

Independent Queensland Fertility Counsellors, Social Workers and Psychologists

29 April 2022

Committee Secretary
Legal Affairs and Safety Committee
Parliament House
George Street
Brisbane Qld 4000
Email: lasc@parliament.qld.gov.au

RE: INQUIRY INTO MATTERS RELATING TO DONOR CONCEPTION

On 24 February 2022 the Queensland Legislative Assembly agreed that the Legal Affairs and Safety Committee (the committee) inquire into a range of matters related to donor conception. As active members of the Australian and New Zealand Infertility Counsellors Association (ANZICA) and key industry stakeholders working within the the current legislative framework supporting Queensland fertility clinics, we as a group of Independent Queensland Fertility Counsellors, Social Workers and Psychologists, are pleased to provide a submission to the inquiry.

Terms of reference for the inquiry

1.	On 24 February 2022 the Legislative Assembly agreed that the Legal Affairs and Safety Committee (the committee) inquire into and report to the Legislative Assembly by 31 August 2022 on: Issues relating to access to donor conception information, including:	In summary, we have the view that:
a.	Rights of donor-conceived persons, including to know their genetic origins	Donor-conceived (DC) persons have the right to know their genetic origins
b.	Extent to which identifying information about donors should be given to donor-conceived persons, taking into consideration the right to privacy of donors	Once they have reached adulthood, DC persons have the right to access identifying information about their donors, however safeguards should exist to protect unwanted intrusion into the lives of donors (particularly if donation was made with the assumption of anonymity)
c.	Access to historical clinical records and implications of retrospectivity	Consideration should be given to all DC persons having access to identifying information. To facilitate this, it would be necessary to establish processes which facilitate access to historical clinical records, and may require retrospective application of legislation, to arrangements which were made in the past under the assumption of anonymity.

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d.	Access to support and counselling for donor-conceived persons and donors	DC people, their parents and the donors should have access to low cost support and counselling at a variety of stages during the donor conception and donor-linking processes.
e.	Whether a register should be established	It is appropriate that a DC register be established, and ideally this should be linked to a national register. A mandatory donor conception register for donations from 2004 and a voluntary register for donations prior to 2004 should be mandated within a specific new piece of ART legislation in Qld. These registers are best held within Queensland Registry of Births Deaths and Marriages (BDM).
f.	Benefits, risks and implications on donor conception practices arising from any recommendations	Although risks exist in the establishment of a DC register, the benefits and positive implications outweigh any potential concerns, and risks can be mitigated by careful processes and provision of counselling by properly trained and experienced fertility counsellors.
2.	That the committee consider:	
a.	Views and experiences of donor-conceived people, donors and industry stakeholders of the current framework	Fertility counsellors are a key stakeholder in the assisted reproduction sector, and provide evidence and empirically based insights into the psychosocial implications of DC practices and processes.
b.	Current governance/regulatory frameworks, including registers established interstate	As specialized fertility counsellors we offer a uniquely informed perspective on the governance and regulatory frameworks currently operating in other jurisdictions, including those involving donor registers.
c.	Options to manage collection, storage, and disclosure of identifying and non-identifying information about donors, donor-conceived persons and relatives	The Privacy Act 1988 (Qld) makes provision for the storage of medical records, and in the case of DC arrangements, it may be appropriate that these records are kept indefinitely to safeguard the right of DC people to access their DC records at any future time. We recommend a centralised DC register as a way to properly collect and store DC records.
d.	Whether and how to collect and disclose identifying information about donors where a donation was made on the condition of anonymity, including matters relating to consent	Guidelines have been established for managing linking of DC adults or recipient parents and their donors, as well as between donor-conceived half genetic siblings and recipient parents who have used the same donor. These protocols

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		respects the interests of donor-conceived adults, recipient parents and donors, and safeguard individual sensitivities regarding privacy by utilising a model of mediation and facilitation.
e.	Whether any model should include information from private donor arrangements	Donors, recipients, and DC people from private donor arrangements, should also be able to register with any established DC register.
f.	Costs of any proposal including to establish and maintain any register and options for efficiencies, including a user-pays model	The costs of any DC register model, (including establishment and maintenance) can be absorbed through existing agencies, and utilise a low-cost “user-pays” structure. We recommend the utilisation of the BDM to establish and maintain a DC register.
g.	Whether regulating donor conception practices and assisted reproductive technology should also be considered as part of establishing a donor conception register; and human rights observed under the <i>Human Rights Act 2019</i> .	Any effective and enforceable donor conception register must be embedded within a general ART regulation.

By way of background, all signatories to the current submission are members of ANZICA, and follow the policies, standards and clinical practices of that organisation. ANZICA is the peak Australian and New Zealand professional counselling organisation dedicated to promoting the psychological and social wellbeing of individuals and couples undergoing fertility treatment (including donor conception and other third-party reproductive treatments). ANZICA has members in every State and Territory of Australia and across New Zealand. First established in 1989, ANZICA has provided an independent voice, both in counselling and advocacy, for people experiencing infertility and acted as a consultative body on psychosocial issues pertaining to infertility, infertility counselling and related matters. It has established Counselling Guidelines to document the minimum standards of service provision and provides a strong professional identity and educational base for all counsellors working in the clinical field of infertility. ANZICA is now a subcommittee of the Fertility Society of Australia and New Zealand (FSANZ), along with SIRT, FNA, DART and the IVF Directors Group, assisting recognition in the industry that counselling is an integral component of fertility treatment in Australia and New Zealand; a view that is reflected in the RTAC code of practice and auditing processes.

Consistent with the 2017 NHMRC Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research (The NHMRC Guidelines)¹, ANZICA considers the best interests of the child to be born from ART techniques a fundamental principle, guiding both counselling practice and process, including in donor conception.

ART activities must be conducted in a way that shows respect to all involved.

¹ National Health and Medical Research Council (2017). Ethical guidelines on the use of assisted reproductive technology in clinical practice and research. Canberra: National Health and Medical Research Council.

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The interests and wellbeing of the person who may be born as a result of an ART activity must be an important consideration in all decisions about the activity.

ART activities must be undertaken in a manner that minimises harm and maximises the benefit to each individual or couple involved in the ART activity, any persons who may be born as a result of the activity, and any other child within the family unit who may be affected by that birth.

Decision-making in the clinical practice of ART must recognise and take into account the biological connections and social relationships that exist or may be formed as a result of the ART activity(p19).

As per NHMRC Guidelines, we believe donor-conceived persons have the right to know their genetic origins and any register must support the seeking of information regarding genetic origins.

‘The interests and wellbeing of the person who may be born as a result of an ART activity must be an important consideration in all decisions about the activity’[pg. 23].

‘Decision-making in the clinical practice of ART must recognise and take into account the biological connections and social relationships that exist or may be formed as a result of the ART activity’[pg. 24].

The primary purpose of a centralised register is to facilitate the exchange of information between donors, recipients and persons born as a result of gamete donation. Such registries have already been established in New South Wales, Victoria, Western Australia, South Australia and New Zealand. NHMRC’s ART Working Committee sought to reinforce the importance of each state/territory establishing its own registry for donor conception in the absence of a centralised National register.

The NHMRC Guidelines acknowledge the importance of the biological connection and support the right of an individual to know their genetic origins. The voluntary exchange of information between the donor, recipient and the persons born, facilitated by a centralised Qld state donor register is crucial in upholding this right. We strongly recommend that a state-run host organisation may take the lead in this endeavour – for example the BDM [which includes adoption and surrogacy], thus also enabling a donor-conceived person to find out more about his or her biological heritage.

All individuals and couples involved in ART activities, including gamete and embryo donors, and persons born, are entitled to privacy to the degree that is protected by law. The NHMRC Ethical Guidelines may not provide sufficient protection to fertility clinics in accessing parental treatment records on behalf of a donor-conceived adult without the parent/s’ express permission. This creates a conflict of interest regarding upholding the rights of donor-conceived people to learn whether they were donor-conceived and discover their donor’s identity versus their recipient parents right to the privacy of their medical records. As per NHMRC Ethical Guidelines, ‘clinics must have a privacy policy that ensures compliance with the relevant legislation’ [pg. 28].

Ideally, access to identifying donor conception information should be made possible where all parties to donor conception have given informed consent. We believe this is best served via access to implications counselling with an accredited ANZICA counsellor for all parties and striking a balance between fulfilling the wishes of DC people to learn of their genetic heritage and respecting the wishes of those who donated to maintain their privacy if they so desire.

As per NHMRC guidelines –

As a **minimum**, the following information should be recorded for each ART activity:

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Full names (including previous names) and contact details of all individuals and couples involved and, whenever possible, the names of any person born as a result of the activity [pg. 84].

We recommend that as long as consent has been obtained via confirmed completion of implications counselling for recipient/s and donor, also all relevant consent forms signifying each party's understanding and agreement prior to conception, then the DC person may upon reaching the age of 18 years and legal maturity, receive the full name, date-of-birth, and donor code of their gamete donor/s. Any contact between donor and offspring could then be facilitated either by the clinic counsellor or one employed by the host organisation responsible for the central register and the subject's agreed contact preference impact what information is released and the type of contact, i.e., email address, telephone number, PO Box, in-person meeting.

Concerning the creation and storage of donor records, The NHMRC Guidelines state

Detailed records must be maintained so that the short and long-term outcomes of ART activities can be assessed in order to document benefit and harm. The objectives of this are to maximise the availability of data for research, monitoring and professional oversight and to identify risks — and facilitate their correction — in order to minimise harm to all parties, including to the persons born (p27).

Unfortunately, it is well established in other jurisdictions (including Victoria and South Australia), that storage of Fertility Clinic records has not always been at an acceptable standard. In recent times, searches for medical records on behalf of the relevant parties to a donor conception, have found donor records pertaining to the same donor, or recipient family, kept at various locations, including different hospitals and various fertility clinics. Clinic staff involved in these searches describe an often gruelling search for records – exacerbated by the fact that some of the organisations holding these records have not been under any **legal** obligation to maintain them or to allow applicants access to them.

Furthermore, the Privacy Act 1988 (Qld) makes provision for the storage of medical records, and broadly speaking, across health professional organisations the current recommended storage period for adult health records is seven years. New South Wales, Victoria and the Australian Capital Territory have specific legislation relating to medical records and health information, and state that medical records are to be retained until a child turns 25 years, and for adults, for seven years from the date of the provision of the last health service. Given that a under the current legislative guidelines for fertility clinics within Qld, a DC person does not have access to their biological records until they turn 18 years of age, we propose more specific legislation for Qld to cover the storage of clinical records involving DC people, including recipients and donors' health records. We suggest that clinical records be stored for a longer period of time to the current recommended period for people under the age of 18 years or infants, and retain the recipients' (parents) and donors' records for a period of 25 years from the child's birth to ensure the DC person has access to records relevant to their biological origins. Obligations for storage of DC records in other states are wide-ranging. For example, under the New Zealand Human Assisted Reproductive Technology (HART) Act, a provider must keep all records regarding donation (e.g. information about recipient and donor) for 50 years or until they shut down and no other provider replaces them, at which time the information must be sent to the HART register. The HART register is sent identifying and contact information once a child is born if a donor is involved in the conception, and must retain information indefinitely. In Western Australia, the Human Reproductive (HRT) Act requires indefinite storage of DC records .

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These systems allow for donor conceived individuals to gain information when they wish to, rather than within a specified timeframe—particularly useful if they find out later in life or develop interest in donation later in life.

It is safe to assume that the same challenges will be faced by Queensland families attempting to locate historical clinical records, particularly for those preceding NHMRC guidelines which articulated more stringent expectations for data collection and storage. These likely challenges have clear implications for efforts to link past donor arrangements.

We might reasonably anticipate particular challenges will be faced by families who undertook donor treatment prior to 2004, when NHMRC guidelines identified the rights of DC people to know their biological identity, and gamete donation was made under the assumption of anonymity. However, precedent management of this exists in jurisdictions such as Victoria, where world leading legislation was established to provide for retrospective removal of anonymity for donors. Victorian counsellors undertaking donor linking for people DC prior to 2004, have demonstrated that with patience and tenacity, donor linking is possible, and the rights of DC people can be upheld, even when clinical records have been completely or partially destroyed or lost.

To properly recognise the rights of DC people, any donor register established in Queensland must include donations made prior to 2004, retrospectively removing the anonymity of these donations, and rectify the harm to people born through past donor conception treatment. Any argument that retrospective removal of anonymity would undermine the right to privacy of people who historically donated is answered through the NHMRC Guidelines, which state:

The right to privacy is not absolute in Australia. However, all individuals and couples involved in ART activities, including gamete and embryo donors, and persons born, are entitled to privacy to the degree that is protected by law.

ART clinics hold large amounts of personal, sensitive or health information. Where an ART clinic operates as a private sector health service provider, it is considered an 'Australian Privacy Principle (APP) entity' under the Privacy Act 1988 (Cth) and is required to comply with the Privacy Act and the Australian Privacy Principles (APPs). It is a requirement for APP entities to take reasonable steps to secure this information from misuse, interference, loss and from unauthorised access, modification or disclosure. ART clinics in the private sector should seek advice from the relevant federal body in order to understand best practice and how to comply with the APPs when it comes to handling and storing this information.

ART clinics that operate as a public health service provider must comply with the relevant state or territory privacy legislation.

Clinics must have a privacy policy that ensures compliance with the relevant legislation (p 34).

The opportunity to establish legislation in Queensland which protects DC people, provides an opportunity for clinics to develop privacy policies compliant with local legislation AND with proper consideration of the wellbeing of DC people.

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With regards to the issue of access to support and counselling for DC persons and donors, the NHMRC Guidelines currently mandate gamete donors and recipients to undertake implications counselling with an ANZICA registered counsellor. However, long term follow up is not required and nor is therapeutic support routinely offered to DC people. We strongly recommend psycho-social preparation and support for participants prior to accessing donor-identifying information while acknowledging that not everyone will require this. This process been recognised as a pivotal point that may have long-term impacts on the DC person's mental, emotional and social wellbeing.

Supportive counselling undertaken by an ANZICA Fertility Counsellor ensures that the emotional-wellbeing of the DC person is being attended to as well as sensitivity being shown to the donor and both respective families. If counsellors were excluded from this arguably crucial stage in the donor-person's journey, this could have deleterious implications for the DC person's welfare and in the lives of donors if not navigated sensitively.

Counsellors hold a critical and experienced role of assisting applicants (DC people, recipient parents, donors and their relatives) to develop a statement of the applicant's reasons for applying to the donor conception registers, for forwarding to the subject of the application. As well as facilitating the donor-linking activities such as facilitating the exchange of information between parties and facilitated meetings between parties if requested.

As a minimum we recommend providing at least one implications counselling session to the DC person. This gives them a point of contact for additional support should the parties require it as well as the potential for support groups. This could be at the user's expense but puts them in contact with an experienced counsellor and provides continuity of care. This model has been implemented successfully in Victoria where mandatory counselling is facilitated by VARTA.

Counsellors can also offer follow-up support for those who are unable to access information from the donor registers or for those who are initiating information exchange or contact. Counsellors could keep appropriate records of the above activities including writing reports and recording counselling activity in the customer relationship database as required. This information would be very relevant to any future searches initiated, particularly when a donor comes forward with new contact information or fresh consent for contact when they originally donated anonymously.

For comparison, the intermediary role played by the counsellor is common in the adoption reunion field. The Infertility Treatment Authority (ITA) model of service provision was based on evidence-based success of this practice model. An average of two counselling sessions per linkage was required. There, the role of the counsellor is to establish the ground rules for information exchange or contact. The counsellor assists the parties with the first steps of contact and then withdrew, allowing the parties to communicate with each other. If either party was experiencing difficulties, they could request further support from the counsellor.

There are clear and established risks to the health and welfare of DC young adults, parents of DC children and donors, if information about an application is not provided within a counselling environment. Services provided to those affected by donor conception are minimal compared to services provided to people affected by adoption yet there are significant complexities in donor conception practice due to the number of families created by one donor (NHMRC Guidelines allowing for up to ten recipient families).

Queensland is in an an opportune position to develop a service of excellence and expand upon the foundation work of others to become the forerunners in donor linking both here in Australia and around the world. This is not only a worthy achievement but when done correctly, that is, with the

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inclusion of counselling support, has the chance to positively impact the wellbeing of both donors and offspring as they enter the next passage of the donor conception journey. Put simply, counselling for DC child/adult is a natural extension of the assisted reproductive technology (ART) community's current duty of care to our patients and clients.

We firmly recommend that a donor conception register should be established to support the linking of DC people to their donors. Ideally, such a register would be established with national reach, facilitating the linking of families who have previously undertaken treatment in different states. This would also help reduce the risk of donors exceeding recommended or mandated family limits by donating in different jurisdictions.

There are inevitable risks in establishing any new system with oversight of donor conception practices, but these are outweighed by the psychosocial benefits to the persons who have been donor conceived. As experts in the preparation of donors and families to undertake donor conception and later facilitating donor linking, ANZICA counsellors have spent decades researching the risks and implications of donor conception and developing protocols and practices to mitigate the psychosocial risks of treatment. Australian and international research has clearly demonstrated the benefit to DC people having access to information about their biological heritage.

ANZICA counsellors currently provide counselling:

- To potential donors (both known or clinic recruited) prior to donation
- To potential recipient parents prior to donation
- When donor and recipient are known to each other, to facilitate a discussion of expectations and wishes for future relationships between all parties
- To donors following conception/birth of the DC child to address any unexpected issues which may arise as a result of the donation
- To recipient parents following conception/birth of the DC child to address any unexpected issues which may arise as a result of the donation
- To DC people, to assist their understanding of the implications of the donor conception².

ANZICA has an established guideline for managing donor linking³, pertaining to requests for exchange of information between a DC adult or recipient parent and their donor, as well as between DC half genetic siblings and recipient parents who have used the same donor. This protocol respects the interests of DC adults, recipient parents and donors as well as individual sensitivities regarding privacy by utilising a model of mediation and facilitation. Figure 1 outlines ANZICA's recommended process for donor linking, which has been adopted across Australia and New Zealand. In this process, the counsellor is not an advocate for one party over another but supports both the client who wishes to find information and the subject of the enquiry throughout the process. This process supports the principle that people affected by donation may have an interest to request information or make contact with their donor, genetic offspring, or genetic half-siblings, and such interest in information or contact is to be treated as normal and responded to positively.

The process is completely respectful of an individual's right to privacy. Information must not be released to another person without the consent of the individual concerned, and evidence from

² ANZICA Guidelines for Professional Standards of Practice Infertility Counselling 2018

³ ANZICA Guidelines for Professional Standards of Practice: Donor Linking Counselling

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Victoria, where retrospective removal of anonymity has been built into the donor linking process, has demonstrated that with the right support, client seeking donor linking have OVERWHELMINGLY respected the rights to privacy of the subject of their query, even when this has resulted in their NOT achieving their original goal of contact.

To ensure that the right support is provided and any donor linking process runs smoothly and respectfully, it is critical that **specialised** counselling be offered at numerous points in any donor conception pathway, including:

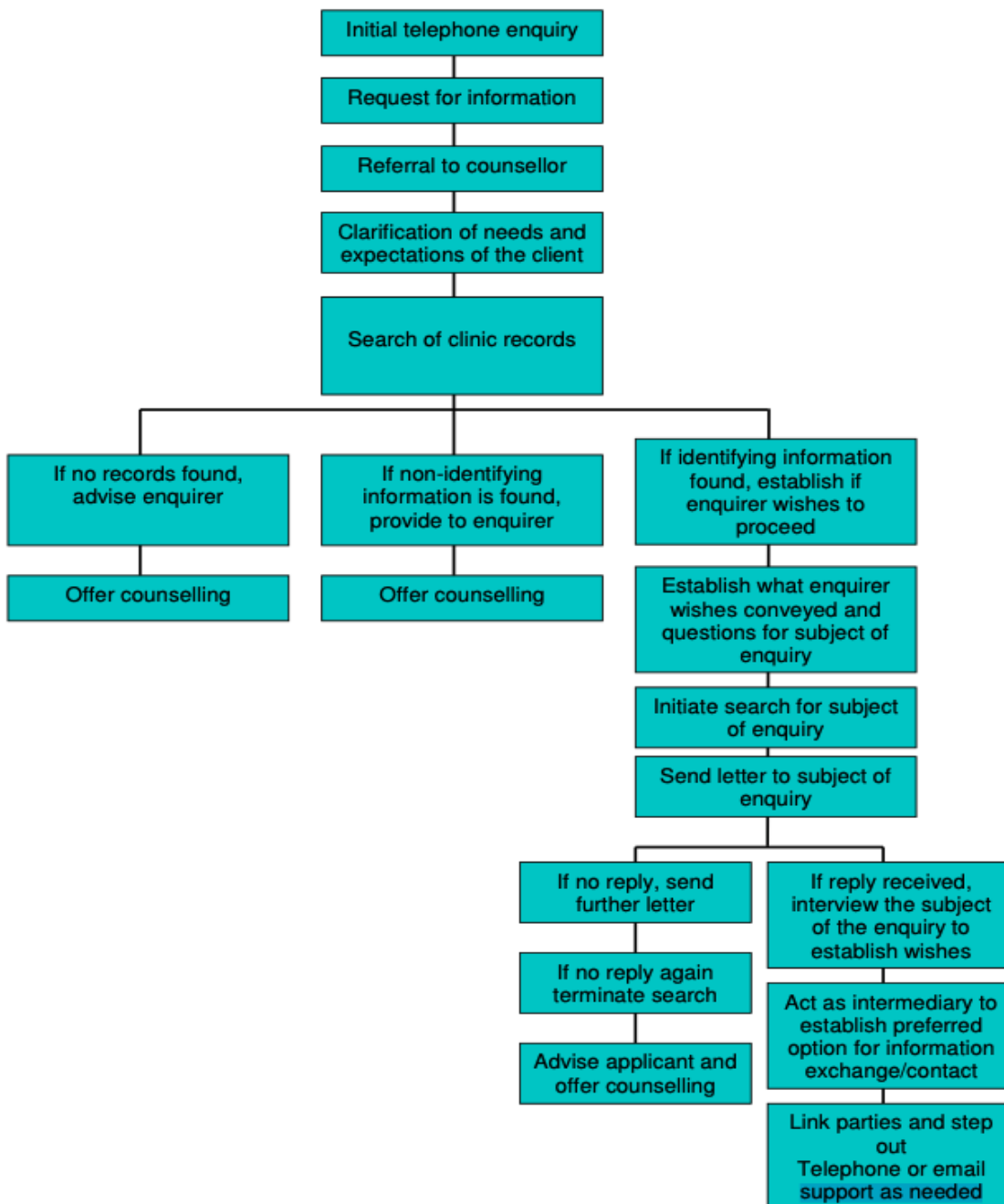
- Following requests for non-identifying information
- For clarification of the specific request for information/contact for that person including their motivation and clarification of their needs and expectations of the possible outcome of the enquiry i.e. what specific information do they wish to know e.g. medical, do they want to exchange emails/letters/meet?
- To facilitate understanding of the context of other life issues including the impact of the search to people close to the enquirer
- For discussion of possible outcomes of pursuing the request including case scenarios of positive and adverse outcomes e.g., where donors and donor-conceived individuals have exchanged information or made contact, the possibility the other party does not consent to provide information
- For consideration of the possible implications for the other party and the possible impact to those close to them
- If the subject of the outreach cannot be located
- If the subject of the outreach is located, to re-establish whether the client wishes to proceed before any attempt is made to contact the other party.
- When contact is made with the outreached party, the subject should be invited to attend counselling.
- To clarify the subject's feelings, thoughts, expectations, and wishes in relation to the enquiry and implications for themselves and those close to them. Would they be prepared to exchange information?
- To establish what information can be passed on to the enquirer, (e.g. would they be prepared to exchange emails/letters, would they be prepared to meet, etc).

Further counselling may also be required by either party, depending on outcomes and emotional reactions, and the counsellor may adopt a mediation role in this instance.

The needs of others in the immediate families of each party should also be considered. It is likely that issues that were salient at the time of the treatment or donation will resurface and will need to be dealt with (e.g. marital conflict, dealing with infertility, grief etc). Disclosure issues are also likely to need to be addressed if people close to either party are unaware of the donation.

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FIGURE 1. PROCESS MAP- Donor Linking Counselling Process



We recommend that a mandatory donor conception register for donations from 2004 and a voluntary register for donations prior to 2004, should be mandated within a specific new piece of ART legislation in Qld. These registers are best held within the BDM. Fertility providers would send birth details through to BDM for recording following a live donor conception birth. The specific details needing to be recorded for the donors, recipients, and offspring, would be clearly mandated in the new legislation. Donors, recipients, and DC people prior to 2004, would contact BDM directly, to have their details entered into the voluntary register. Donors, recipients, and DC people from private donor

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arrangements, should also be able to register with the donor register. BDM would be responsible for having processes in place to keep personal details up to date.

The rights to access information on either register, should be clearly defined in the new Qld legislation. BDM would also need to have appropriate processes and supports in place, (some reasonable level of detail of which should be included in the legislation), to ensure the safe, sensitive, timely, and culturally appropriate disclosure of this very important and potentially life changing identifying and non-identifying information about donors, DC persons and relatives. The process should include a mandated information session for all parties seeking and receiving information through either of the donor registers. Such sessions are an important way of helping to ensure the long-term well-being of all parties and giving the communications and contacts the best possible chance of going well.

Regarding the question of whether and how to collect and disclose identifying information about donors where a donation was made on the condition of anonymity, including matters relating to consent.

DC persons are entitled to know who their donors are, should they want this information. They can request access to donors identity once they have either reached the age of 18 years or have acquired sufficient maturity to appreciate the significance of the request. A voluntary register would allow for past anonymous donors the fresh opportunity to list their identifying information to any potential offspring. Some may have participated anonymously but may now be open to contact from their donor-conceived offspring. This is particularly important where hereditary health concerns have come to light since the original donation. A Qld voluntary register could mirror VARTA's whereby initial written contact is sensitively established via the third party such as via the ANZICA counsellor who conducts the applicants counselling session. Alternatively, BDM personnel could make reasonable efforts to notify the gamete donor prior to release of information, once the counselling session has been completed and donor consent gained. Any anonymous information can be cross-referenced through a code.

We have the view that any DC register model should include information from private donor arrangements. However, it would need to be made clear to participants and those seeking information that this is a voluntary register and one not overseen by any fertility clinic, professional body, or government agency. Therefore, it may be of benefit to corroborate any claim of genetic kinship between donor-conceived offspring via DNA testing.

We recommend that the costs of any DC register model, including establishment and maintenance can be absorbed through existing agencies, and utilise a low-cost "user-pays" structure. We recommend the utilisation of the BDM to establish and maintain a DC register.

This would utilise the existing infrastructure of BDM, and donor registers could be 'added on' rather than setting up a whole new system. BDM would also be likely to be able to tap into existing systems for updating personal details-this would obviously be very important with the donor registers and carrying out linking and information requests in a timely and sensitive manner.

We propose a modest cost to participants for access to the register in line with VARTA's search and outreach service for people linked through donor-conception treatment [\$77.86]. Donors, DC adults, parents of DC people and descendants of DC people can all apply and receive this service. Alternatively, as per the Brisbane registry, an example of cost to participants may be 'receiving of a pre-adoption certificate' \$51.30 and 'search fee' \$25.55 which could give an indication as to the cost

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for the organisation in searching the register and communicating relevant information to a donor-conceived person regarding their donor and any donor-conceived siblings. Further counselling/support session for DC people might incur additional costs to register users.

It is widely recognised that any effective and enforceable donor conception register is established and embedded within a more general ART regulation. Queensland donor conception practices already operate within an environment of self-regulation, but while clinics and individual practitioners are only required to comply with unenforceable practice/ethical guidelines, there will be room to repeat damaging practices.

As outlined above, psychosocial preparation and counselling support at a variety of points in the donor conception process is critical, and to be confident that this is undertaken at an appropriate standard can only be achieved through the mandate of legislation.

The language of consent forms which have not been couched in legislation leaves room for interpretation, and the establishment of ART regulation would give DC people a legislated right to their own information, without being potentially prevented access through privacy law restrictions (as is the current case in Queensland where privacy law “trumps” clinical guidelines, and DC people could potentially be prevented from accessing records, which actually belong to the birth mother.)

However, it is essential that the drafting of any Queensland ART regulation or legislation provides for access to services for ALL people. There are historical and active examples of ART legislation in Australia which overtly discriminates against certain groups (including on the basis of marital status or sexual preference) and it would be a clear violation of the anti-discrimination act if any such restrictions were incorporated into Queensland legislation. We would welcome the opportunity to remain involved and to be consulted as a key stakeholder in any ongoing ART policy and legislative development.

Submission Date: 29 April 2022
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Following are the names of Queensland fertility counsellors, social workers and psychologists who have endorsed the above submission:

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