AUSTRALIAN AND NEW ZEALAND INFERTILITY COUNSELLORS ASSOCIATION

Guidelines for Professional Standards of Practice Infertility Counselling

A Sub-committee of the Fertility Society of Australiaand New Zealand

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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 practicing 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 practiced, 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 additional 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 practice 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 psycho-dynamically 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.

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 (on-line sessions permitted at the discretion of the Senior Counsellor)
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

Under certain circumstances a review session(s) is strongly recommended. These include where:

a) a significant change in circumstances has occurred, such as:

I. changes in legislation warranting patient review
II. change in relationship status
III. change from clinic-recruited to known donor or vice-versa
IV. the person has moved to a different location, where different legislative regulations are in place

b) at the request of clinic staff or participants of the donor programme
c) at the discretion of the counsellor.

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 us 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 RECIPENT 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.

2.10 INTER-CLINIC COUNSELLING RECORD TRANSFERS

A client may move their donor treatment to a new clinic after initial implications counselling has been completed. It is appropriate that any report (s) from previous implications counselling be made available for consideration by the counsellor at the new clinic. If the new counsellor is not fully satisfied that counselling has been finalised, or believes that any other issues remain outstanding, follow-up counselling session(s) may be requested at the discretion of the counsellor. In line with professional clinical practice, for inter-clinic transfers, client(s) must consent for release of their counselling information for review by the fertility counsellor employed/and or contracted by their new clinic.

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

2.11 RETENTION OF COUNSELLING RECORDS AND CONFIDENTIALITY OBLIGATIONS

According to NHMRC (2017), clinics must have processes in place for the audit and/or peer review of clinical decisions. ANZICA counsellors are encouraged to consider the purpose of all clinical reports and client records, and particularly consider methods for long-term storage and access of any clinical records pertaining to donor conception. Retention requirements may vary according to location of counselling and professional practice guidelines (APS/PACA). In private practice, counsellors have an ethical responsibility to retain adult client records for 7 years and child related records of counselling until the minor reaches 25 years. Storage of counselling records within ART clinics must be in line with legislative and NHMRC requirements and principles and policies of hospital record retainment.

Whilst donor conceived people may wish to access donor counselling records, any disclosure of counselling notes and/or personal information can only occur with the consent of the client to ensure that confidentiality obligations are observed. Any third- party information (e.g., from an organisation or other family member) cannot be provided without the consent of that party and/or unless stipulated in law.

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 (on-line sessions permitted at the discretion of the Senior Counsellor)
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

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

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.

SECTION 6: ADDITIONAL RESOURCES

- ANZICA Surrogacy Guidelines and Addendum:
- https://www.fertilitysociety.com.au/wp-content/uploads/ANZICA-SURROGACY-GUIDELINES-OCTOBER-2022.pdf
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- https://www.fertilitysociety.com.au/rtac/
- http://www.healthlawcentral.com/assistedreproduction/
- http://www.healthlawcentral.com/donorconception/
- http://www.healthlawcentral.com/surrogacy/
- https://gaffney-law.leapwp.com.au/wp-content/uploads/sites/1120/2017/04/Australian-Surrogacy-Handbook_WEB.pdf
- https://www.eshre.eu/Specialty-groups/Special-Interest-Groups/Psychology-Counselling/Archive/Guidelines.aspx