

STANDING COMMITTEE ON LEGISLATION

SURROGACY BILL 2007

**TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 20 FEBRUARY 2008**

SESSION ONE

Members

**Hon Graham Giffard (Chair)
Hon Giz Watson (Deputy Chair)
Hon Ken Baston
Hon Peter Collier
Hon Sally Talbot**

Hon Kate Doust (Participating Member)

Hearing commenced at 10.02 am**MIDFORD, MRS SUZANNE****Clinical Psychologist/Approved Counsellor, Perth Psychological Services,
sworn and examined:****RODINO, MS IOLANDA****Clinical Psychologist/Approved Infertility Counsellor,
sworn and examined:****CLISSA, MS ANTONIA****Approved Counsellor/Social Worker,
sworn and examined:**

CHAIR: On behalf of the committee I welcome you to the meeting. Before we begin, I ask you to take either the oath or the affirmation.

[Witnesses took the oath or affirmation.]

CHAIR: Please state your full name and the capacity in which you appear before the committee.

Mrs Midford: My name is Suzanne Midford.

Mrs Midford: I appear before this committee in the capacity of a clinical psychologist/ approved counsellor and a member of a group of approved counsellors under the act.

CHAIR: Thank you.

Ms Rodino: My name is Iolanda Rodino. I present to this committee in the capacity of clinical psychologist and approved infertility counsellor who consults to several clinics.

CHAIR: Thank you.

Ms Clissa: Antonia Clissa. I appear today as an approved counsellor under the HRT act.

CHAIR: Thank you. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

The Witnesses: Yes.

CHAIR: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to talk into them. Ensure that you do not cover them with papers or make noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that premature publication or disclosure of public evidence may constitute a contempt of Parliament and may mean that material published or disclosed is not subject to parliamentary privilege.

We have a number of questions that we will ask you that are based on the submission you have made to the committee. Thank you; we have received that submission. Before I do that, I invite each of you, if you wish, to make an opening statement to the committee. If you prefer, we will just go straight to the questions.

Mrs Midford: I was going to speak briefly to a few issues before we answer, happily, your questions. First of all I would like to say that Antonia, Iolanda and I are all approved counsellors under the act, as you have heard, and we have all had direct experience in working with consumers, donors, recipients, children—including surrogacy. All of us have also been involved in considering these issues over many years. We have discussed this with our broader group, and our experience individually is at least 12 years and more, so we come to this with a lot of understanding and thought of this very complex issue. We represent a group of mental health professionals who cannot, obviously, all be here today. In fact, that group comprises a majority of the clinic counsellors and we have substantial agreement on the basic tenets of our submission, which is that it is important that the best interests of the child are paramount and that harm minimisation needs to be looked at.

We have, as a professional group, always had concerns about surrogacy arrangements. We acknowledge that people have a strong biological desire to have their own children and in the past—and indeed in the present—many have resorted to informal arrangements in the community, which leave everyone, the children in particular, extremely vulnerable. In relation to that we draw your attention to the well-known Re Evelyn case, which I was personally involved—as a witness—and considerably involved in that case. It is important to state here that that caused a pivotal change in my thinking on surrogacy and I am happy to discuss that later, if that is of relevance to you.

The first thing we would like to add to our submission is that we would really encourage the committee to look at endorsing—we endorse the legislative framework, which enable surrogacy arrangements to be carried out within highly regulated and prescribed parameters. We believe it is in the best interests of all the parties, particularly the unborn child. We strongly recommend that the paramount interests of the child to be born and the harm minimisation approach form the basic underpinning of the legislation. We would like to suggest that this intent be clearly outlined in a preamble to the legislation.

We believe that the strengths of the proposed legislation is the focus on subsidiary legislation; that is, the directions on the preparation and assessment process, because that provides a view to reducing the potential harm to all the parties, again, particularly the child to be born. The group agrees with the proposed details of the assessment process being outlined in the subsidiary legislation; that is, the directions that have accompanied this and that they are consistent with the current directions under the Human Reproductive Technology Act 1991.

Before I finish, I would like to raise a few concerns and highlight them. The first one is the paramount interest of the child. We strongly believe that the best interests of the child are paramount and as such, the group that we represent strongly advocates that there be a genetic relationship with at least one arranged parent. We know that currently embryo donation is permitted under the Human Reproductive Technology Act 1991 but we consider that the added complexity of surrogacy where a child could potentially be related to four sets of parents—arranged parents, birth parents, egg donor and sperm donor—not to be in the paramount best interests of the child.

The second issue we would like to raise is in regard to the surrogate or the birth mother. We believe it is imperative that the surrogate be able to give her informed consent freely and without coercion. To that end we have serious concerns that an 18-year-old is expected to do this; therefore, we recommend that the birth mother, to be a surrogate, must have a live child and preferably have completed her family before she is considered as a potential surrogate. We are not suggesting an age change but that. We also recommend that where a prospective surrogate has not completed her family or has suffered a maternal loss, that she is required to undertake a psychiatric assessment because this is known to be a potential risk.

In terms of the reasonable expenses to be paid to the surrogate, as well as the medical expenses being covered, we recommend that mental health expenses need to be included and that these need to be included for up to 12 months post-natally.

[10.10 am]

It is recognised that it is not always possible to predict future outcomes even with the best preparation and the best assessment.

The next issue we would like to raise is the unenforceability of the surrogacy arrangement. Our group endorses the unenforceability of the surrogacy arrangement for the following reasons. The first is that we are very concerned with the commodification of children; we do not believe that that is in any way good. The second is that we believe that there needs to be protection for the surrogate or the birth mother because surrogacy is a complex and unusual life experience, and it is not always possible to predict how the birth mother will respond postnatally. It is also really important to recognise that it provides protection for the recipient couple. The surrogacy arrangements should not be enforceable for either the birth parent mother—the surrogate—or for the recipient couple.

We have information which has been obtained from the surrogacy parenting centre in the United States, which has now been going for well over 20 years. The statistic that we obtained from them was that in 900 cases only three had broken down, and in all, they related to the recipient couple. We believe it is really important in preparation for both the surrogate and for the recipient couple that they be aware of the unenforceability of the surrogacy arrangement. To that end, it is vital that there be very good preparation available for them, well before they start producing a child.

The next issue is parentage orders. We recommend that the transfer of parentage should only be granted following the recommendations of the child representative who has considered fully the paramount interests of the child. There needs to be a person nominated to be a child representative for surrogacy at the time of the application for the parentage orders.

The next concern we have is an educative process. We recommend information sessions for prospective parties interested in surrogacy. We believe that these sessions should be conducted by the WA Reproductive Technology Council throughout each year, and that they should be similar to the information sessions which are currently offered for fostering and adoption; they are carried out by the Department for Child Protection, as it is now known. This is really important in providing people with early information and the opportunity to get accurate and reliable information.

Our final point—you will be pleased to know—is that we would like to strongly recommend that there be a review of the surrogacy legislation in five years, following the implementation of the act, because of the extremely emotional and controversial nature of the issues involved. Thank you.

CHAIR: Thank you. I will move now to the questions that we have prepared for you. Firstly, your submission recommends assessment by external, professional, independent parties. Can you just advise the committee if counselling is currently provided on this basis for IVF clients? In other words, is it consistent with requirements under the existing HRT directions?

Ms Clissa: So, the question is about independent parties—assessment by independent parties?

CHAIR: Yes; you are recommending assessment by external, professional, independent parties. We are asking if counselling is already provided on that basis for IVF clients.

Ms Clissa: Currently, counselling for IVF patients is carried out by the clinic councillor. What we are recommending is that it actually be an independent external party not employed by the clinic; so it is actually an independent psychometric assessment by a clinical psychologist who is not employed by the clinic.

Ms Rodino: Could I add to that?

CHAIR: Yes.

Ms Rodino: It does not preclude the clinic councillor from requesting a second opinion or additional assessment outside of the clinic.

CHAIR: Currently?

Ms Clissa: Currently, yes.

Ms Rodino: Currently. So it does not preclude it. It depends on —

CHAIR: Does that happen?

Ms Rodino: It can, yes.

Mrs Midford: Not very often.

CHAIR: Does it happen very often?

Ms Clissa: Not very often, no.

Ms Rodino: Not often; it is not standard practice but at times you might require a second opinion and it is not precluded—the counsellor is not precluded from doing that.

Ms Clissa: What we are recommending here is that it is completely separate; that there is not any element of coercion. Also, not all of the clinics employ people who would be able to give that psychometric testing.

CHAIR: What are your reasons for recommending that?

Mrs Midford: It is objective; so that there is no confusion for either the people involved—that there is collusion, well, not collusion, that there is not any pressure on them to come to a particular conclusion—and also so that you can have people who have developed a particular expertise.

Ms Rodino: The other point I was going to make is that when patients actually present to a clinic—so, if they are already, almost, like on the rollercoaster of the clinic experience—having external assessment and recommendations are very important to give an independent perspective for that patient or for all patients who actually present. So, it is quite useful and, I think, paramount to actually have independent assessments—which are quite separate from the exchange of gametes, which would take place in surrogacy—to the actual transfer to a third party as a surrogate mother. So, you certainly need someone quite separate to the actual IVF clinic experience as well.

Hon PETER COLLIER: Who would constitute the professional independent agencies? Who would you be referring to?

[10.20 am]

Hon PETER COLLIER: So would there be a register? What would you be looking at?

Ms Rodino: Of clinical psychologists? Yes, I guess there would be a need to establish a particular register of clinical psychologists who have expertise in the area of reproductive health. That is certainly something I would have in mind.

Hon PETER COLLIER: Can you think of anyone other than clinical psychologists?

Mrs Midford: Because of the nature of the assessment, we would require a clinical psychologist, and then a psychiatrist. The approved list of counsellors would be the logical list, and to have people identified on that list who are suitable. There are more people on that list who are not clinic counsellors than there are clinic counsellors. There are a lot of counsellors in the community providing fertility counselling who are not clinic counsellors, and the thrust in this state has been to encourage that, so that people have an alternative. The reality is that that does not happen very often, and most people actually use the clinic counsellors, which is fine, but we have always believed that it is really important that people have at least a potential choice. We are very lucky that a number of people have been prepared, even though they do not get a lot of work from it, to remain on that list and maintain their expertise, while remaining in the community.

Ms Clissa: I just wanted to add to the comments about the independent assessment. It would include the clinical psychologist to provide the psychometric testing. The feedback from our overseas and interstate colleagues is that it is really important for people to have an objective measure, in which they are actually put through a battery of tests. If they are rejected, there are

specific reasons for it. That would include the surrogate and the recipient. It would also include the clinic counsellor giving the psychosocial perspective, which currently happens. It would just be another level of independence, well recognised in the ART community as a benchmark for assessing the sorts of qualities that people would need to undertake such a complex program.

Hon KATE DOUST: Who determines and maintains this list?

Mrs Midford: The Reproductive Technology Council reviews the criteria and we insist on people maintaining their currency, so anyone who is on that list must regularly attend training sessions to keep their knowledge base up. That has developed over time, but that is how it is now. There are specific criteria, and they have to maintain their currency.

CHAIR: Your submission also recommends a mandatory cooling-off period for all parties. At what stage should this occur, and how long should the cooling-off period be? Is there any research to support that recommendation that you can point us towards?

Ms Clissa: A lot of this is based on what is currently the case with patients who are using donated gametes—donated egg, embryos or sperm. The current situation under the legislation applies in cases of known donation only, and of course surrogacy parties all know each other. Because of the complexity of surrogacy, the group feels that it is really important that, after all the assessment and selection had been done, there is an opportunity for all parties to have a time of reflecting in order to prevent any level of coercion. We know that, particularly when the birth mother is likely to be someone within a family, that can be very subtle, particularly if there is an age and power relationship. There can be very subtle coercion. Based on our clinical experience with known donation we have made this recommendation for a cooling-off period. We have all had experiences in which initially all the parties absolutely detest having the cooling-off period because they want to get ahead and have this child, and we are in the way, saying that they must have this cooling-off period. I particularly remember one case in which all the parties were friends, and wanted to get on with it. They were so angry that we made them wait. Within the three months that they had to wait, they came back and said “Our relationship has broken down; there is no way we can go ahead with this.” Apparently, during that time, the parties talked to their extended families, not just to each other. The reactions they got from the extended family indicated that this was not going to work, and they had concerns about that. In fact, they came back and thanked us for not listening to them in the first instance. Part of what you are dealing with in issues of assisted reproductive technology is that people have this very strong drive to have a child, and when they have to use non-conventional methods of having a child, they are still focussed on wanting the child, but when you go into the more complex areas, they do not even know themselves how they are going to respond, and how their families are going to respond. They have not considered all the issues, and that is what I think the counsellors, doctors and the psychometric testing is about. It is about ensuring that people have all the information intellectually and also emotionally about themselves and what they and their families can cope with. Often, you do not know because you are not there in that situation, and that is why we want to give them all time to ensure that this is the right thing for them as much as possible. It is not going to be perfect, but it is really a built-in mechanism for people to leave the arrangement at that point, before there is a child, because once there is a child — with the Re Evelyn case, it went to the High Court, and it has been a very difficult situation for everybody. It is based on our clinical experience, but others might want to add to that.

Mrs Midford: I have been involved in a number of cases, including the Re Evelyn case, and some of those have proceeded, but some of them have not proceeded. The time they have had to think about it after they have done the assessment, is when people have the opportunity to really think through things and talk to people. It is important that that occurs before a child is created. If we are talking about the child as being the primary person to be protected in this, and we are talking about harm minimisation, then having a cooling-off period is a relatively simple way of ensuring that that occurs for people. As far as I know, there is no research evidence, and it would only be post hoc,

because it is not the kind of area that you can do anything forward; you need to go backwards. Certainly, from the evidence we have had clinically, where people have had time to consider it and think about it, it has been successful. The Kirkman sisters have had a very successful surrogacy arrangement, but where it has been unsuccessful — I know absolutely in the Re Evelyn case, if those two couples had actually talked to each other, and if they had actually discussed their different views of what was going to happen on the other side of the child being born, they would never have proceeded with having that little girl. Nobody wants that little girl not to exist now, because she does exist, but that case caused extraordinary pain to the child, to the recipient couple, the surrogate and the children on both sides of the family, and our group is really very strong on trying to —

CHAIR: Are you suggesting that the cooling-off period occurs prior to the IVF procedure?

Mrs Midford: Absolutely.

Hon SALLY TALBOT: That point you just made is really about the benefits of counselling, rather than the cooling-off period, is it not?

Mrs Midford: Both—the counselling is very important, so that people actually understand what each wants, but the cooling-off period is different. I have been involved in cases where everyone agrees it is a great idea, and they will do it. Everyone is carried away with the enthusiasm of it and then it stops for a period and everyone sits back and thinks about it. That is when the doubts creep in, and if the doubts creep in, it is much better for it to stop before the child is created. That is basically what we are saying.

[10.30 am]

Hon SALLY TALBOT: So your two points are related?

Ms Rodino: Yes. The reality is that even at a very basic level, excluding the surrogacy situation, people do change their minds. They have counselling, and hopefully they gain the benefits of that counselling. We then implement a mandatory cooling-off period, and we have a review with them, and we find that people just do not come back. It may be that we have talked them out of it, or it may be that they have thought more about the issues, but either way it has been worthwhile in the sense that it occurs prior to the creation of any embryo that is going to be used or transferred. So people do change their minds after counselling.

Hon KATE DOUST: The directions provide for a three-month cooling-off period. Is it your view that that is sufficient, or should we be looking at what they do in New South Wales, where they have a six-month cooling-off period, or do you have another specific period of time in mind?

Ms Clissa: We used to have a six-month cooling-off period, but the feedback from the clinic counsellors was that they were saying that if you give people six months, they will take six months, and if you give them 12 months, they will take 12 months. They felt that three months actually forced people to make a decision. So it was six months, and it was reduced to three months. We have based that on consistency with what actually already happens with known donations of gametes or embryos.

Hon PETER COLLIER: So you are supportive of three months?

Ms Clissa: Yes, based on the feedback from the clinic counsellors, who felt that when people have to make a decision, that was sufficient time.

Mrs Midford: But that three months starts after they have gone through all of that process, so it is a plus. It is not part of the counselling or the assessment period.

Hon KATE DOUST: Is there a cooling-off period for couples who are just using IVF processes that are not connected with surrogacy?

Ms Clissa: Only when they are using donor gametes; that is, if they are using donor eggs, donor sperm or donor embryos.

Hon KATE DOUST: In that case it is three months?

Ms Clissa: Only if there is a known component—that is, if it is a known embryo donor or egg donor—not if it is anonymous.

Mrs Midford: It is six months if it is anonymous.

Hon KATE DOUST: But if it is a straight IVF process —

Mrs Midford: Sorry. The six months is actually related to the quarantine period. It has changed recently. That is why I am confused.

Ms Clissa: It is just for a known donation of eggs, sperm or embryos.

CHAIR: But couples who are unable to conceive and are seeking assistance do not need to wait for three months?

Ms Clissa: No, because it does not require a third party.

Ms Rodino: For standard IVF procedures in a clinic, there is no cooling-off period, because there is no third party, so we just offer an introductory session. It is because we are moving to the area of third-party reproduction that we actually have a mandatory, and I feel very necessary, cooling-off period.

Hon KATE DOUST: If that is the case and you feel so strongly about that, would it not be better to have the cooling-off period defined clearly in the legislation rather than just in the directions, as is currently proposed?

Ms Clissa: One of the reasons that we want it to be in the directions is the experience that we have had with the directions under the HRT act. For instance, last year the cooling-off period was changed from six months to three months. That was possible only because it was in the directions. I guess what we are saying is that because surrogacy is new for WA, our view is that some of these things are going to be refined with time. If it is in the main legislation, it always takes a long time to make any changes. We might find clinically that six months is better than three months as a cooling-off period for surrogacy, and we could then ask for the directions to be changed, otherwise what will happen is that it will not be enforceable, and we will have a gap. It was about having something that would be more responsive to what is happening in the community. That is why we want some of the detail to be in the directions in case we find that what we have proposed is not actually going to work.

Hon KATE DOUST: But these are not simply directions, are they? Are they enforceable?

Ms Clissa: Yes, they are enforceable. They are subsidiary legislation. That is why the clinics have to abide by them.

CHAIR: But they are not disallowable, are they? They might be subsidiary legislation, but they are not disallowable instruments.

Hon KATE DOUST: No, they are not.

Ms Clissa: But they are enforceable. That is what we are saying.

CHAIR: Yes, but they do not come before the Parliament as regulations. They are just directions.

Ms Clissa: But they are gazetted directions.

CHAIR: But they are not disallowable. That is just a distinction that we are making about subsidiary legislation. There is subsidiary legislation, which can still be disallowed by the Parliament, and then there are directions, which do not require any parliamentary scrutiny.

Hon SALLY TALBOT: When parties change their minds during the cooling-off period, which parties change their minds? Is it both sides?

Ms Clissa: Yes, both sides.

Mrs Midford: It is absolutely both sides.

Ms Rodino: Yes. Even at the basic IVF level, sometimes the recipients change their minds and sometimes the donors change their minds. Under the surrogacy legislation, any of the parties could change their minds.

Mrs Midford: We believe that is the way it should be. People should know that that is their opportunity to change their minds, and that people do change their minds. It needs to be normalised that there are people who do not continue to go ahead with what they had planned to do because they realise that there is something that they cannot handle in the process and they need to bail out of it. Sometimes people need help with that, because in some instances it can be quite difficult to say to people that they cannot do this any longer or they do not want to do this any longer. It is really important that that is seen to be part of the process and that it is okay for people to change their minds.

CHAIR: Can I just ask you to focus on the point of Kate's question? To me, what Kate is doing is drawing attention to the lack of reference in the bill to any notion of a cooling-off period or period of reflection, or whatever we may term it. Your answer was that you would rather that that was in the directions, because essentially it would then be more flexible and more responsive to the needs and demands of the new procedure. I think the point of the question was do you think there is a need for the Parliament to indicate in the bill that there should be a period of reflection. The actual period might well be a matter for subsidiary legislation, but at least there should be something in the bill that says that the Parliament believes that in these sorts of arrangements there should be a period that will allow the parties to reflect on what they are doing. Would you support that?

Hon KATE DOUST: I think that is very important, because the directions could go the other way, where a reference to a cooling-off period might at some point—who is to say—be deleted totally because there is nothing in the bill about that matter.

CHAIR: It might be deleted from the directions, without reference to the Parliament. That is the problem that we are grappling with.

Ms Clissa: So the amount of time should be detailed?

Hon KATE DOUST: Yes.

CHAIR: What Kate is putting is essentially that the Parliament would express an expectation that the subsidiary legislation would provide for this period.

Mrs Midford: I am sure that our group would thoroughly endorse that.

CHAIR: Your submission recommends that, consistent with the Adoption Act, the birth mother be given 28 days before having to decide whether to relinquish the child. Can you expand upon that for the committee? My second question is: should this also be the case if the surrogate is not a biological parent of the child?

[10.40 am]

Mrs Midford: It should happen in both cases.

Ms Clissa: The reason that we agree with a minimum amount of time is related to giving the surrogate mother time to think about her decision after agreeing nine months earlier to being a surrogate and after having the baby. Surrogacy is a complex arrangement. It is a new experience for women. They do not know how they will react to having the child even though we have in place all the mechanisms for minimising that. What we are saying is that we want that to be consistent with the Adoption Act so that surrogates have at least 28 days to make their decision before relinquishing the child. I have forgotten your question.

CHAIR: I asked about biological linkage. You indicated that there should not be any discrimination on that basis.

Ms Clissa: No. We need to acknowledge that carrying a child is carrying a child regardless of whether the woman is biologically or genetically linked to it. The nine months gestation must be given acknowledgement. That is very, very important.

Mrs Midford: A woman develops a relationship with her unborn child. That is probably not understood by anyone who has not carried a baby. A woman develops a relationship with a baby when she is carrying it. The 28 days is a minimum amount of time that will allow the woman to deal with the hormonal things that happen after birth. It was selected as the minimum time in adoptions so that a woman could make a coherent decision after thinking about the issues clearly.

Hon SALLY TALBOT: You referred to “before having to decide to relinquish the baby”. Could a woman decide within the 28 days?

Mrs Midford: They cannot sign anything until after the 28 days.

Ms Clissa: They could have decided, but they would not have signed away.

Hon SALLY TALBOT: If there was an agreement with the arranging parents that the baby would be handed over on day one —

Ms Clissa: Yes, that is fine. The child can live with whomever. It is about the birth mother deciding that that is what she wants to do. The child may not necessarily be living with the birth mother.

Mrs Midford: I remind you that in the 900 cases in the United States, it was not the well-prepared birth mother who changed her mind; rather, it was the recipient couples who changed their mind. Even though that is a small proportion, they were the ones who changed their minds.

CHAIR: Do you support the current provision of a 28-day minimum and a six-month maximum?

Ms Clissa: Yes.

CHAIR: You are okay with that?

Mrs Midford: Yes.

Ms Clissa: Yes.

Ms Rodino: Yes.

CHAIR: In your opening statement you referred to a recommendation in your submission about there being a genetic relatedness to one arranged parent, which is not a requirement in the bill. Why have you made that recommendation? Can you point us to any research that might support that proposition?

Mrs Midford: To my knowledge there is not a lot of research on surrogacy. From the work that has been done in adoption and donations, we know that surrogacy situations become very complicated for children when they have more than—the standard arrangement for most children is that their parents are their mum and dad who are their biological and social parents and they are all wrapped up in one package. What has happened with adoption and other things is that that has been expanded and more people are involved. As the situation becomes more and more complicated, it becomes more and more difficult for the child to cope with it and for the other parties to cope with it. Given the incredible complexity of surrogacy and the issues surrounding it, we are looking at harm minimising and the best interests of the child. We are saying that a surrogacy that involves one genetic parent minimises the harm to the child and maximises the best interests of the child, because the complexity for the child has been reduced. If you start to have too many people involved as potential parents—I have done a lot of work in the area of adoption over a number of years and I have talked with those involved at length. I have talked to relinquishing parents, the adoptive parents and the offspring or the adopted people. I have also had a lot of contact with people involved in donation, which is a similar but different arrangement. In all of those cases, people talked about the same sorts of emotional issues; that is, their disconnectedness and their

difficulty in understanding. If at least one genetic parent is involved, we provide some kind of underpinning of the stability of the child.

Ms Rodino: There is a concept called genealogical bewilderment that often comes about in donor-related literature. It is about the child's sense of identity and who they belong to. Is it the person who donated the egg, the person who donated the sperm, the person who gave birth to the child or the recipient parents, who have been very loving? The strength of that argument comes from the child's perspective and from the terminology of genealogical bewilderment. There are no children who can give views on that.

Hon KATE DOUST: Last Saturday *The Australian* ran a very interesting article in its *Weekend Inquirer* section. It featured a young woman who was born as a result of a donation. She has very strong views. In fact, she is opposed to the new reproductive technology legislation in Victoria because of the difficulties she and others have experienced trying to access information and working through their identity issues.

Ms Clissa: This particular issue is one that we have struggled with because, as we outlined earlier, embryo donation is permitted under the HRT act. Given that we want this legislation to put the interest of the potential child at the front of everything, we believe that it is in the best interests. We are concerned that if that is legislated, certain people would be excluded. That is always the balance—that we could exclude potential people who want to have children but who do not have the genetic material to contribute. That is a concern. We are trying to balance those interests with the interests of the child being at the foremost. We are hearing more feedback from adult offspring of donations who are voicing concerns about how they were created. Given the fact that advocacy is not fully available, we are trying to promote that in the interests of children whilst fully acknowledging that if the legislation does include that, it would exclude a number of people from accessing surrogacy.

[10.50 am]

CHAIR: Your submission recommends that the birth mother should have one live child and have completed her family. Can you expand on why you have made that recommendation? Should this be a requirement or a consideration taken into account by the persons approving the IVF procedure and the surrogacy arrangement?

Ms Rodino: A comment I would like to make about that particular issue relates to the status of maturity that, say, an 18-year-old would have, and the ability for them to give full consent without having had children. The bill says “to have had a birth”; it does not use the phrase “live birth”. That is a phrase I would be encouraging. We would want a woman who has had a live birth, because pregnancy loss will put the woman at risk of adverse psychological outcomes. We would also encourage women to have completed their families. We do not know what kind of adverse reaction may occur per pregnancy, both medically or emotionally, and whether this places the birth mother at risk of things that she may not be aware she is consenting to. It is about a true sense of understanding this process, they have had a live birth, they know what it is like to have a baby, they know what the postnatal period is like, we know how they responded during that postnatal period and the attachments they formed with the child. There is no point down the track, having completed their family, being at risk of adverse medical events. Women could lose their own uterus as a surrogate. I believe a surrogate in the UK died of a heart attack after giving birth. We want to ensure that the birth mother herself has been prepared and cared for, her needs have been met, she is aware of what she is doing and she has had a live birth. Foetal loss does put a woman at risk of adverse mental outcome. It is not that she has had a birth but that she has had a live birth, completed her family and knows what she wants and what she is engaging in.

Mrs Midford: And what she is giving up. It is really important for her to know what she is giving up, whether the child is her biological child or not.

Ms Rodino: The issue about the postnatal period tends to be underestimated. There are risk factors for any woman who goes through this within a relationship or for someone else. The risk of postnatal depression is 15 per cent and the risk of psychosis is one in 500. These are adverse events that occur within the first three to four weeks post-partum. That postnatal period is a very serious period and to the best of her ability she needs to know what she has, that she has completed a family and what she may be giving up. It is about informed consent.

Ms Clissa: It concerns me that in the media and on the Internet, being a surrogate, a donor, is simplified and glorified. It is an amazing gift, but we want to counter that by saying that it is not for everybody, and we want there to be safeguards. People can be caught up in the hype of actually wanting to help someone else. We also want to ensure that their own family or their own self is not endangered in that process in any way.

Hon KATE DOUST: I just note the comments you have made about what you would see as the minimum requirements for a woman to be a surrogate, which all sound very logical. Whilst it is expressed in the directions, I cannot find anything in the actual bill that refers to any age requirements. Would you like to see something clarified in the legislation to provide that certainty?

Ms Clissa: Perhaps we could add something at the back, an eligibility criteria or a requirement that women meet certain conditions in order for them to be an appropriate surrogate. I am not sure what wording we would have. That could work.

Mrs Midford: We have tended to rely on the directions because of the need to be able to change things to reflect changes, because things move so quickly in this area in terms of certain techniques and even the community. We agree that there needs to be eligibility criteria.

CHAIR: Can you explain what is involved in psychosocial preparation and psychometric testing?

Mrs Midford: Psychosocial preparation helps people to understand exactly what surrogacy is in terms of relationships, what it means to them as a person and what it means to their partner and their children. There would be an overlap between the preparation for the surrogate and her partner and children and the recipient couple but there would also be some specific differences. We also talk about the fact that it is not just about having a child and that is the end of it. With surrogacy, we are talking about a child and, therefore, that goes on forever. The child is around for the rest of that person's life. It is important for them to understand the implications of that personally. It is something that can be supported by material that they are given to read or attending seminars, but is also really important for them to discuss issues within a counselling environment so they can raise issues and where things that are of concern can be discussed.

The psychometric part of it is really to try to ensure that for people who have underlying psychosis or other problems—perhaps cognitive ability—a range of basic planks can be explored to ensure that the person is capable of making an informed decision.

Ms Clissa: The thrust of the psychosocial preparation that happens in IVF counselling consists of a battery of questions in relation to surrogacy that raises issues for people. That may take three or four sessions, and that would be separate to the psychometric testing. It would involve all parties, including children over the age of four. If the surrogate has children or any party to the recipient has children, they would also be involved in the psychosocial preparation. It involves all the parties who will potentially be affected in that family.

CHAIR: You said that that should be enforceable. Is that prior to the procedure? When you say enforceable, do you mean mandated?

Ms Clissa: Yes, it is mandatory counselling.

CHAIR: Would you envisage that that would occur prior to that procedure?

Mrs Midford: Yes, because people will drop out. That sort of psychosocial preparation is consistent with what happens with adoption, fostering and donor counselling. It is not different; it is just an extension of that.

Ms Rodino: Psychosocial preparation raises issues that all parties or participants had not really thought about. They say, “We never thought about that.” They are very standard questions that focus on the relationship issues that Sue mentioned.

Hon PETER COLLIER: Presumably, it will be done prior to the three-month cooling-off period.

Ms Clissa: Well and truly. That is why we recommend the education sessions. If anyone is ever interested in surrogacy, they can come along and we say, “This is what’s going to be involved if you want to go down this track.” It is a bit like what happens with fostering when people go to so many sessions and interviews. People know well and truly beforehand and they are not surprised when they arrive at a clinic and say they want to be a surrogate. They know what is involved. That could take 12 or 18 months.

CHAIR: You are not advocating that there be any time on that?

Ms Clissa: No, not at this stage.

CHAIR: That will be quite variable?

Ms Clissa: It is going to be variable. Also, with people’s availability and time, it will often drag out rather than be very brief.

CHAIR: There is a balance about giving people adequate opportunity to learn and reflect as opposed to just holding them up.

[11.00 am]

Ms Clissa: Absolutely, yes.

Ms Rodino: Yes, so if people want to proceed quickly, they can go through that process very fast, but then they have the three-month cooling-off period.

CHAIR: What is involved in implications counselling?

Ms Rodino: Implications counselling is a form of counselling that occurs in all of your infertility clinics when you have either standard IVF or donor-related counselling sessions. The kinds of questions that might occur just offhand—usually I have a form that gives me probe questions—it includes looking at how long they have thought about pursuing the kind of treatment, whom they have talked to about this treatment, what issues they may present with in regard to the decisions regarding the treatment. It talks about some legal aspects that we draw from the relevant acts in regard to their treatments. We talk about very much, importantly, in these sessions the best interests of the child, because the counsellor represents that as yet unborn child, particularly in donor cases, and have they thought about that unborn child and have they thought about the legislation by way of where information is kept by way of registries; have they thought how they might tell the child about the special circumstances of the conception. So there are a lot of questions that hopefully raise more questions from them, so that when they leave your rooms, if you feel you have done your job well, it is that they can leave with a little bit more informed consent about the process and journey that they are about to enter. It is a very accountable way of working with your patients, because what you do not want them to say is, “Well, no-one told me I might have a psychological reaction to this.”

Mrs Midford: We would also include in surrogacy the parenting arrangements and what was going to happen on the other side. If I can mention the Re Evelyn case to you in that context, that broke down really because the two couples were very friendly before the child was born. They had a great arrangement. They lived in separate cities, but they met and had holidays together. They were very close. The surrogate mother volunteered to be a surrogate for her friend because she was sad that

she did not have a child. She did actually have an adopted child, but she did not have her own biological child, and so she volunteered to be the surrogate mother, including the genetic mother because the woman was infertile, but to use her husband's sperm. So she went into it—the surrogate I am talking about—believing it was going to bring them together, that they would have a wonderful, close relationship, that it would make their relationship even more wonderful and magical, and she was really quite carried away with the emotional potential of this arrangement; that they were going to have this wonderful, close family where everything would be just really beautiful. The recipient couple were a very nice couple, very reasonable. They wanted to have a child. They were delighted that this woman was prepared to provide them with the opportunity to have their child, but they wanted to be left alone. They actually wanted to have the child by themselves. They were happy to meet for holidays, like they had already been doing with the other family, but they just wanted to get on with being the parents, and that is fundamentally where the clash came. Now, if those couples had actually talked to each other and discussed it in a way whereby they could have discussed a parenting order, how that would work, they would never have proceeded with that.

Hon SALLY TALBOT: Can you just remind us what the genetic relationships were?

Mrs Midford: The child was the biological child of the surrogate and of the recipient father, and they were both excellent parents. Fundamentally, it came down to which family was going to be the most open, and the judge decided that the family that was going to be the most open was in fact the surrogate's family. However, it was a very sad case. For me, I was very negative about surrogacy until that time. After that case, in particular, my whole view changed, because it became really clear to me that surrogacy legislation was really important, because the only way that you could help people to avoid those kinds of things was by having a prescribed pathway by which they could actually examine and be—I want to say “forced” but it is not right—but a process that actually facilitated them considering very important issues, because they are for-life issues; they are not about just giving birth to a child. It is for life.

CHAIR: The last couple of questions have focused on types of preparations and testing and counselling. Can you just outline to the committee the different stages that you envisage, whether or not each and every one of the surrogacy cases would be required to go through each stage and what sort of minimum requirements we would be contemplating for those stages of preparation of everyone involved?

Ms Clissa: So, what minimum requirements —

CHAIR: What counselling, what preparation of persons involved would you require?

Ms Clissa: We agree that, in every case, everybody would have to go through the psychosocial preparation, would have to seek independent legal advice. For the surrogate, she would obviously need to seek medical—that is a very important one, that she is actually able to do this. In all cases, we would also do psychometric testing. The only part that would be optional would be if the woman had not formed her family and she had suffered maternal loss—or had not finalised her family, rather. In those cases, we would recommend a further psychiatric assessment. The psychiatric assessment would not be compulsory for everybody, but apart from that it is a standard procedure, as currently happens with, I guess, all the ART. If you are just having IVF without any donor, you go one way. If you are having IVF with a donor, there is a pathway, and if you are just doing donor without IVF, there is another pathway. So it is a standardised sort of practice, what is expected once you go to a clinic. With the surrogacy, those assessments would be sent—because they are benchmarks, certainly nationally and internationally what happens. However, several of our approved counsellors have provided surrogacy assessments for interstate cases, where they have actually been Western Australian applicants or residents, and they have actually done the psychometric or the psychosocial—in fact, I think, Sue, you have done some of those.

Mrs Midford: Yes, I have done them.

Ms Clissa: There might be slight variations, but there is a general agreement of a pathway for all surrogates and recipients to go through, as well as the legal and the medical again to ensure that people are safeguarded. I guess the other thing is that we certainly support there being a review panel that is an independent review panel. I think that the directions currently say that that is to be set up by the clinic. Again, the idea of that is to ensure independence and that in fact the pathway is followed and that there are reports for that panel to review.

Hon PETER COLLIER: You mentioned a benchmark; you said that there is a benchmark. I presume that once you get to that benchmark, that is when the three-month cooling-off period commences. Is that what occurs, or what you envisage would occur?

Ms Clissa: The three-month cooling-off period would happen only if they are going to proceed with the surrogacy; they have got to the point where they are going to proceed, and then they have the cooling-off period.

Hon PETER COLLIER: Presuming you have come along, the three-month cooling-off period will not commence when you first walk through the door of the clinic, obviously —

Ms Clissa: No.

Hon PETER COLLIER: — and you are going to go through these processes and procedures. There does appear to be, from what you have just mentioned, a fair degree of subjectivity in terms of when that period commences, but then you did mention a benchmark. Is there a prescribed process, as the chair has asked, before you reach the benchmark?

Ms Clissa: Yes. They would have the psychosocial report from probably the clinic counsellor, the psychometric assessment from the independent clinical psychologist, the legal report that they have each been to see a lawyer and understand exactly what is to be undertaken, and also a medical report. Once all of those pathways —

Hon PETER COLLIER: And that is essential.

Ms Clissa: That is essential.

Hon PETER COLLIER: That is not negotiable.

Ms Clissa: No, it is not negotiable.

[11.10 am]

Mrs Midford: No, and the clinic coordinator would actually tick all those off, so there would be somebody responsible for ensuring that that process happens.

Hon PETER COLLIER: And once all that is done, that is the benchmark and then you start your three months; is that what you are saying?

Ms Clissa: No, I think it goes to the panel and if the panel okays it, then I think the three-month cooling-off period happens after that.

Mrs Midford: Yes, that would be logical.

Ms Clissa: Yes, so it has to be approved, it has to get the tick from the panel basically.

Hon PETER COLLIER: So the panel is the benchmark.

Mrs Midford: Yes, the panel is the end point, or the beginning point.

Hon PETER COLLIER: That is all I am looking for. I hate to be difficult; I am just trying to find —

CHAIR: What is the panel going to do? I mean, you can go off to a lawyer and have a lawyer explain your legal rights and declare at the end of the session that you have had all your legal rights explained; you do it with lots of things, financial planning and all sorts of things. I do not see any

difficulty in prospective parents going off to a lawyer and having all of the legal implications explained to them.

Ms Clissa: Yes.

CHAIR: Equally, I do not see any difficulty in having a medical assessment, because if someone is medically unable to do what it is they are proposing to do based on the medical evidence, then clearly the review panel would be required to say, "I'm sorry, we can't allow you to proceed because it's not going to happen anyway." There is going to be some really contentious stuff in a psychosocial preparation.

Mrs Midford: We would actually expect that most of them would go through.

CHAIR: They may well all go through but I suppose —

Mrs Midford: We would not expect all of them to go through.

CHAIR: No, but if you are preparing a psychosocial preparation report —

Mrs Midford: Yes.

CHAIR: So are you envisaging that someone might prepare that report and say, "I don't think these people understand it properly" or "I don't think these people are appropriate for this procedure"?

Mrs Midford: Yes.

CHAIR: And if they want to proceed, then you are going to say no.

Mrs Midford: The review panel will say no.

Ms Clissa: Yes, and also the review panel might say no for now but might say, "We recommend you go off and have some further counselling or further kind of psychological support."

CHAIR: I envisage people are going to say, "We've had counselling. We understood everything. We might have a different view of the world to the counsellor who provided that counselling. We might have disagreements on a range of important issues about how to bring up children" or whatever. I sort of envisage some serious potential conflict there.

Mrs Midford: That would be fine if it was their procedure and it only involved them, but what we are saying is that we have to look after the interests of the person who is not there at the decision, and that is the child, and if there are serious problems —

CHAIR: And who has to do that; the people who want to be the parents?

Mrs Midford: All of the people need to consider that. The medical person has to consider, for instance, whether the person is likely to survive it, because you do not want a child created —

CHAIR: I understand these aspects of it.

Ms Clissa: The big difference with this is it is a screening assessment. With IVF we do not have that kind of same sort of screening. There is capacity for doctors to refuse treatment or to say they have concerns or whatever. But with this what we are recommending is if the recommendation of the independent psychologist says, "These people shouldn't go through with it", that that actually has weight. So everybody who provides a report for the panel must be recommending that it go through; and if there are concerns, then it is up to the panel to look at whether they are going to okay it on this round or whether they are going to say, "We want some more report or we want some more information about this."

Hon KATE DOUST: Can I just ask something about the panel? I think you said that your preference was to have an independent panel, as opposed to what is currently set out in the directions, which would be that each clinic would provide their own panel.

Mrs Midford: We would actually anticipate that if more than one clinic were going to do this, and it may be only one clinic that is prepared to do it, but if there were more than one clinic that they would actually arrange to share an independent —

Ms Clissa: It is a panel set up by the clinic with independent people on it, so it is not made up of all people employed by the clinic. I think the directions talk about the sorts of people that would be on the panel.

Hon KATE DOUST: They do. So you do not think it should be a panel totally separate to any of the clinics and any of the potential conflicts or interests that they may have in providing the service?

Ms Clissa: Some of these people, I think, would be independent enough because they are not going to be people that the clinic is going to be able to employ. I think it also says that the applicants for the panel need to be approved by the council. So that is where the independence is. The clinic cannot just decide who they want. They actually have to —

Hon KATE DOUST: So it still goes to the HRT council for the final tick-off.

Ms Clissa: Yes, of what the membership is of the panel.

Hon KATE DOUST: Okay.

Ms Clissa: That is where the independence is ascertained of the —

Hon KATE DOUST: I was just wondering how many people per year would come to you in Western Australia seeking counselling in relation to a surrogacy arrangement; just a general ballpark figure for indication.

Mrs Midford: Probably virtually no-one.

Ms Rodino: I guess because people are aware of the formal status of surrogacy—some are and some are not—there is not a lot who will actually ask about surrogacy directly within the clinics. So to my knowledge what is taking place is probably more on an informal basis, because the current status is that it is not available, so why go and ask about something? But for those who might present, we will inform them where it is available.

Hon KATE DOUST: You have already said earlier that you actually provided some counselling for couples who have had to go interstate.

Mrs Midford: That comes separately. So they do not present to you because that comes from that clinic. Sorry, maybe I misunderstood.

Hon KATE DOUST: No; that is all right.

Mrs Midford: I was thinking of people coming to you spontaneously asking the questions.

Ms Clissa: So you are wanting to know what kind of numbers we are looking at?

CHAIR: Yes, what volume are you dealing with?

Hon KATE DOUST: Yes, because we are just getting different numbers.

CHAIR: What does “small” mean?

Hon PETER COLLIER: Half a dozen?

Mrs Midford: Perhaps six to 12 maybe.

Ms Clissa: A year; we are probably thinking maybe in the first year there might be a dozen people.

Mrs Midford: It is small; it is definitely small.

Hon KATE DOUST: A dozen in total?

Mrs Midford: Yes, it is not large volumes.

CHAIR: It is hard to anticipate, is it not?

Ms Clissa: It is.

CHAIR: From making something not legally available to legally available, it is hard to guess.

Mrs Midford: We know that there are people waiting.

CHAIR: Yes, we do too.

Mrs Midford: How many exactly, we do not know.

Hon KATE DOUST: In your submission you talked about surrogacy being the last resort. I sometimes wonder whether, for people who are this keen to have a child and looking at this option, it is because our avenues for adoption are so limited. Does that cut out for these people?

Mrs Midford: There is a very tiny number of local children available for adoption. It has been plummeting; it is probably less than 10, unless they are special needs. In fact it is probably a lot less than 10 per annum in Western Australia, and international adoption is extremely difficult to organise. It is exceptionally costly, so it is very difficult for people. So certainly we would expect surrogacy to be the last resort for a biological child, and in some cases people would see it as a last resort because of the difficulties involved in obtaining a child.

Hon KATE DOUST: So if there is a greater ease of access via adoption for these couples, do you think they would be less inclined to want to resort to a surrogacy option?

Ms Clissa: My view is that people want to have a baby; they want babies. There are not babies to be adopted. I think, as Sue said, last time I heard there were about six Western Australian babies available. They do not want a special needs child. They do not want an older child. There are probably those available for adoption, but people want actually to have a baby and preferably one that they are biologically related to and, if they can experience it, the birth itself would be the bonus. I guess the people who would be accessing surrogacy would be women who are born without a uterus, women who have lost a uterus, women who have difficulty carrying and have had numerous losses. There are women in Western Australia at the moment who have embryos in storage who have accessed IVF, have lost their uterus, and now have these embryos that are potentially their babies, and they are waiting for surrogacy because that to them is a potential, so—

[11.20 am]

Hon SALLY TALBOT: Can I clarify your response? You are using last resort in a special way.

Ms Clissa: Yes.

Hon SALLY TALBOT: Really, adoption would be the last resort.

Ms Clissa: If it was available.

CHAIR: It is practicality.

Ms Clissa: In this state it is really not an option.

Mrs Midford: In fact in Australia, not just this state.

Ms Clissa: Australia—that is true.

Mrs Midford: In other countries adoption is much more readily available. If you talk to people from the United States about adoption in Australia, they are always shocked because adoption is much easier in the United States, inter-country and local adoption. In Australia, and certainly Western Australia, you are exceptionally lucky if you get an infant; you are exceptionally lucky to hit the jackpot.

Hon KATE DOUST: You talked earlier about reasonable expenses. I think it is also in your submission. You talked about extending that out to include 12-month post-natal counselling. There has been a lot of discussion in the Parliament about what is a reasonable expense and how far it

should go. What in your view is a reasonable expense? What sort of things should it include in terms of your concerns in commodifying the child and commercialising the process?

Mrs Midford: There are a number of components to that in terms of the 12 months.

Hon KATE DOUST: That is a comment you have made. With everything else, what do you see as a reasonable expense between parties?

Ms Rodino: Medical costs, psychological costs, ongoing psychological care if the birth mother experiences an adverse response, psychosis, mental health and ongoing issues that are functional to their involvement. I am a very strong advocate of postnatal mental health care and how it is observed—my feeling is that it needs to be provided. It has not often been considered. Often the medical side is considered—if there are any adverse medical effects—but not the psychological effects. The reason I suggested it be extended to at least 12 months minimum is the view that that is when a lot of postnatal issues will occur by way of definition of postnatal depression. It is very hard to predict what might happen and that is where this legislation can be tricky. Therefore, we should say that medical expenses and certainly mental health expenses—they are the two primary expenses that come into play—cover at least the postnatal period of up to 12 months. The postnatal period should be defined as up to 12 months rather than a shorter time.

Ms Clissa: As part of the implications counselling and the psychosocial preparation, reasonable expenses must be considered and discussed. There could be an area where people agree. Say, for instance, the surrogate is a working woman and the pregnancy ends up being problematic and she can no longer work, who pays for the loss of income? It is very important that that is discussed in the implications counselling in the psychosocial preparations. The answer to that would not need to be the same for everybody. Someone's financial situation might be that it is covered and it is not an issue, whereas it might involve a single birth woman with a child and the lack of income would create a problem. That might be a deciding factor in whether she continues with the surrogacy. They are the sorts of issues that need to be raised because it would be reasonable, if she was no longer able to work as a result of being incapacitated through pregnancy, that that would be considered a reasonable expense. However, they might reach an agreement where the birth mother says, "If I get sick, I have my provisions for that and I don't expect that." Another couple might say, "No, we want to pay for anything adverse that is associated with this pregnancy." Reasonable expenses must be considered by all the parties because it might vary.

Mrs Midford: It needs to be considered before —

CHAIR: It must be contemplated by all the counselling phases.

Ms Clissa: These are the things that people do not discuss and that is why third parties, having a counsellor, bring up these issues—what will happen and what if the child is disabled? In terms of reasonable expenses, that is where it is important.

CHAIR: That concludes our hearing with you today. Thank you very much. We appreciate the evidence you have given. You will receive a copy of the *Hansard* and you will be asked to make any corrections to it and send it back.

Hearing concluded at 11.25 am