectations about physical discomfort of treatment
- Possibility of more than one stimulated cycle for donor if the donor agreed
- Understanding of the chances of a successful outcome as a result of the donation
- Consideration of the impact of possible treatment failure or miscarriage
- Availability of support (emotional and practical) during course of treatment.

2.2.5 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Thoughts about disclosure to donor conceived person (DCP) about their donor conception
- Expectations regarding contact/relationship with donor conceived child/ren
- Have they considered that any children they have/may have in the future will be genetically related to any donor conceived offspring they have helped to create?

2.3 ADDITIONAL ISSUES FOR CLINIC RECRUITED/BANK DONOR

2.3.1 MOTIVATION

- Attitudes to prospective recipients of their donation
- Awareness of ability to restrict/not restrict donation dependant on jurisdiction and clinic guidelines
- Who do they wish/ imagine the potential recipients to be; do they identify with potential recipients in any way, and is this related to their motivation?
- Impact of donation on own and future family.

2.3.2 LEGAL ISSUES

- Legal/regulated limit to number of recipients who can receive donated gametes
- Additional consent, provisions in will for posthumous donation (If permitted in state jurisdiction)
- Conditions of donation
- Withdrawal of consent as per state/country legislation (this differs).

2.3.3 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Thoughts about the possibility that their donation may be used to assist conception in several different families. Do they have a preference re number of families created (within legal limits)?
- Their willingness to meet with recipients both prior to and after treatment (depending on clinic practice)
- Openness to providing more information and meeting offspring in the future, Expectations regarding contact with donor conceived child. Understanding of needs/reasons for recipients/DCPs contacting them

- Understanding concerns/anxieties that recipients/DCPS may have about making contact with them
- Exploration of what it might be like if they don't receive any contact from offspring?
- Discussion of requirements should a previously unidentified heritable disorder be identified within their family after the donation.
- Discussion of implications if a heritable disorder is identified in offspring.
- Exploration of whether they would, at some time, like to know the outcome of their donation, including non-identifying information about the recipients, the number and gender of children born. Intentions about telling existing/ future children about donation.
- Have they considered that any children they have/may have in the future will be half genetic siblings to any DCPs?

2.4 ADDITIONAL ISSUES FOR RECIPIENT RECRUITED (KNOWN) DONOR

A major focus of counselling where a recipient recruited donor is being used, is ensuring that all parties have similar ideas/preferences for how the arrangement should be undertaken, both in the short and long term. Where there are differences between the parties on significant matters, these should be identified to all parties and addressed in counselling. Further discussion should also focus on the parties preferred means of resolving any future differences.

If there are any indications that proceeding with treatment could result in significant tension or estrangement between any of the parties, the counsellor should raise and explore these concerns and implications in counselling. Potentially these issues could be raised with the treating doctor and/or clinical team.

2.4.1 MOTIVATION

- Who initiated the possibility of donating (potential recipients, donor, family member, other)? Reactions and implications.
- Personal reasons for wishing to donate.
- Relationship (actual and desired) to the potential recipient(s).
- How does this relate to motivation? How could this impact on way in which important issues are discussed/ negotiated?
- Expectations (overt and covert) the donor has of the potential recipients, now and in the future.
- Extent to which any coercion explicit or implicit exists e.g. if donor is an employee of the recipient.
- Limits or conditions to their donating.

2.4.2 SOCIAL SITUATION

- Reactions, involvement and support, if applicable.
- Possible involvement of other family members/ friends (knowledge of the situation, their reactions, level of support).
- Potential impact on donor's children or future children (especially relevant if potential donor has not yet had children).
- Supports available to themselves, in addition to the anticipated support from the recipients.
- Consider possibility that they may not be a suitable donor, or may not be able to donate.

- Capacity to be clear about the role and boundaries of a donor in view of this being a “known” donation.
- Expectations of the recipients in relation to treatment, post treatment (including ante natal testing of the foetus), future relationship with the recipients and the donor offspring.
- Wishes regarding the disposition of remaining embryos.
- If donation is cross generational, consider perceived and possible implications for donor recipients, offspring and other family members; consider longer term implications.

2.4.3 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Wishes regarding “disclosure”, in relation to offspring; implications for self and others.
- Implications given offspring should to be told the story of their conception by the recipients/ their parents.
- Wishes regarding their future relationship with offspring(s) and their role in the recipients’ and offspring(s)’ life.
- Proposed arrangement with recipients regarding contact/relationship with child.

2.5 CONTENT OF SESSIONS - ALL RECIPIENTS

This section highlights issues to be included in a thorough counselling session for the recipients by clarifying themes relating to their motivation, social/relationship context, understanding of the implications of treatment including legal and procedural issues, and issues related to the donor conceived person.

2.5.1 MOTIVATION

- History and meaning of potential treatment to the recipient(s) and their resolution of fertility issues if relevant (exploration of possible anger, unresolved grief, resentment or blame?)
- Consider the individual/couple’s decision making process regarding treatment and if in a relationship, the extent of agreement between the partners.
- Explore the decision-making process and the recipient(s)’ preference for “recipient” or “clinic recruited” donation.

2.5.2 SOCIAL SITUATION

- Age(s).
- Relationship status and history.
- Any existing children (e.g. from current or previous relationship(s)) and possible impact on them?
- Wishes regarding family size.
- Relevant “family of origin” information/ issues.
- Any relevant social, psychological, psychiatric history (e.g. adoption experiences, depression)?
- Any issues that may impact on existing personal relationships?
- Desire/ opportunities to discuss plans with others; their reactions/ support?
- Are there any cultural, ethical/ moral issues to be addressed?
- Their understandings/ beliefs regarding the impact of genetic and social parentage.
- Reproductive history eg miscarriages, terminations of pregnancies, stillbirth, death of a child.

2.5.3 LEGAL ISSUES

- Extent of donor's/recipient's right to change their mind/ withdraw consent.
- Information to be provided/ recorded, for the ART Unit ,Donor Register and Voluntary Register.
- Birth certificate (and addendum where such exists).
- Implications of confidentiality of medical records.
- Donor offspring's' legal entitlements for information.
- "Ownership" of gametes/ embryos and legal parentage of offspring, disposition of remaining embryos.
- Possibility of future legislative changes.

2.5.4 PROCEDURAL ISSUES

- Awareness of all aspects of treatment include expectations of success of treatment.
- Awareness of procedures specifically related to donation (e.g. matching/allocation, quarantine periods).
- Expectations of donor.
- Impact of possible treatment failure.

2.5.5 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Understanding of the needs of offspring (eg. to be told of the nature of their conception, information available to them and likelihood that they may wish to have contact with the donor etc.).
- Current guidelines and research and information to assist to tell donor offspring about the story of their conception and advice re available resources.
- Who else will be informed about how they became a family? (family, friends, school etc)
- Knowledge of the donor's motivation and the importance of having some information for the benefit of their offspring.

2.6 ADDITIONAL ISSUES USING CLINIC RECRUITED DONOR/BANK DONOR

- Attitude to donor(s) receiving non-identifying information about the child(ren) born, and of themselves.
- Understanding of possible questions/thoughts/issues their children may have about being donor conceived at different stages in their life.
- Openness to the offspring meeting donor(s) in the future.
- Openness to seeking information from donor if child requests this.
- Openness to providing updated information (identifying and/or non-identifying) to the ART Unit, "Donor Register" and/or the "Voluntary Register".
- Thoughts about the possibility of the child having donor siblings in multiple families. Are they open to the child having contact with these donor siblings?

2.7 ADDITIONAL ISSUES USING RECIPIENT RECRUITED/KNOWN DONOR

2.7.1 MOTIVATION

- Review choice of donor. Explore motivation to use donor they have chosen and any concerns/ unresolved issues re choice of donor.
- Explore any differences between the partners regarding choices and possible coercion /submission by one partner.

2.7.2 SOCIAL SITUATION

- Relationship with the donor(s); past, current and anticipated future relationship. Any concerns?
- Impact on the potential non-biological parent (if applicable) of receiving “known” donated gametes from a person that they know and are likely to have a future relationship with.
- Any other implications for the couple relationship?
- Implications for future relationship with the donor(s) and their partner if they have one.
- If “interfamilial” / cross generational donation, implications for other family members, in both the short and long terms.
- Impact on their relationship should donor decide to donate to other recipients.

2.7.3 ISSUES RELATED TO DONOR CONCEIVED PERSON

- Recipients’ understanding of the needs of the person born as a result of the donation as they move through life, and of their responsibilities in relation to their needs.
- Their plans/ concerns re disclosure to others. The need for discretion by extended family members/ friends (and their children) where they are aware of the situation, so as to preserve the recipients’ right/responsibility to tell offspring themselves about the circumstances of their conception.
- Anticipated role of the donor(s) and the relationship between the donor(s) and the offspring.
- What has been agreed to with donor regarding their relationship/contact with child?
- Anticipated relationship with (genetic) half siblings, full siblings in donor(s) family.

2.8 ADDITIONAL ISSUES TO EXPLORE - SAME SEX COUPLES

- Consider the decision-making process and degree of resolution between the partners as to who will receive treatment or who will undertake treatment first if both want to carry a child (female same sex couples) or whose gametes will be used/used first (male same sex couple).
- Whether they will use same gamete donor so that children are genetic half siblings.
- For same sex women – use of wife/partner’s eggs – psychological, social and legal consequences.
- Discuss issue of disclosure and advice regarding relevant resources.
- Explore implications re absence of a father and plans re male role models and relationships.
- Possibility that treatment may not work.
- Explore other options for family formation.
- Discuss the legal status of the child and the non-biological parent.

2.9 ADDITIONAL ISSUES TO EXPLORE - SINGLE WOMEN

- Explore their motivation to, and expectations of, becoming a mother.

- Explore the extent to which they have resolved having a child outside the context of a relationship.
- Discuss the personal, social and economic consequences of becoming a single parent.
- Discuss the woman's support network (immediately and in the short term) in relation to their decision, for the duration of treatment and during pregnancy/childbirth. If appropriate, suggest that they nominate a support person who can be available to them for the duration of treatment and beyond.
- Discuss matters related to "disclosure" and how family structure may influence the child's needs to understand their particular circumstances and timing of the 'disclosure'
- Discuss the implications of the absence of a father for a child.
- Possibility that treatment may not work.
- Explore other options for family formation.

SECTION 3: CO-PARENTING

In some jurisdictions, it is possible for parties to enter into a co-parenting situation. This is an intent to parent as equal partners though not in a co-habiting/couple relationship with one another. This arrangement could be between 2 individuals or 2 couples or 3 people.

3.1 CONTENT OF SESSIONS

- Background and history of this arrangement.
- Relationship history – between parties and partners.
- Possible outcomes.
- Views on number of children.
- Views on pregnancy issues (e.g. termination of pregnancy).
- Disclosure – to child and others.
- Legal issues – co-parent is full parent.
- What if parties have or get partners?
- Conflict management strategies.
- What if parties decide to move state/countries?

SECTION 4: EMBRYO DONATION

This section highlights issues to be included in embryo donation counselling over and above what is discussed in relation to gamete donation. There are some counsellors who prefer to see this form of donor treatment as pre-natal embryo adoption so as to acknowledge the additional complexities this treatment involves. As no consensus has been reached ANZICA retain the more common clinical and research nomenclature of embryo donation.

4.1 GENERAL

Principles and protocol

- a. the health and well-being of children born as a result of embryo donation should be considered paramount
- b. donor offspring should be made aware of their genetic origins and be able to access information about those origins

Counselling Protocol (Minimum standards)

- c. For the unknown donation arrangement, all participants and their partners to be seen for a minimum of two sessions in a face to face consultation
- d. For the known donation arrangements, all participants and their partners to be seen for a minimum of two counselling sessions each and a third session in a group meeting.
- e. Cooling off periods to be determined by statutory frameworks

4.2 DONOR(S) OF EMBRYOS

- Background infertility history.
- Background mental health history/traumas.
- The pros/con of embryo disposition options that have been discussed.
- Decision to proceed forward with embryo donation.
- Feelings about sense of completeness with respect to own family structure (gender structure; numbers of children; health of children; age of children).
- How the donation is conceptualized – cells, potential for pregnancy experience for someone else; actual baby.
- How is parenthood conceptualized.
- Impact of giving up embryos that were intended for own family.
- Implications of prospective donation for own children and family of origin.
- Agreement between partners on embryo donation.
- Grief; loss; guilt, fears, fantasies.
- Attitudes towards disclosure of donation and agreement between partners.
- Clinical implications of donation (i.e. potential for no successful pregnancy outcomes; child with disability; termination of pregnancy).
- Legal implications of donation according to State/Federal legislation (nil legal advice to be given).
- Known donation scenario – clarity on disclosure, contact and boundary issues, managing possible changes in contact expectations.
- Unknown donor situation – gauge future orientated concerns about contact with prospective child).
- Preferences for recipients of their donation, couples often struggle to find the “right” recipients.

- What information would they like and/or can be provided by clinic or recipient e.g. successful pregnancy, birth of baby, all embryos used or how many are remaining, what will happen if embryos still remain after recipients have completed treatment?
- Possible communication with the recipients, e.g. write a letter to donor conceived person and their unknown recipient family.
- Role of statutory registers (if available) – storage of data, data access, donor-linkage processes
- Psychological capacity to give informed consent.
- Support options and resources post embryo donation.
- Option for the capacity to withdraw.

4.3 RECIPIENT(S) OF EMBRYO DONATION

- Background physical and mental health information including lifestyle risk factors.
- Family formation options that have been considered (pros/cons of each option).
- Agreement between couple on decision to move forward with donor assisted conception.
- Readiness for treatment – giving up dream of own biological child, grief/guilt.
- Attitudes about parenting a child not genetically related to them.
- Attitudes towards disclosure to prospective donor conceived person.
- Attitudes towards disclosure of donor conception to significant others.
- Legal implications of donation according to relevant State/Territory.
- Awareness of statutory registers – storage of donor conception information, access and donor-linkage protocols .
- Unknown donor situation – check future orientated expectations and concerns about contact with embryo donor(s).
- Known donation arrangement – perspectives to disclosure, (when/who/what); clarity on expectations for contact and boundary issues, managing possible changes in contact expectations.
- General problem solving and conflict management skills.
- Unknown donor situation – check future orientated expectations and concerns about contact with embryo donor(s).
- Psychological capacity to give informed consent.
- Availability of support during and post donor assisted treatment.
- If patients plan to find an embryo donor online they should be encouraged to consider what their expectations are around future contact.
- Transition to parenthood after treatment as embryo donation is often a “last resort” and couples may not really expect it to be successful.

4.4 PROFILES

In clinics where there is a process of selection of recipient or donor or reciprocal, clinic processes need to be established to enable enough time and space to create one’s profile, work out what one is looking for in the other party, review those profiles, ask additional questions, seek additional information. This process needs to move at the pace of the slowest member of the group. This also represents an opportunity for an exploration of the different ethical, spiritual, and cultural perspectives in society that participants present with that should be explored and respected.

4.5 COOLING OFF

It is strongly recommended that a cooling off period of 3 months is allowed in all arrangements and that the youngest child of the donor is at least 12 months old.

Additional counselling post treatment may be required for some or all parties regardless of outcome.

4.6 NEW ZEALAND

All embryo donations in NZ are carried out on a known basis. Ongoing contact between the parties and donor siblings is encouraged if the birth of a child occurs. This is thought to assist with the well-being of the child.

All embryo donation applications must be approved by the Ethics Committee on Reproduction Technology, the guidelines can be found here:

<https://acart.health.govt.nz/system/files/documents/publications/guidelines-embryo-donation-nov08.pdf>

In addition to joint and individual counselling, both parties are required to have separate legal advice on the Human Assisted Reproductive Technology Act 2005 so that they fully understand that donors have no legal rights or responsibilities to any embryo donation offspring.

SECTION 5: SURROGACY

In New Zealand and most states of Australia, surrogacy has now been legislated. However, a significant degree of variation in the laws and practice of surrogacy exists between the Australian states/territories and New Zealand. In the jurisdictions where surrogacy is legally sanctioned, the role and responsibilities of the infertility counsellor are generally clearly defined. In other jurisdictions where surrogacy is not legally sanctioned, the role of the infertility counsellor has generally not been established or defined. In these circumstances, clinics should establish their own clearly documented framework for managing surrogacy and associated counselling processes.

5.1 GENERAL PARAMETERS

- It is an RTAC requirement that all parties and partners to a surrogacy arrangement must have counselling with a suitably qualified counsellor with training and experience in assisted reproductive technology prior to proceeding and that surrogacy arrangements are likely to require multiple counselling sessions.

- The NHMRC Guidelines also requires that all parties to a surrogacy arrangement ‘have undertaken counselling to consider the social and psychological significance for the person born as a result of the arrangements, and for themselves’.

ANZICA requires that:

- Counselling is only undertaken by a counsellor eligible for full membership of ANZICA.
- It is recommended that all parties and their partner should have separate interviews with a minimum of 2 interviews for each party; and a joint session. This process may vary between clinics and jurisdictions but will usually include an independent counsellor and a psychological assessment of all parties.
- Given the complexities involved in surrogacy, it is recommended that face-to-face counselling is the optimal mode of conducting counselling sessions.

5.2 CONTENT OF SESSIONS

5.2.1 MOTIVATION

- Motivations of surrogate and intended-parent(s), in the context of their family and social history.
- Current relationship between surrogate (and partner) and intended parent(s). How long have they known each other?
- Expectations regarding relationship between surrogate and intended-parent(s) and child.
- Length of time they have considered decision.

5.2.2. PSYCHOSOCIAL SITUATION

- Individual medical and mental health history for all parties including identification of any risk factors for the surrogacy arrangement/ wellbeing of all parties or ability to provide informed consent.
- Examination of the risks and benefits of the surrogacy arrangement.
- Psychological suitability of all parties to undertake the arrangement.
- Short and long-term consequences for all parties concerned, including the possibility of an adverse outcome(s) e.g. treatment not successful, either partner withdrawing from arrangement.
- The additional demands on, and expectations of, the surrogate, her partner and her existing children.
- Exploration of the needs of any children born as a result of the surrogacy arrangement.
- Attitudes to telling others and plans to disclose method of conception to the child.
- Attitudes of all parties to managing a pregnancy including pregnancy testing, decision-making re multiple pregnancies, termination and other pregnancy complications, lifestyle factors of the surrogate.
- The intention of parties if the child is born with a serious medical condition or disability.
- Possible grief reactions for parties e.g. not being able to carry her own child for intending woman, relinquishing child for surrogate.
- Agreed process for resolving disputes during treatment, pregnancy and post birth.

5.2.3 LEGAL ISSUES

- Relevant federal and state legislation.
- Relevant FSA/NHMRC guidelines.
- Ensure all parties understand that any party can withdraw from arrangement including surrogate refusing to relinquish the child and commissioning parent(s) refusing to accept child.
- Ensure all parties understand legal status of child after birth and required process for changing parentage.
- Plan for managing post birth period until commissioning parents are declared legal parents including medical emergencies.

5.2.4 ISSUES RELATED TO CHILD BORN THROUGH SURROGACY ARRANGEMENT:

- Participants' understanding of the needs of offspring (e.g. to be told of the nature of their birth, information available to them etc.).
- Agreement between parties about disclosing to others and child about how they were born.
- Expectations of all parties regarding ongoing relationship between intending parents and surrogate and child and surrogate.
- Current guidelines/ suggestions for "telling" offspring about the story of their birth and advice re available resources.

For additional in-depth surrogacy information, see attached Addendum entitled – ANZICA Surrogacy Guidelines (version January 2017).

4.0 Additional Resources

4.1 ANZICA Surrogacy Guidelines (hyperlink) –

4.2 <https://www.fertilitysociety.com.au/rtac/>

4.3 <http://www.healthlawcentral.com/assistedreproduction/>

4.4 <http://www.healthlawcentral.com/donorconception/>

4.5 <http://www.healthlawcentral.com/surrogacy/>

4.6 [https://gaffney-law.leapwp.com.au/wp-content/uploads/sites/1120/2017/04/Australian-Surrogacy-Handbook WEB.pdf](https://gaffney-law.leapwp.com.au/wp-content/uploads/sites/1120/2017/04/Australian-Surrogacy-Handbook_WEB.pdf)

4.6 <https://www.eshre.eu/Specialty-groups/Special-Interest-Groups/Psychology-Counselling/Archive/Guidelines.aspx>

ADDENDUM

ANZICA SURROGACY GUIDELINES

Surrogacy legislation in each state or territory of Australia, and in New Zealand, and requirements for counselling related to surrogacy arrangements (version January 2017)

Australian Capital Territory				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
<p>Parentage Act 2004 Requirement for commissioning couple to have at least one genetic parent, hence allowing for one donor. Thus IVF surrogacy only, and no traditional surrogacy.</p>	<p>Intended parents (known as substitute parents) must be a heterosexual couple. They must live in the A.C.T. to be able to get a parentage order. The surrogate must also be in a couple relationship. The surrogacy arrangement can be oral.</p> <p>There are two clinics in the A.C.T. offering surrogacy, with the information from one of them below as an indication of requirements.</p> <p>Canberra Fertility Centre (CFC) requirements: An assessment by an external counsellor who is registered (or eligible for registration) with AASW, ANZICA or APS. Assessment must attend to the required “questions” in CFC booklet, including legal wills etc. No longer is full personality testing required but this is at the discretion of the counsellor. The external counsellor also makes recommendations for counselling during pregnancy and post-delivery.</p>	<p>No legislative requirements.</p> <p>Canberra Fertility Centre: Counselling recommended though it is no longer a requirement of the clinic, as it was found to be impossible to monitor, and patients refused to do it due to expense/imposition on their time etc.</p>	<p>No legislative requirements.</p> <p>Canberra Fertility Centre: Counselling recommended though it is no longer a requirement of the clinic as it was found to be impossible to monitor, and patients refused to do it due to expense/imposition on their time etc.</p>	<p>In clinic and external counselling required.</p> <p>Pre-surrogacy assessment done by external counsellor who is registered or eligible for registration of AASW, ANZICA, or APS.</p>

	<p>Canberra Fertility Centre clinic counsellor also sees patients before treatment, and also repeats the clinic surrogacy “questions). CFC has a cool off period before treatment commences, and it usually takes a good six months or more to start treatment.</p>			
New South Wales				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
<p>Surrogacy Act 2010 Surrogacy Regulations 2011 Assisted Reproductive Technology Act 2001 and amendments 2010</p>	<p>Surrogacy Act Section 35 (1) Each of the affected parties must have received counselling from a qualified counsellor about the surrogacy arrangement and its social and psychological implications before entering into a surrogacy arrangement. The independent counsellor must assess the parties for their suitability to participate in a surrogacy arrangement and for the intended parents to be parents. AND A.R.T. Act 2007 amendments 2010 Before treatment a medical practitioner must receive an assessment report from a qualified counsellor, which gives the counsellor’s opinion as to whether the parties are suitable persons to enter into a surrogacy arrangement. The report is also required by legal practitioners as well as for the court if there is a surrogacy birth. Clinic counselling Some clinics also cover the</p>	<p>No legislative requirements though some clinics do provide counselling support and implications counselling as part of their processes; and when it is required for a particular surrogacy arrangement.</p>	<p>Surrogacy Act Section 35 (2) The birth mother and the birth mother’s partner must have received further counselling about the surrogacy arrangement and its social and psychological implications after the birth of the child and before consenting to the parentage order. Surrogacy Act Section 17 An application for a parentage order must be supported by a report about the application prepared by another independent counsellor. Section 17 outlines the issues which are to be considered for the writing of the parentage order counselling report.</p>	<p>Surrogacy Act Section 4 No formal accreditation process for counsellors. “Qualified counsellor” means a person who has the experience or qualifications or both of a kind required by the regulations to exercise the functions of a counsellor under the Act. AND Surrogacy Regulations Section 6 “Qualified counsellor” must be a member of ANZICA or eligible for this, and must be familiar with relevant guidelines. Surrogacy Act Section 17 (7) An independent counsellor cannot be a clinic counsellor and/or cannot be connected with a medical practitioner who did the surrogacy treatment AND must be a qualified psychologist, psychiatrist or social worker</p>

	counselling issues listed in the ANZICA guidelines, as well as providing supportive counselling.			with specialised knowledge.
New Zealand				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
HART Act 2004 Adoption Act 1955 Status of Children’s amendment Act 2004 The Hague Convention ACART (Advisory Committee on Assisted Reproductive Technology) Advice to ECART ECART issues guidelines to fertility providers	<p>Legislation only applicable to surrogacy involving fertility providers. All fertility providers must apply to ECART (Ministry of Health Ethics Committee on Assisted Reproductive Technology).</p> <p>All parties must have counselling from an ANZICA counsellor independent of each other and together. All parties must seek legal advice separately. All parties must have medical consultation separately.</p> <p>If birthing woman is over 45 it is usual for an obstetric physician’s review to be called for. No payment for loss of earnings, only medical and some legal expenses.</p> <p>Prior approval for adoption via surrogacy needs to be sought by intending parents from Department of Child Youth and Family. Additional medical specialist reports required sometimes.</p>	<p>Pregnant woman has all legal rights to make decisions about the pregnancy.</p> <p>Birthing mother is regarded as the legal mother and her partner as the other legal parent.</p> <p>Cannot sign consent to transfer of parental right until baby more than ten days old.</p> <p>Illegal to take parental responsibility unless Child Youth and Family have “sanctioned” this.</p> <p>Clinic counsellors provide follow up and counselling if needed.</p>	<p>Child Youth and Family give consent to baby being in care of intending parents (if not then baby cannot be in their care until consent to adoption signed after baby ten days old)</p> <p>Consent to relinquishing parental right must be signed by birth mother and her partner when baby more than ten days old. Interim adoption order applied for by intending parents’ lawyer.</p> <p>Final adoption order applied by intending parent’s lawyer. Clinic ANZICA counsellor follow up.</p>	<p>Each party must have a different counsellor who is an ANZICA member.</p> <p>Independent psychological assessment or psychiatric assessment sometimes required.</p> <p>An independent pre-surrogacy (from the clinic) psychology report is often required as an addition to counselling but not always.</p>
Northern Territory				
No legislation No order can be made			As there is no legislation, no parentage order can be made.	

Queensland				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
Surrogacy Act 2010 Status of Children Act 1978	<p>Prior to conception and signing of a surrogacy arrangement all parties, being the intending surrogate and partner, and the intended parent/s (must) attend counselling with an experienced counsellor regarding the potential surrogacy.</p> <p>Routine for assessment counselling to include personality and mental health assessment using standard testing procedures, though it is not a legal requirement.</p>	<p>Nil legal requirements or clinic requirements. Recommended follow-up only by counsellor.</p>	<p>Qld Surrogacy Act 2010 Requires Surrogacy Guidance report, to be completed by independent counsellor post birth. Content and qualifications, and independence, defined under the Act, and includes a requirement that NOT the initial counsellor associated with the treating doctor/clinic.</p>	<p>All fertility groups in Queensland recognize that the counsellor ought to be a member of ANZICA as well as being a registered psychologist or a social worker.</p> <p>There is however no legislative requirement.</p>
South Australia				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
Family Relationships Act 1975 Assisted Reproductive Treatment Act 1988 Statutes Amendment (Surrogacy) Act 2009 Family Relations (Surrogacy) Amendment Act 2015 Only available to married	<p>Prior to conception and prior to signing a surrogacy agreement all parties, being the Commissioning Parents and the Surrogate and any partner must attend individual and joint counselling.</p> <p>Under recent legislation amendments all such counselling should be provided by one counsellor.</p> <p>Counselling must be consistent with ANZICA and NHMRC guidelines. A</p>	<p>No legislative requirements.</p>	<p>Family Relations (Surrogacy) Amendment Act 2015</p> <p>Under recent changes to legislation the Commissioning Parents must take reasonable steps to ensure the Surrogate and her partner are offered counselling</p>	<p>Statutes Amendment (Surrogacy) Act 2009</p> <p>Counselling must be provided by an accredited counselling service.</p> <p>Family Relations (Surrogacy) Amendment Act 2015</p> <p>Counselling must be</p>

<p>couples or those who have been living in a husband/wife de facto relationship continuously for at least three years. Must be residing in S.A. Requirement for at least one of the commissioning parents to provide genetic material unless they have a medical certificate as to why this cannot occur. Child must be conceived as a result of fertilisation procedures carried out in S.A.</p>	<p>Counselling Certificate must also be issued by an accredited counselling service for the Commissioning Parents and the Surrogate and partner stating that they have received counselling about personal and psychological issues that may arise in connection with a surrogacy arrangement AND that, in the opinion of the counsellor who undertook the counselling, the proposed recognised surrogacy agreement would not jeopardise the welfare of any child born as a result of the pregnancy that forms the subject of the agreement.</p>		<p>after the birth (including stillbirth) of a child from the surrogacy agreement at no cost to the Surrogate or her partner.</p>	<p>consistent with ANZICA and NHMRC guidelines.</p>
Tasmania				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
Surrogacy Bill 2010	<p>Parties must receive counselling from a counsellor accredited under the Act, prior to entering into an arrangement. All parties must come from Tasmania unless they have dispensation.</p>	<p>No requirements.</p>	<p>After the birth, counselling is to be used to ensure that all parties are still comfortable with the arrangement. No detailed written report is required here unless the court requests it, though a certificate needs to be signed stating that the counselling has occurred.</p>	<p>Accreditation of counsellors through Department of Justice (Births, Deaths and Marriages). For accreditation: to demonstrate “appropriate experience” the counsellor must be registered with the Psychology Registration Board, have level 2 Membership of the Australian Counselling Association or be registered with the Psychotherapy Counselling Federation of Australia. Note – No specific infertility</p>

				experience is required in Tasmania.
Victoria				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
Assisted Reproductive Treatment Act 2008	<p>Section 40 (1)(c) The Patient Review Panel may only approve a surrogacy arrangement if the commissioning parent/s, surrogate mother and surrogate mother’s partner have received counselling.</p> <p>Section 41 Part 4 – Surrogacy Assisted Reproductive Treatment Act 2008 No 76 of 2008 35</p> <p>(a) undergo counselling, by a counsellor providing services on behalf of a registered ART provider, about the social and psychological implications of entering into the arrangement, including counselling about the prescribed matters; and</p> <p>(b) undergo counselling about the implications of the relinquishment of the child and the relationship between the surrogate mother and the child once it is born; and</p> <p>(c) obtain information about the legal consequences of entering into the arrangement.</p> <p>Section 43 (a) and (b) the counselling must address the social and psychological implications of entering into the arrangement and implications of relinquishing the child and the relationship between the surrogate mother and the child once it is born.</p>	None legally required. Some clinics offer supportive counselling throughout entire journey including pregnancy and post birth.	None legally required. Some clinics offer supportive counselling throughout entire journey including pregnancy and post birth. If any parties not living in Victoria they may be required to have further counselling.	<p>Section 43 (1) the aforementioned parties must be counselled by a counsellor providing services on behalf of a registered ART provider.</p> <p>Section 3 A registered ART provider is a person/body registered under Part 8 of the Act.</p> <p>A clinic counsellor is required to complete the pre-treatment counselling. The Victorian Patient Review Panel (PRP) which must approve all surrogacy applications in Victoria, also requires an independent psychological assessment which is done external to the clinic (though this is not a legal requirement).</p>

Western Australia				
Legislation	Before Surrogacy Treatment	During Treatment & Pregnancy	After the birth of child/ren	Counsellor/s
<p>Surrogacy Act 2008 Surrogacy Regulations 2009 Submissions for a review of the Surrogacy Act (2008) W.A. were commissioned in February 2014. As of July 2016 the current status of the Surrogacy Act (2008) remains.</p>	<p>Section 17 c (i) 1. Counselling about the implications of the surrogacy arrangement. Counsellor must prepare a written certificate regarding the counselling and any concerns. 2. Assessment by a clinical psychologist with a written report.</p>	<p>Surrogacy Directions (2009) Section 12: Ongoing counselling and support throughout treatment including counselling at a time where there is a decision by participants to discontinue the surrogacy process. Section 13: Counselling requirements during pregnancy by an approved counsellor for both surrogates and intended parents at 20 and 34 weeks after the beginning of a pregnancy and at 14 days after either a miscarriage or a live birth.</p>	<p>Surrogacy Regulations Section 6 Appropriate counselling for the purposes of Section 21 (2) (b) of the Act is counselling about the effect of the proposed order provided by an approved counsellor following the birth of a child. In W.A. an “approved counsellor” tends to be the clinic counsellor, not the independent psychologist. It is not written but presumed all participants to the arrangement would be there. Unlike the implications counselling in Section 4 it is not defined what is covered in post order counselling nor surrogate relinquishment. However there does need to be consideration of “whether the making of a parentage order would be for the wellbeing, and in the best interests of the child.”</p>	<p>Two different counsellors: 1. “Approved Counsellor” is the clinic counsellor who conducts the implications counselling and then writes a certificate indicating dates patients were counselled with final statement highlighting any concerns. “Approved Counsellors” must be qualified and experienced counsellors, who also possess a significant knowledge of the issues associated with fertility and infertility. They must also demonstrate evidence of keeping up to date with technological developments including fertility specific professional development. To become formally recognised as an “Approved Counsellor” under the HRT Act 1991 (WA) a counsellor must make an application to the Reproductive Technology Council for formal recognition. Approved counsellors must be eligible for ANZICA. 2. Independent psychosocial assessment is done by a clinical psychologist. The independent clinical psychologist does assessment psychological report.</p>

ANZICA SURROGACY GUIDELINES

Version September 2016

1. Mission Statement:

ANZICA (Australia and New Zealand Infertility Counsellors' Association) is the peak professional Australian and New Zealand counselling organisation dedicated to promoting the psychological and social wellbeing of individuals and couples undergoing fertility treatment. Consideration of the best interests of the child to be born from ART techniques, including through surrogacy, is paramount and is a fundamental principle guiding both counselling practice and process.

2. Background

Family formation through the process of surrogacy is a complex psychological social process. A surrogacy arrangement is one in which *before the child is conceived*, the intended parent/s and the surrogate mother (and her partner, if she has one) agree that the surrogate will become pregnant *with the intention* that the child will, at birth, be given into the care of the intended parent/s to raise as their own. The most common reasons for surrogacy are absence of the uterus (such as after surgery for women, or for men who may be in a same sex relationship or may be single), congenital malformation of the uterus, or a medical condition that compromises pregnancy making it unsafe for the woman or her prospective baby.

Potentially, there are a number of situations that could be encompassed within the definition of surrogacy. A surrogate conception may occur where the genetic material is provided by both intended parents or by one only of them, by both of the surrogate parents, or by one only of them, or by third-party donors who are not involved in the actual surrogacy arrangement.

It follows that conception in a surrogacy arrangement has the potential to come about naturally, through assisted reproductive technology, or through the surrogate's self-insemination. Surrogacy as practised in Assisted Reproductive Technology (ART) clinics is primarily IVF or gestational surrogacy, which does not involve any genetic material of the surrogate or her partner; with insemination surrogacy (also known as traditional or partial) being less common; and natural conception surrogacy being extremely rare.

There is significant variation in the laws that govern the practice of surrogacy across the Australian states and territories and New Zealand. Counsellors should therefore have a thorough knowledge of the relevant legislation in their own jurisdiction including knowledge of

the assisted reproductive treatment and psychosocial implications associated with the differing forms of a surrogacy arrangement.

Information about the legislated requirements for surrogacy counselling in each jurisdiction is included in an addendum to these guidelines - Addendum: Surrogacy Legislation in each state or territory of Australia, and in New Zealand, and requirements for counselling related to surrogacy arrangements. This information includes the counselling requirements before, during and after a surrogacy birth, in addition to the requirements for the qualifications of counsellors who undertake surrogacy related counselling.

In Australia in May 2016, a report was released following an Inquiry by the House of Representatives, Standing Committee on Social Policy and Legal Affairs, entitled:

“Surrogacy Matters: Inquiry into the regulatory and legislative aspects of international and domestic surrogacy arrangements. Recommendations April 2016

(http://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Inquiry_into_surrogacy/Report)

In the Foreword to this report it was stated *“The Committee recommends that the practice of commercial surrogacy remain illegal in Australia.”* The Committee also made recommendations in an attempt to improve the processes related to Australian children born through overseas surrogacy arrangements. The Committee supported altruistic surrogacy in Australia and recommended the development of a nationally consistent legal framework in Australia to be based on:

- **“Four key principles:**
- *the best interests of the child,*
- *the surrogate’s ability to make free and informed decisions,*
- *ensuring the surrogate is free from exploitation, and*
- *legal clarity about the resulting parent-child relationships.”*

The reported timeline for the implementation of the Committee’s recommendations was predicted to be approximately two years from release of the report, however as of this revision of the ANZICA Surrogacy Guidelines (Version September 2016) there had not been a commencement to the implementation of the Committee’s recommendations. Nevertheless these counselling guidelines have been written in the context of the recommendations of the Committee particularly in regard to those related to counselling in surrogacy arrangements.

3. Counselling Roles in Surrogacy Counselling

a. Clinic Counsellor:

The role of the clinic counsellor in providing counselling is different from that of a practitioner providing independent psychological assessment and/or advice and guidance. Although it is inevitable that clinic counsellors working with participants to a surrogacy arrangement will note the characteristics and functioning of their clients the work of such a counsellor should not be confused with that of an independent counsellor who has been commissioned to provide surrogacy advice and guidance or a formal assessment on these matters, including participants' suitability for the proposed treatment.

Counsellors' reports which might be requested by clinic management prior to a surrogacy arrangement proceeding should be written using a descriptive framework – that is, to summarize the issues that have been discussed. A clinic counsellor would typically focus on current issues, including communication and relationships between all parties, clarify strategies for managing conflict, determine recommended preparations for surrogacy, investigate competing life priorities, explore and manage expectations of treatment and ensure that the best interests of any children involved are paramount.

b. Independent Counsellor:

In a number of jurisdictions there is a requirement for there to be assessment and/or counselling conducted by a counsellor who is independent of the treating fertility clinic. This counsellor may be involved at various stages throughout the surrogacy arrangement including: the pre-surrogacy or post-birth stage of a surrogacy arrangement or at times, both. Pre-surrogacy assessment counselling is a requirement mandated by many legislations and a number of treating clinics, and may include psychometric testing which must be provided by an appropriately qualified professional.

At the pre-surrogacy stage this role varies according to the jurisdiction in which the surrogacy arrangement is to take place. In some jurisdictions the independent counsellor's role is to provide a detailed psychosocial assessment or it may be more focussed on implications counselling and/or decision making counselling, and it may or may not require a comprehensive report. In other jurisdictions the independent counsellor is not required to do any implications or decision making counselling but has a role restricted solely to assessment of the parties for the purposes of determining treatment suitability.

During the pre-surrogacy assessment stage, the impact on children, including those of the surrogate, should be considered as part of the overall assessment and in some jurisdictions it is a mandatory requirement that children be seen as part of the counselling. Whilst pre-surrogacy counselling addresses many of the issues which may have been raised in counselling by a clinic counsellor the primary purpose of an independent counsellor is to provide the treating clinic with an objective, succinct, accurate description of the emotional and psychological preparedness of the participants to the proposed surrogacy arrangement. It is not an opportunity for on-going supportive counselling, crisis counselling or psychotherapy.

Pre-surrogacy counselling requires a formal structured counselling process to gather and assess relevant information about the functioning and motivation of all involved in the proposed surrogacy. This includes structured clinical interviews of all involved (as individuals, as couples and as a group) and may include the use of an objective measure of psychopathology as part of the psychosocial screening process. In some jurisdictions there is a legislated requirement for the independent counsellor to give their written opinion as to the suitability of the parties to participate in a surrogacy arrangement.

Pre-surrogacy counselling requires for there to be at least one occasion in which all the parties to the proposed surrogacy arrangement are seen in person by the counsellor who is undertaking the pre-surrogacy counselling. This is consistent with Recommendation 3 from the recent Australian Federal Government Inquiry Surrogacy Matters which stipulates:

“The need for mandatory, independent and in-person counselling for all parties before entering into a surrogacy arrangement, during pregnancy, after the birth, and at relinquishment.”

This is also required by the guidelines issued by the Family Court of Australia for assessment:

Australian Standards of Practice for Family Assessments and Reporting February 2015

(<http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/about/policies-and-procedures/asp-family-assessments-reporting>) where it is stated in Section 14:

“Family assessors should conduct at least one in-person interview with each parent and other adults who perform a caretaking role with the children.

d. Telephone or video interviews can be used as a supplementary means of interview with adults.

e. Where there is no alternative but to interview an adult by telephone, this must be noted as a significant limitation of the assessment, and the reasons for undertaking a phone interview articulated.”

4. Pre-Surrogacy Counselling

The provision of client or (patient) centred counselling is an indispensable part of the preparation of those wishing to access surrogacy treatment. It should be provided by appropriately qualified and trained practitioners, who are full members of ANZICA, and should be integral to clinic protocols for surrogacy treatment which might also include consultations with one or more medical specialists, including an independent gynaecologist; one or two legal practitioners; possibly a psychiatrist; as well as counselling by a clinic counsellor and/or assessment by an independent counsellor.

The current status of surrogacy counselling by clinic counsellors varies from little or no surrogacy counselling (where all such counselling is left up to an independent counsellor) to much more intensive clinic counselling where there are multiple contacts by clinic counsellors with all parties to the proposed surrogacy arrangement over a number of months. Irrespective of how it is organised, pre-surrogacy counselling needs to be respectful of the needs of all involved in the proposed surrogacy arrangement, including the intended parent/s, the surrogate and partner if she has one, and any children of the intended parent/s or of the surrogate, and of possible unborn offspring of the surrogacy treatment.

A comprehensive biopsychosocial evaluation of a proposed surrogacy arrangement, often done by an independent counsellor, includes consideration of the connections between the parties to the arrangement, reproductive history and any history of trauma or loss, the possibility of coercion or financial inducement (explicit or implicit) and expectations of a surrogacy pregnancy and delivery and the implications of potential medical or psychological complications.

The pre-surrogacy counselling process must give time, space and intensity for a thorough consideration of the implications of the proposed treatment and the opportunity for a change of mind, minimising possible rupture of relationships which may be longstanding. Comprehensive pre-surrogacy counselling is an integral part of ensuring full informed consent as well as assessing surrogacy suitability.

Issues that may need consideration in pre-surrogacy counselling:

Psychological Wellbeing:

- Reproductive and infertility history, coping strategies used.
- Consideration of the capacity of the intended mother to manage the challenges, including the emotional, of another woman carrying her baby.
- Mental health history and current psychological state.

- Indications of psychological entitlement or of a party to the surrogacy having a sense of being more deserving or owed.
- Any other stress factors – major upheavals or transitions.

Relationships:

- Relationship between the individuals involved and implications of surrogacy (capacity to make independent decisions – financial or emotional dependence issues.)
- Relationship stability of all parties to the surrogacy arrangement.
- How discussions about the surrogacy arrangement with the surrogate first came about.
- Commitment to and motivation for surrogacy and its unique demands, potential benefits and cost to the surrogate and her family.
- Implications for any existing partner and risk factors (i.e. partner support)
- Implications for any existing children and risk factors such as any loss issues and how parents intend to deal with them. (Some jurisdictions require for children between 4 and 18 years of age to be counselled in an age appropriate manner. Most legislations do not require that the children be seen, but that the issues of the children be considered in the counselling.)
- Differences in parenting styles.
- Possibilities of complications that may affect a couple or individual, e.g. relationship breakdown, medical problems, even death.
- Contraceptive measures used by all parties and the psycho-social implications if a spontaneous pregnancy were to occur during surrogacy treatment.
- Attitudes regarding future relationships and the role of each party in the life of any child born as a result of the surrogacy arrangement.

Gametes/Embryos:

- If donor gametes or embryos are to be used - the implications and understanding of all parties to the surrogacy arrangement.
- If the intended parents are a same sex male couple, decision making around whose sperm is to be used to form the embryos in the surrogacy arrangement.
- Decision making about number of embryos to be transferred.
- Intentions regarding disclosure and explanation to others.
- The availability of a permanent, accurate record of conception, gestation and birth for the child born from the surrogacy arrangement.
- Decision making regarding additional embryos and any plans for another child.

Surrogacy Treatment:

- The amount of perceived control that the intended parent/s have over the birth mother's behaviour during the pregnancy and whether this is a concern.
- Lifestyle factors that may be of concern during a surrogacy pregnancy.
- Pregnancy risk factors: pre-eclampsia, gestational diabetes, risk of death of the surrogate.
- The possibility of a multiple birth, and positions of all parties.
- Attitudes to pre-natal screening and termination of pregnancy.
- The possibility of legal termination of a pregnancy if a child is diagnosed before birth with a disability or abnormality.
- The possibility of the surrogate/birth mother deciding against a termination in the above situation and responsibility for the subsequent care of the child.

Legal/Process:

- Forensic history of all parties.
- Awareness and acceptance of legal ramifications, and informed consent issues.
- Information on research outcomes in the area.
- Change of mind by a party before or during the process.
- The possibility of a breakdown in the arrangement, such that the surrogate or birth mother refuses to relinquish the child to the intended parents and/or wishes to keep the baby.
- Dealing with a disabled child including refusal by the intended parent/s to take on and parent such a child.
- The need for the parties to agree on a process for resolving disputes if there is any conflict or significant difference of opinion over issues such as treatment decisions, reimbursement of expenses, or post-delivery issues.

5. Counselling during ART treatment and surrogacy pregnancy

Counselling requirements, if any, including mode of counselling, frequency of counselling and provider of counselling are determined by specific legislation in each jurisdiction. (See Addendum) Even if not legislated there may arise a need for counselling during treatment or after a pregnancy (but before delivery of the baby).

Counselling at this stage would usually be focussed on supportive counselling, though sometimes issues may arise between the parties to the surrogacy arrangement which can call for intensive implications and relationship counselling. Counselling may also include discussion

of plans for the delivery and handover of a baby, and discussion of planned post-delivery contact.

Counselling at this stage tends more often to be provided by the clinic counsellor, but there could be contact with an independent counsellor, depending on the preferences of the parties to the surrogacy arrangement. In this latter situation it may necessitate a review of the external counselling implicit 'contract' to move from an assessment counselling role to a supportive or therapeutic counselling role.

Follow up counselling after treatment, whether there is a pregnancy or not, is however highly recommended and should be available to all parties to a surrogacy arrangement. It is however not common for there to be a legislated requirement for surrogacy pregnancy counselling before delivery of a child/ren conceived through a surrogacy arrangement or if there is a miscarriage. (See Addendum for information on legislation for each jurisdiction)

6. Post-Surrogacy Birth counselling:

Follow up counselling of the surrogate and her partner after delivery of a surrogacy baby is highly recommended and should be available to all participants. In some jurisdictions, there is a formal requirement for counselling post-delivery which may be provided by either the clinic counsellor or an independent counsellor. This professional may or may not be the same person who has completed the pre-surrogacy counselling.

In some jurisdictions a post-surrogacy birth report, for use in an application for a Parentage Order, must be prepared by an independent and appropriately qualified counsellor with there being a legislated requirement for this to be an independent counsellor other than the counsellor who did the pre-surrogacy counselling. Therefore there are two different types of counselling required after delivery of a child/ren conceived through a surrogacy arrangement:

a. Relinquishment Counselling of surrogate and her partner:

The focus of this counselling is on the needs of the surrogate and her family after the delivery of a baby through a surrogacy arrangement.

Issues that may need consideration in relinquishment counselling:

- The surrogacy pregnancy and how it was the same and different from the surrogate's own previous pregnancy/s;

- The delivery and handover of the baby – how it proceeded, who was present, and reactions of all parties during delivery and afterwards;
- Emotional and physical reactions of the surrogate mother before, during and after delivery of the baby;
- Effects on the surrogate’s partner and family;
- Post-birth contact of the surrogate with the baby and the intended parents;
- A review of the overall impact of the surrogacy experience compared with expectations and how any differences have been experienced and dealt with, as well as plans for the future.

b. Parentage Order Counselling:

In counselling for Parentage Order reports the focus of the counselling is on the best interests of the child/ren born as a result of the surrogacy arrangement.

Implications for pre-existing children of the surrogate should also be considered. Sometimes a report for the court is required following this counselling, in other situations there may only be a requirement for the counsellor to sign a certificate confirming that the counselling has occurred.

Issues that may need consideration in Parentage Order counselling:

- The understanding of all parties involved in the surrogacy arrangement of the social and psychological implications of the making of a Parentage Order (both in relation to the child and to any affected parties);
- Each party’s understanding of the principle that openness and honesty about a child’s birth parentage is in the best interests of the child/ren;
- The care arrangements proposed by the intended parent/s in relation to the child/ren;
- Any contact arrangements proposed in relation to the child/ren and the intended parent/s with his or her birth parent/s or biological parent/s;
- The parenting capacity of the intended parent/s;
- Whether any consent given by the birth parent or parents to the Parentage Order is informed consent, freely and voluntarily given;
- The wishes of the child/ren, if the counsellor is of the opinion that the child is of sufficient maturity to express his or her wishes.
- Consideration of whether the making of a Parentage Order would be for the wellbeing and in the best interests of the child/ren.

7. Conclusion

There are different types of counselling roles related to surrogacy treatment at each stage of a surrogacy arrangement. Each counsellor must ascertain the specific requirements of practice in their particular situation to ensure that the counselling protocol fits the regulatory requirements. (See Addendum) Whilst there are differing legislative situations in each state of Australia and in New Zealand which outline the counselling recommended before, during and after a surrogacy pregnancy and delivery, the essential aspects of surrogacy counselling remain as outlined in these guidelines.

Differences in whether the counselling is done in-clinic or by a practitioner independent of the clinic or by a combination of both depend on the requirements of differing jurisdictions (See Addendum to these guidelines) as well as the approaches of individual ART clinics. It is however the responsibility of any counsellor undertaking any part of surrogacy related counselling, to ensure that the issues suggested in these guidelines are covered where appropriate, either by themselves or by another counsellor/s involved in the surrogacy case.

8. Attachment to Surrogacy Guidelines:

Addendum: Surrogacy Legislation in each state or territory of Australia, and in New Zealand, and requirements for counselling related to surrogacy arrangements August 2016