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Youth Mental Health

Adolescence and young adulthood are a time of change. It is also a time where there is an increased chance of being diagnosed with a mental illness. Professor Patrick McGorry has driven the agenda to transform the approach to youth mental health. This article is a review of the recommendations of McGorry and others within the mental health field on how best to care for our youth with a mental illness. We also briefly look at some of the services offered by a Catholic agency.

With physical health issues, early detection or intervention can be a determinant in improving the long term health outcome. This is also probably true of mental health issues. However, 90% of those with a physical health concern are treated, but only 15% of Australians who require medical help for a mental illness receive assistance.[1] Funding for services, research and resources for mental health is yet to find equality with physical health. The burden of disease generated by mental illness is estimated to be between 12-14% of the total; however only 9% of the Australian health budget is allocated to mental health. The actual cost of a mental illness is eclipsed by the related costs of lost productivity, and associated income loss by family or those suffering with a mental illness.[2] The Royal Australian and New Zealand College of Psychiatrists in their submission to the National Health and Hospitals Reform Commission stated that "the nation has a responsibility to offer equivalent access to mental health care to all Australians."[3]

The most recent figures from the Australian Bureau of Statistics state that one in four of Australia's young people aged 16-24 years experienced a mental health disorder in the previous 12 month period. However, mental health services were accessed by less than a quarter of these affected young people. The most common disorders identified in the survey were: anxiety disorders (e.g. post traumatic stress disorder, panic disorder) affecting 15% of young people; affective disorders (e.g. Bipolar affective disorder, depression) affecting 13% of young people; and substance use disorders (e.g. harmful use of alcohol) affecting 6% of young people. Approximately one-third of young women suffered a mental illness compared to approximately one-quarter of young men.[4]

Adolescence and early adulthood are a time of change where there is pivotal maturation, physically, emotionally, socially and spiritually. This process includes an increased autonomy from family. At the same time, the foundation stones for a young person's future are often laid through educational and career choices. These changes in a young person's life can frequently be complicated by turmoil and stress. This journey can also be accompanied by substance use, or abuse, and or the onset or progression of a mental illness such as anxiety and mood disorders.[5] Thus, if one in four young people are to experience a mental health issue, we need to be able to detect and treat their illness aptly, in a timely manner, to minimise the impact at such a critical time in their lives. Therefore, improving the long term health outcome of these young people requires access to the most appropriate health care in a setting that will enable the best outcome.

Our current health system is a two part paradigm: paediatric and adult. The transition that presently exists in our health system is in line with the usual transitions of our communities, where most 12-17 year olds are dependent on their families for health, well being, and education.[6] However, while these young adults can often be emotionally and financially supported by family, they are also legally entitled to access services targeted at adults.[7]

Orygen and Headspace

Professor Patrick McGorry, the 2010 Australian of the Year, has been an advocate of two issues related to youth mental health; early intervention and an all inclusive health model for youth, aged 12-25.[8] The youth model is further endorsed by the Victorian Mental Health Reform Strategy 2009 – 2019.[9] Early intervention involves "early detection and the phase specific treatment of the earlier stages of illness with psychosocial and drug interventions."[10] The key outcomes achieved by early intervention in psychotic disorders are to shorten the period between onset and treatment, and to ensure that during the critical phase of the illness there is care that is constant and inclusive of all the needs of the patient.[11] The strategy of clinical staging allows for appropriate

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treatment of the disease determined by the stage of the illness. It also creates an exit door for those who have been incorrectly diagnosed or are well after minimal intervention.[12] This latter point is important as a "false positive" rate of at least 50-60% has been documented in the early invention data, even though the young people in these programmes were seeking care and fulfilled criteria suggesting care was required.[13]

Orygen Youth Health is a mental health organisation located in Melbourne, McGorry is the Executive Director of its Research Centre. Orygen offers research, training and clinical programmes, with a specialist focus on psychosis. The Early Psychosis Prevention and Intervention Centre (EPPIC) is located at Orygen, and has influenced global mental health services.[14]

McGorry is also a founding board member of Headspace, Australia's National Youth Mental Health Foundation. Headspace centres can be found around Australia. They provide youth a place where they can access both general health information and more specialised health services such as those related to mental health. Relationship, and alcohol and drug advice are also available. Complementing these services at Headspace, information can also be accessed on accommodation needs, education and training and social activities.[15] At both Orygen and Headspace, the services are designed to acknowledge youth as 'emerging adults.' Further, these services aim to engage with youth and their families and peers, while recognising that a young person's development occurs in varying stages and does not mysteriously terminate at 18 when a young person is legally emancipated.[16] Nor does brain development arrest at 18, with evidence demonstrating development continues into the mid-twenties.[17]

However, while McGorry's initiatives have been gaining momentum and changing the face of treatment for mental illness, this particular approach is not shared by all in the professional field of psychiatry. There are a number of issues that have been raised by others that can encourage us to ponder the drive to change the approach to youth mental health.

Other Perspectives

Birleson and Vance suggest that the change advocated by McGorry will create a third part to the health practice paradigm. There are numerous concerns with this, including the risk of the 12-17 year olds being "adultified" by placement with the 18-25 year olds.[18] Further, Birelson suggests strengthening and utilising readily available platforms such as schools and primary health for early intervention and prevention programmes. Needs could be identified and then referred to the level of care required.[19] Furthermore, various authors argue that we have an existing mental health system that could be upgraded and the early treatment, if required by youth could be integrated into the existing system.[20] However, Birelson and Vance argue that our present system is not supporting youth in their transition from the child/adolescent based system, (Child and Adolescent Mental Health Service or CAMHS) to the adult system, (Adult Mental Health Service or AMHS). They state that due to the strict entry criteria of AMHS few adolescent patients' access services after being part of CAMHS. AMHS focuses mainly on psychotic disorders and major mood disorders, which have a risk of suicide, whereas CAMHS treats a range of illnesses which includes, psychotic disorders, self-harming, and anorexia nervosa and other conditions. The authors call for greater collaboration between services and funding across both sectors as well as greater research collaboration between CAMHS and Orygen.[21]

Numerous authors raise concerns over the possibility of over-treating or over-medicalising problems.[22] Based on a number of clinical studies, Bosnac et al raise several concerns. One is vigilance with anti-psychotic drugs, due to the well-documented risk profile for adverse events for these drugs. Risks include weight gain, diabetes, and in some, cardiac problems which may be fatal. These are significant and must be balanced against the greater clinical response achieved in early psychotic illness to anti-psychotic treatment.[23]

Further, the Royal Australian and New Zealand College of Psychiatrists in their Submission to the National Health and Hospitals Reform Commission raised two main concerns related to The Reform Directions 10.1 and 10.2.[24] Whereas the Commission's reforms generally encompass a "whole life" approach, the College considered the mental health reforms to focus mainly on youth. The College has concerns regarding the investment in a single age group. They requested further evidence that a stand alone youth model is the ideal treatment process, adding that it would be a difficult model to implement in rural and remote areas. The early intervention/prevention model is appropriate irrespective of age of the patient. The College embraces a youth friendly not necessarily youth only model. Another concern was the focus on one particular illness (psychosis) at the risk of neglect of many other mental disorders, some of which are more common. These include anxiety, depression, and older aged group onset diseases.[25]

Other Programmes

For those who may be suffering from a mental illness, there are also a variety of programmes and strategies available within our communities that can identify and help with intervention or referral to other services. Centacare is one example within the Catholic community. This organisation whose mission builds on 'life to the full' for all in our society, has for a number of years been offering services that are responding to those who could be at risk of developing a mental health issue.[26]

Centacare has provided counselling in schools for over 20 years. The service is available to all Catholic schools, and is offered free of charge to students. The counselling services provide confidential assistance to students in schools who may be experiencing difficulties, emotionally, behaviourally or interpersonally. As these

issues can affect the overall welfare of a student, the programme endeavours to eliminate the risk of these students developing into adults who may be involved in risk taking behaviours or have the potential to develop a mental illness. The aim of this service is to provide young people with the best opportunities so they can reach their full potential as adults.[27]

One of the more specialised programmes offered through Centacare is their School Refusal Programme. Research has shown that some school refusers are at risk of developing a mental illness, such as obsessive compulsive disorder, social phobia and depression. Students can develop a fear of attending school through trauma or environmental factors at home or school. Symptoms can often show as physical illnesses such as headaches, emotionally by crying spells and fear of leaving a parent or confronting a teacher or other student. The School Refusal Programme aims through early intervention and counselling with these students, their families and schools to re-engage the student back into the school system. In 2009, 77% of the students through the programme had returned to pursue their studies. This service picks up and helps those who may otherwise not be able to access a service, due to pressure on more specialised services.[28]

These programmes and others for example, family relationships, developing healthy relationships in adolescents, and mental health ministry may be of benefit. Although not able to offer medical intervention, these programmes do offer the ability to identify and possibly stem the further development of anxieties that some children or young people experience. Centacare can refer students and families to the appropriate medical interventionists as required.

Conclusion

There is no doubt within our community Professor Patrick McGorry has given us impetus to improve the outcomes for those suffering from a mental illness. However as this article illustrates there is much academic debate about the most effective system to care for youth with a mental illness. At the same time we can be proud of the Catholic tradition of providing out-reach services, some of which currently engage with those at risk of developing a mental illness, and are well-poised to continue to do so in the future.

Useful websites

- Orygen: http://oyh.org.au/
- Headspace: http://www.headspace.org.au/
- CAMHS: http://www.health.vic.gov.au/mentalhealth/camhs/index.htm
- Centre for Adolescent Health at the Royal Children's Hospital: http://www.rch.org.au/cah/index.cfm?doc_id=10392
- Lifeline: http://www.lifeline.org.au/
- Beyond Blue: http://www.beyondblue.org.au/index.aspx?
- Mental Health Advice Line: http://www.health.vic.gov.au/mhal/
- Centacare: http://centacaremelbourne.org/

ENDNOTES

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[16] Patrick McGorry, et al., "The 'youth model' in mental health services," *Australasian Psychiatry* 16 (2008): 136-137 at 136.
[17] Ian Hickie, "Alcohol and the Teenage Brain: safest to keep them apart," Brain and Mind Research Institute, (The University of Sydney, 2009): 1-38 at 14 http://www.drinkwise.com.au/CMSPages/GetFile.aspx?guid=69f069e2-5e47-447d-8fff-83fe0736d40d
[18] Birleson and Vance, 24, 22. [19] Birleson, 834.
[20] Anthony Pelosi, "Is early intervention in the major psychiatric disorders justified?" *British Medical Journal* 338 (4 April 2009): 802-803, P. Bosnac, G.C. Patton and D.J Castle, "Early intervention in psychotic disorders: faith before facts?" *Psychological Medicine* 40 (2010): 353-358, Birleson, 834-835.
[21] Birleson and Vance, 24.
[22] Pelosi, 802-803, Birleson, 834-835, Bosnac, Patton, and Castle, 353-358.
[23] Bosnac, Patton and Castle, 356.
[24] Reform direction 10.1 We propose that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service. Reform direction 10.2 We propose that the early psychosis prevention and intervention Centre model be implemented nationally so early intervention psychosis become the norm. The Royal Australian and New Zealand College of Psychiatrists. [25] Ibid.
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Kerri Anne Brussen ✠

Adoption is Better than Abortion

When a girl or woman has an unplanned pregnancy, her choices are to keep the child, to give the child for adoption, or to have an abortion. The best outcome is any situation which allows her to keep and successfully raise the child. When this is not possible, this article argues that modern open adoption is a better outcome for both the woman and her child than abortion. In making this argument, this article reviews the complex social history of adoption in Australia.

Just as much as abortion, the issue of adoption evokes both powerful emotions and strong opinions in many people. Many people have a story of adoption which has affected them, or someone in their family, or someone whom they know. Whether this story is predominately positive or negative colours to a large extent our personal opinion about adoption. In this article, I seek to situate these many experiences within a larger perspective. I trace the complex social history of adoption in Australia and, from this, seek to identify conclusions and implications for the future.

The Rise of Adoption in the Twentieth Century

Adoption has existed since the dawn of time, and most societies throughout history have had laws and customs to regulate the practice. The modern period of adoption began with legislation passed in Massachusetts in 1851. At this time, giving birth outside wedlock greatly stigmatised both the woman and her child. Throughout the eighteenth and nineteenth centuries, many women escaped this stigma by abandoning or even killing their child. One reason for the Massachusetts law, therefore, was to provide an alternative to infanticide. This statute became the model for similar laws around the world. In this country, this first wave of adoption legislation led to laws in Western Australia (1896), Tasmania (1920), New South Wales (1923), South Australia (1926), Victoria (1928), and Queensland (1935).

Throughout the twentieth century, adoption took different forms in response to contemporary concerns. In the 1920s and 1930s, most children were adopted when they were between twelve and eighteen months old. The fear in this era was that these children might have inherited defects from their parents who were perceived as being both morally and intellectually inferior. This delayed adoption was from a care home. It meant that adoptive parents could also be assured that this child was meeting the usual developmental milestones.

In the 1930s, a rise in the extra-nuptial birth rate meant that there were more babies for adoption. Several churches in Australia opened maternity homes for unwed mothers, and this involvement of the churches in the process of adoption increased its social acceptability. At the same time, the first generation of adopted children had grown up. Oswald Barnett's *Would You Adopt a Child?* was a scientific study of the first hundred children adopted from the Methodist Babies Home in Melbourne. It demonstrated that these were happy, normal children whose adoptive parents were delighted by them.

By the 1940s, there was general social acceptance of adoption as a good solution after extra-nuptial birth. By this time, too, children were usually adopted soon after birth. The peak of adoption activity in Australia is generally regarded as extending from the end of the Second World War in 1945 until the mid-1970s. During this period, there was still great social stigma associated with giving birth outside wedlock. At the same time, changing social mores particularly in the 1960s greatly increased the number of such births. From the end of the First World War to the mid-1970s, about three hundred thousand Australian children were adopted. The highest number of adoptions in Australia in a single year was 9,798 in 1971-72. About 4,800 of these were "relative adoptions." In most of these, a woman with children married, and her new husband adopted her existing children. However, about 4,997 of these were "non-relative adoptions," in which children were adopted by a married couple previously unknown to them.[1]

There was a second wave of adoption legislation in Australia in the 1960s. This included laws in Victoria and Queensland (1964), New South Wales and the Australian Capital Territory (1965), South Australia (1967), and Tasmania (1968). These new laws were based on what was then the usual practice for adoption. While at the time this was believed to be best for everyone, we now know that this practice harmed many relinquishing mothers and many of those adopted. The principles enshrined in these laws were secrecy and a clean break from the past.

In this era, when a girl or young woman told her parents that she was pregnant, there was much upset within the family. In some cases, she quickly married the child's father. In other cases, particularly from the 1970s, the child was aborted. In many cases, however, the girl or young woman was told to leave town and to go a long way away to somewhere where she was not known to have the baby. Unless her parents offered to raise the child, everyone – her family, her boyfriend if he was still on the scene, the churches, and health care professionals – told her that she should give the child up for adoption. Indeed, in this era before the supporting mother's benefit, financial considerations alone meant that many of these women

really had no other realistic option. Either formally or informally, hospitals had different protocols for these unwed mothers. Their hospital records often carried a special code (e.g. 'AB' for 'adoption babe'). Birthing techniques like caesareans which left a mark were avoided if at all possible. The child was taken away immediately after birth. Sometimes a screen was set up so the woman would not even see her child as it was born. They may or may not have been told what sex it was. And they were not supposed to see, hold or nurse the child afterwards. After signing the adoption papers, they were told to go home and to pretend that the pregnancy had never happened.

In the same way, the origin of these children was often kept secret from them at least until they were adults or when they were about to marry. If and when they were told, it was often a great shock which left them considerably disturbed and unsettled. And often, if they sought information about their birth parents, they found that records were either non-existent or sealed. With good reason, this form of adoption is called closed adoption. It was harmful to many but not all relinquishing mothers, and many but not all adoptees.[2]

There are four groups from this period whom we should particularly note. While many in some of these groups were not adopted, they are relevant to our discussion as children who were not raised by their biological parents. The first group is the Stolen Generations. These are the Aboriginal and Torres Strait Islander children who were forcibly removed from their families in the nineteenth and twentieth centuries. With many records destroyed, there has been much debate about both the motivation for this practice, and the numbers of children involved. It is clear, however, that the practice was motivated at least in part by false racist beliefs such as that Indigenous women were not good mothers, and false eugenic beliefs such as that the best future particularly for children of mixed descent was assimilation into white society. While some put the figure much lower, it is likely that between twenty thousand and one hundred thousand Indigenous children were removed.[3]

A second group is the Forgotten Australians. These are the five hundred thousand or so Australians who were placed in institutional or other out-of-home care in the twentieth century. Almost all of these suffered from a lack of love, affection and nurturing as they grew. Many also suffered from emotional, physical and sexual abuse, including criminal physical and sexual assault. A third group is the Lost Innocents, the ten thousand or so British child migrants sent to Australia in the twentieth century. Their experience in institutional or out-of-home care was similar to that of the Forgotten Australians.[4]

A final group is the just less than three hundred Vietnamese children who were evacuated to Australia and adopted during the closing days of the Vietnam War in April 1975 as part of an international Operation Babylift. Controversial even at the time, this was Australia's first large-scale experience of what is now known as intercountry adoption.

The Decline of Adoption in the Twentieth Century

Despite many difficulties, between 1945 and 1970 roughly fifty percent of Australian unwed mothers kept their babies. This increased significantly when the Whitlam government introduced the supporting mother's benefit in 1973. Thus, whereas there were about 4,997 non-relative adoptions in Australia in 1971-1972, there were only about 2,748 in 1974-75.[5]

Throughout the 1970s, evidence accumulated around the world of the deep and persistent grief experienced by many relinquishing mothers, and the sense of dislocation and loss experienced by many adoptees. In Australia, a grassroots movement developed. It offered support, validation of these deep emotions, networking, and practical advice about how to seek out either a lost child or a lost birth mother. In this period, there were three national adoption conferences in 1976, 1978 and 1982. These conferences also provided a national platform for Indigenous people to express their concerns about the Stolen Generations. Political advocacy also developed as the movement called for recognition and for much-needed reforms.

What was arguably the first methodologically sound study anywhere in the world of the effects of relinquishment on the birth mother was published in 1984. *Relinquishing Mothers: Their long-term adjustment* by Western Australian psychologists Robin Winkler and Margaret van Keppel used a theoretical framework to generate hypotheses which were then tested in their research. Two hundred and thirteen relinquishing mothers were recruited using a variety of strategies, and each completed a comprehensive questionnaire. The study yielded both quantitative and qualitative results, which are thoroughly detailed in a one hundred page report.

Forty-six percent of these relinquishing mothers reported an increasing sense of loss over periods of up to thirty years, with the sense of loss being more intense at particular times such as birthdays, milestones in their child's life, and Mother's Day. Another five percent said that their sense of loss had remained much the same. On the other hand, thirty-seven percent reported that their sense of loss had weakened over time, and eleven percent said that it had disappeared. Compared to a carefully matched comparison group, relinquishing mothers had significantly more problems of psychological adjustment. Both social support and the opportunity to talk through their feelings lessened the effects of relinquishment. The relinquishing mothers expressed the clear view that their sense of loss and their problems of adjustment would be eased by knowledge of what had happened to their child.[6]

For our purposes here, it is useful also to summarise what this report noted about the effects on a mother of the death of her child either just before or just after birth. These include somatic complaints such as sleep disturbances, inappropriate cognitions such as a preoccupation with thoughts of the deceased, a wide variety of extreme emotional responses including grief

and anger, and disturbed behaviour including both apathy and compulsive overactivity. In one study, twenty-one percent of mothers were identified as having a marked deterioration in health after their baby's death. In another study, a third of the mothers developed serious symptoms including psychosis, anxiety attacks, obsessive thoughts, and deep depression.[7]

Let us return to our account of closed adoption, the Stolen Generations, the Forgotten Australians and the Lost Innocents. Building on the work of many people, awareness of the harmful effects of these past injustices continues to be disseminated. The Human Rights and Equal Opportunity Commission's 524-page *Bringing Them Home* Report on the Stolen Generations was released in April 1997. On 8 December 2000, the 245-page Report of the New South Wales Legislative Council Standing Committee on Social Issues *Releasing the Past: Adoption Practices 1950-1998 was issued. The 336-page* Report on Child Migration by the Senate Community Affairs References Committee *Lost Innocents: Righting the Record* was released on 30 August 2001. The 438-page Report also by the Senate Community Affairs References Committee titled *Forgotten Australians* was released on 30 August 2004. After apologies by the State and Territory governments between 1997 and 2001, on 13 February 2008 there was a National Apology to Australia's Indigenous Peoples moved by then-Prime Minister Kevin Rudd and passed unanimously by both Houses of Parliament. On 16 November 2009, there was a National Apology to the Forgotten Australians and the Lost Innocents again moved by then-Prime Minister Kevin Rudd and tabled in both Houses of Parliament.[8]

There is still much unfinished business here. Organisations such as the Association of Relinquishing Mothers and Origins continue to support and advocate for those affected by closed adoption.[9] There has not been a National inquiry into closed or forced adoption, and some believe that such an inquiry is needed. The Western Australian Government has announced that in October 2010 WA Premier Colin Barnett will move an apology in parliament to the women, children and families affected by past adoption practices: this will make them the first Australian state to offer such an apology.[10] In all the cases which we have discussed, there is an ongoing need to provide people with opportunities to tell their story, for that story to be heard by the appropriate authorities, and for an official response which acknowledges the harm done and also offers avenues and resources for healing.

Concerns about Abortion

At least until the 1970s, adoption was generally regarded as the best solution in those situations where a woman was both pregnant and either unable or unwilling to keep the child. Nowadays, this opinion has changed, and it is sadly clear that the majority of Australians now regard abortion as the best solution in these circumstances. There are at least 80,000 abortions in Australia every year. That is roughly one abortion for every four live births. As many as one in three Australian women has at least one abortion at some time in her life.

In recent years, however, there has been increasing concern about the effect of abortion not only on the unborn child but also on the woman who has the abortion. Selena Ewing from Women's Forum Australia has examined all the articles about abortion in peer-reviewed journals over the last fifteen years. From this comprehensive review of 168 articles, she concluded that there is "substantial evidence of psychological harm associated with abortion." She wrote:

- Abortion results in short-term relief for most women, usually accompanied by negative emotions. Such relief tends to be transient.
- Ten to twenty percent of women suffer from severe negative psychological complications after abortion, despite the frequent presence of relief soon after the abortion.
- Many more women experience emotional distress immediately after the abortion and in the months following. Women experience a range of negative emotions after abortion including sadness, loneliness, shame, guilt, grief, doubt and regret.
- Depression and anxiety are experienced by substantial numbers of women after abortion.
- For a small proportion of women, abortion triggers Post-Traumatic Stress Disorder.
- After abortion women have an increased risk of psychiatric problems including bipolar disorder, neurotic depression, depressive psychosis and schizophrenia.
- Women who have experienced abortion also have an increased risk of substance abuse and self-harm. This is particularly true during a subsequent pregnancy.[11]

Towards a Reappraisal of Adoption

Nowadays, there are relatively few adoptions in Australia. Statistics now report on intercountry adoptions, known child adoptions (in which an Australian child is adopted by a step-parent, another relative, or his or her foster-parents or other carers), and local adoptions (in which an Australian child is adopted by parents who have had no previous contact with the child). The most recent statistics are for 2008-09. In that year, there were a total of 441 adoptions throughout Australia. These included 269 intercountry adoptions, 104 known child adoptions, and 68 local adoptions. These figures are now fairly typical: in the previous year there were 440 adoptions; in the ten years before then, there were mostly just over 500 adoptions each year.[12]

Australian couples often consider intercountry adoption because there are so few Australian children for adoption. They must apply to the appropriate governmental agency in their State or Territory - or in Victoria, New South Wales and Tasmania they may instead apply to an approved non-governmental adoption service provider. They have to satisfy certain criteria (which vary somewhat across the jurisdictions). If they are successful, the process may take two or three years or even longer. The cost could be $30,000 or more, which covers

processing costs both here and overseas, airfares and other expenses.[13]

The *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoptions was concluded on* 29 May 1993 and came into force on 1 May 1995. It establishes standards and procedures to ensure that intercountry adoption is in the best interests of the child. After Australia ratified the Convention on 25 August 1998, it came into force in this country on 1 December 1998. While Australia has intercountry adoption programmes with both Hague and some non-Hague countries, it requires that the standards and procedures of the Convention be followed in every case.

In 2008-09, just over 80 percent of Australia's intercountry adoptions came from Asia; another 14% came from Africa; and smaller numbers came from South and Central America and elsewhere. Almost three-quarters of intercountry adoptions came from four countries: China (23%), South Korea (17%), the Philippines (17%), and Ethiopia (14%).[14]

One concern about intercountry adoption is that in some countries unwed mothers may be virtually forced by their circumstances to relinquish their child. These situations must be remedied to ensure that women overseas do not suffer as Australian women have done after forced adoption.

From the late 1990s, there has been an international reappraisal of the place for adoption in those situations where parents have repeatedly demonstrated that they are unable to care for their children (often because of drug addiction or other problems). In the past, these children experienced serial foster-care placements in the hope that eventually their parents would be able to care for them again. These serial placements proved very harmful for children who need stability during the crucial years of early childhood development.

Thus, in 1996 US President Bill Clinton issued an Executive Memorandum seeking to increase adoptions in order to provide chronically neglected children with a permanent home. The 1997 US *Adoption and Safe Families Act* requires with very limited exceptions that if a child has been in foster care for fifteen of the previous twenty-two months, the state welfare agencies must initiate legal action to terminate parental rights, and at the same time actively seek out potential adoptive families.

In February 2000, UK Prime Minister Tony Blair committed his government to a review of adoption. The White Paper *Adoption – a New Approach* and the UK *Adoption and Children Act 2002* expedites the welfare and legal processes in order to provide permanence and a fresh start to those children whose parents are unable to care for them.

The Australian reappraisal of adoption began with the 256-page 2005 Report *Overseas Adoption in Australia* by the House of Representatives Standing Committee on Family and Human Services. After extensive consultation, the Committee declared itself "unequivocally in support of intercountry adoptions." At the same time, it noted a "general lack of support for adoption – both local and intercountry – in most of the state and territory welfare departments." Indeed, departmental attitudes ranged "from indifference to hostility," and in many cases "potentially relinquishing mothers" were "likely to be counselled against giving up their child for adoption." Such attitudes surely arose because of past adoption practices. However, the Committee noted that these "past social attitudes and practices" now no longer existed. The Committee was particularly concerned about the effects of these attitudes in child protection cases. As they noted, "This has led to tens of thousands of children being placed in foster care and other forms of out-of-home care when adoption could well have been in their best interests." The Committee called for reform of this "anti-adoption culture" and increased support for both intercountry and local adoption.[15]

This advice was repeated even more strongly in the 407-page 2007 Report *The Winnable War on Drugs: The impact of illicit drug use on families,* also by the House of Representatives Standing Committee on Family and Human Services. Its fifth recommendation is that the Commonwealth, State and Territory ministers "develop a national adoption strategy which acknowledges that… adoption is a desirable way of providing a stable life for a significant proportion of children with drug-addicted parents" and "establish adoption as the 'default' care option for children aged 0-5 years where the child protection notification involved illicit drug use by the parent/s."[16]

Since the 1970s, there has been around Australia a third wave and in some jurisdictions arguably even a fourth wave of adoption legislation.[17] This State and Territory legislation shares at least four common features:

Firstly, there is much emphasis on **ensuring free and informed consent** from a relinquishing mother or relinquishing parents. Over a series of meetings, an adoption counsellor will give the parent(s) complete information about other possible options for their child's care, the possible psychological effects of adoption – both short-term and long-term – for both parent(s) and child; the adoption process and its legal effects, and so on. This is usually supplemented with written information,[18] and the adoption counsellor must confirm that the parent(s) truly understand the information. Parent(s) must wait for a period after birth before relinquishing their child, and there is then a period in which this consent can be revoked. (The child may be placed in foster care during this entire period, but the birth parents are able to visit at any time.) In Victoria, for example, a child cannot be relinquished until sixteen days after its birth. The mother is then free to change her mind for the next twenty-eight days – and this period can be extended by another fourteen days if she is still uncertain.

Secondly, there is a strong preference for **open adoption,** which is sometimes also called access adoption. This means that the child knows that s/he is adopted, and that there is ongoing information exchange and access between the adoptive parents, the birth parent(s) and the child. Information exchange might include photographs,

letters, school reports and so on sent between the adoptive parents, the birth parent(s) and the child. Access might be a meeting between the birth mother, the adoptive parents and the child for a few hours in a neutral place maybe several times a year. Birth parents may opt out from either or both information and access. If, however, they later change their mind, they are then able to re-negotiate either information or access or both.

Thirdly, adoption is facilitated by an **adoption plan.** In an adoption plan, the birth mother or birth parents are able to express their wishes about the type of couple who will adopt their child (eg religion, race and ethnic background), what information and access will be provided, and so on. In some jurisdictions, the birth parent(s) are able to express a preference after considering a short list of descriptions of potential adoptive families, or to meet the family who are selected before the placement of their child.

In Australia, adoption by same-sex couples is permitted by the laws of the Australian Capital Territory, Western Australia, and New South Wales. The birth mother or birth parents should be able to indicate if this is not acceptable to them. Along with other Christian Churches, the Catholic Church does not approve of adoption by same-sex couples.[19]

Fourthly, all States and Territories follow the **Aboriginal and Torres Strait Islander Child Placement Principle.** This means that the first preference for the placement of an Indigenous child outside their immediate family is with their extended family. Only if this is not possible, the next preferences are within that child's Indigenous community, and then with other Indigenous people. Five Aboriginal and Torres Strait Islander children were adopted in 2008-09, with a total of 72 over the last 15 years.[20]

While these legislative changes have been taking place, there has also been a renewed interest in adoption in popular culture. The recent movie *Mother and Child* is a sometimes harrowing dramatisation of the harms of closed adoption. Another recent movie *The Waiting City* illustrates how a couple truly become parents through intercountry adoption. Interestingly, the adoptive mother Fiona reveals that, because the time wasn't right, she had aborted the couple's first child – not suspecting that they would be unable to have any more children. Yet another movie *Juno* is about open adoption US-style (where in some states the relinquishing mother interviews and chooses the adopting parents). On her way to an abortion clinic, sixteen-year-old Juno is told by her classmate Su Chin that "All babies want to get borned." This and Juno's own sense of right and wrong deter her from abortion, and the movie is about her selection of adoptive parents for her child. Social commentator Bettina Arndt noted that at this time adoption has "dropped off the list of choices for dealing with unwanted pregnancy." She believes that adoption "will be the right decision for some women," and hopes that *Juno* "may open women's eyes to that possibility."[21]

Open Adoption is Better

In the Bible, the prophet Isaiah asks, "Can a woman forget her baby, or a mother the child within her womb?" (Is 49:15) The short answer is: as a general rule, no. In this article, we have looked at the psychological consequences for many women of the death of their child near birth, and of closed adoption and abortion. These consequences are actually quite similar, and they jointly remind us of the profound connection between women and their children. Psychologist Jennifer Rice when speaking about closed adoption observed that "there is pre-natal bonding in many cases between a woman and a foetus. And even if she knows that she's going to relinquish that child, the body remembers, in a sense, the presence of the child."[22] This is just as true after perinatal death and after abortion.

Because of this profound connection, the best outcome even for unplanned pregnancy is any solution which allows the mother to keep and raise her child. As there have been throughout history, there are many girls and women who continue to do this.[23] In some cases they are able to do so together with the child's father; in other cases, this is not possible. It is entirely right and proper that our governments provide benefits to help women keep their children, and that we as a society encourage and support them to do so.

In some cases, this is simply not possible. In these cases, once again because of the profound connection between mother and child, the best outcome is any solution which allows the woman as much ongoing contact as possible with her child. Closed adoption did not do this. Abortion can never do this. But open or access adoption can. This is why in those situations where the mother cannot keep her child, the next best solution is open adoption. It is better for the woman who is still able at least sometimes to see her child, and to be there as her child grows and develops. It is better for the child, who is not killed but instead is able to enjoy the many opportunities of life. The evidence is that children generally do well in adoption, particularly if they are adopted at an early age.[24] For both the woman and her child, open adoption is simply better than abortion.

Sadly, far too many biological fathers simply absent themselves from these situations. When the biological father remains involved, open adoption offers him options too for ongoing contact. Such contact can be also good for the adopted child.

Of course, open adoption is not an easy choice for a pregnant woman. She must do two hard things. In an era where abortion is sadly so readily available, she must carry her child to term. And when her child is born, she must recognise that she really cannot care for this child, and she must give this child to another family who can. In one of the *Harry Potter* movies, Dumbeldore observed that "we must all face the choice between what is right and what is easy." This observation recognises that what is right is often not easy – and that what is easy is often not right. In the short term - during the pregnancy and immediately afterwards - the choice for open adoption is

not easy. But in the long term – in the many years that lie ahead – the choice for open adoption is right both for the woman and her child. The short-term pain is justified by the long-term gain.

Nowadays, when girls and women must decide what to do about an unplanned pregnancy, it seems that for many of them adoption is something unthinkable which they dismiss immediately almost without any consideration. In other words, their choice quickly becomes either keeping the child or having an abortion. It is strange that killing an unborn child seems a realistic option, whereas giving that child a chance at life does not. Is it because they do not know about open adoption? Is it because adoption asks hard things of them? Or is it because they are only deciding what they would like to do, rather than thinking about what would be best both for themselves and their unborn child in the long-term? It is strange too that abortion which is known to harm women seems a realistic option, whereas open adoption which will allow them to continue to be part of their child's life does not.

I hope that any girl or woman with an unplanned pregnancy gives herself time to get over the initial shock. I hope that she takes the time to think, and to speak with trusted advisors. I hope that she tries to remember what her values have been throughout her life, rather than simply what seems most expedient in this time of crisis. And when women recognise for whatever reason that they really cannot keep and raise this child, I hope that many women think seriously about adoption. Even while this is still only a possibility, a good first step is to speak to an adoption counsellor.[25] Such an inquiry does not commit anyone to adoption, but it does provide more information for an informed choice. If she makes this decision, she will give her child the gift of life – and she will herself be part of that life. When a woman cannot keep her child, open adoption is the best choice, both for the mother and her child. For both of them, open adoption is far, far better than abortion.

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[13] For the names and contact details of the various State and Territory agencies, as well as the assessment criteria in each jurisdiction, see Ibid, iv, 56-63.

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All online resources accessed 21 September 2010.

Kevin McGovern ✠

Paying Women for Egg 'Donation'

Some advocates of embryonic stem cell research want women to be paid for donating their eggs. This article details reasons why this would be bad public policy that would harm women.

Interest groups are arguing that women should be paid for donating their eggs. Women are not volunteering in enough numbers, and lobbyists believe that incentives need to be found to encourage egg donation. Advocates argue that given the invasiveness of the procedure, it seems reasonable to pay compensation rather than just reimbursement of costs (which women currently receive). They want Australia's law banning the payment of additional fees to be overturned.

A number of groups want access to women's eggs: infertility specialists and researchers, infertile couples, commissioning surrogates, and scientists involved in embryonic stem cell (ESC) research, as well as would-be egg brokers who plan to obtain and sell eggs.

Scientists doing ESC research usually obtain ESC from so-called "spare" embryos, left over from IVF programs. They are not legally permitted to form embryos for research purposes by *fertilisation*, but they are permitted to use human eggs to form embryos for research purposes by *cloning* or *somatic cell nuclear transfer (SCNT)*.

There are few "spare" eggs on IVF programs as the normal approach is to fertilise them because eggs are unlikely to survive freeze-drying for storage purposes. Embryos on the other hand have a much better chance of surviving thawing and rehydration.

So far, all attempts to produce human ESC from cloned embryos or SCNT embryos have been unsuccessful. Not a single cloned human embryo has ever been produced. Reports that Korean scientist Dr Hwang was able to manufacture cloned human embryos proved fraudulent – even though he used 2061 eggs harvested from 169 women (including his research assistants) in the attempt.[1] If scientists are to continue down this path, they will potentially need hundreds of thousand of human eggs.

Prominent leaders in the field such as Prof Alan Trounson, President of the *California Institute of Regenerative Medicine,* have recently claimed that scientists will be able to derive all the stem cells they need from human body cells or from human induced pluripotent stem cells (hIPS) instead of embryos. This process does not involve ethical issues such as the destruction of human embryos. However, this has not stopped others, such as Prof Loane Skene, former Deputy Chair of the 2005 Lockhart Committee which advised Federal Parliament on stem cells and cloning, from calling for women to be paid for donating their eggs.[2]

Prof Skene argues that preventing women from being paid for donating eggs may be "an unwarranted restriction of their autonomy — the hand of the nanny state." She asserts that women should be allowed to choose to be involved if they wish and that since we allow others to engage in risky occupations egg donation should be no different.[3]

This flies in the face of Australian public policy that has rejected selling not only human eggs, but all human tissues. In this, paying people for human tissue has been recognised as unethical because it would:

- undermine the "social capital" that exists in the donation of tissue for the blood bank, bone marrow and eye banks, and for transplantation – if some people were paid then others may be unlikely to continue to donate
- result in the development of perverse incentives whereby people may behave badly if they are paid and may, for instance, not disclose health risks
- cause loss of access to and loss of the equity of the current donor system by increasing cost and becoming dependent on the development of private trade in place of the current system of donation and the equity of the current donor system of donation and equity of access according to need
- treat the human body as an object by commodifying it.

The Catholic Church opposes trade in human tissue. The Catholic Health Australia *Code of Ethical Standards* states, "Parts of the human body are not to be treated as commodities. Trade in human body parts is unacceptable, as is any other disrespectful use of the organs or tissues of a living or deceased person." (II.3.16)

Collecting Eggs

Women are usually far less willing to donate their eggs than men are to donate sperm. Egg harvesting is a complicated business. Usually a woman only produces one egg per cycle from a ripened follicle in her ovaries. Women undergoing IVF and egg donors are given hormones to stop their menstrual cycle. Then they are given fertility drugs in order to induce the ovaries to release multiple eggs in the one cycle. They undergo surgery and are given a general anaesthetic so that the eggs, often 10-20 or more, can be collected by a surgical procedure.

Each developing follicle can grow to be around the size of a golf ball. Artificially stimulating the ovaries to produce so many eggs at the one time can be extremely painful for the woman. Common side effects include: hot flushes, abdominal distension and discomfort, ovarian enlargement, blurred vision, nausea, vomiting, diarrhoea, bone pain, headaches, dizziness, pain, redness and itching at the injection site, breast tenderness and swelling, irritability and mood changes.

Ovarian Hyperstimulation Syndrome (OHSS)

Women exposed to fertility drugs can go on to develop the more dangerous ovarian hyperstimulation syndrome (OHSS). More serious symptoms of OHSS can require hospitalisation, and include unintended pregnancy, renal failure, intrauterine polyps, ovarian cysts, thromboembolism, respiratory distress, haemorrhage from ovarian rupture, and infertility. OHSS can necessitate the removal of one or both ovaries. The American Society of Reproductive Medicine has said that the occurrence of these more severe symptoms is "by no means rare."[4]

It appears that on average each woman undergoing IVF in Victoria produced an average of 10 eggs (9.8) per cycle. In 2004, 308 women on ART programs in Australia developed OHSS, and 257 (83%) had to be admitted to hospital. In total, 1.3% of women developed this condition while undergoing ART treatment. In Australia, there have been at least three documented deaths of women undergoing IVF programs.[5] Other research puts the number of women who experience (OHSS) at between 0.3% and 10%.[6]

Additional reasons for concern are starting to emerge in the media. OHSS is blamed for causing a 22-year-old Stanford USA graduate, Calla Papedemas, to suffer a massive stroke and brain damage after she had commenced egg extraction. She was to be paid a fee of US $15,000. Complications after IVF treatment are linked to the deaths of Jacqueline and Rushton Temilola Akinbolagbe. Another woman died from internal bleeding and renal failure, complications induced during egg retrieval.[7]

Concerned about the exploitation of young women, *The Centre for Bioethics and Culture Network* recently produced a new documentary called *Eggsploitation.* It highlights the hidden dangers and health risks occurring in the infertility industry's human egg trade and profiles women who all suffered extreme health consequences related to their egg donation and either died or almost died as a result.[8]

Long-Term Health Risks

One US committee assessing the medical risks of egg donation was struck by just how little is known about the long-term health outcomes of women who have undergone egg extraction.[9] They were shocked to learn that there were no registries that track the health of women who undergo ovarian stimulation, despite the large numbers of women who have undergone the procedure. Most of the studies were anecdotal or focused on relatively small groups of women.[10]

Some researchers have linked infertility treatment with ovarian, breast, and endometrial, and uterine cancers. But as few long-term studies have been carried out, the links between fertility drugs and cancer may have been missed. Longitudinal studies of women involved in reproductive technology programs, as well as those who have become egg donors, would have to be carried out. (It may not be in the best interest of the fertility industry to carry out such studies!) This lack of information undermines the argument that women can give informed consent and choose whether or not they wish to be involved. Women cannot give informed consent without being informed of any likely long-term risks to their health and well-being. This cannot occur if such studies never take place.[11]

Some people have argued that paying women for egg donation would give women some protection. But it is hard to see how women such as Ms Papedemas were protected by the payment of a US$15,000 fee. Ms Papedemas almost lost her life as a result, and the experience left her with long-term health problems. As we have seen, she is not the only woman whose health has been adversely affected as a result of egg harvesting. If anything, payment was an inducement to become involved in something which they may not have done otherwise, a decision which almost cost them their lives. Additionally, some women, despite being well-educated, felt that they were not given all the information, and therefore could not make an informed decision. Without studies, women cannot be told of all the risks to their health, but they should at least be informed of the known risks.

Prof Skene argues that preventing women from being paid for egg donation may restrict their autonomy. All too often, the risks to women's health are dismissed by liberal feminists as their choice: they say, it is up to them, give them the information and let them chose. Prof Skene argues that we let people be involved in other risky things such as film stunts and bridge construction. However, it is one thing to allow people to take known risks that they can understand and predict. No one can yet know the risks involved with egg donation. And it seems at best irresponsible to encourage women down this path.

As, founding member of Women's Forum Australia Katrina George points out, decisions to be involved in egg donation do not occur in a vacuum. "Women's decisions to provide eggs should be considered against the background or powerful social, political and economic forces which have vested interests in women's decisions about their eggs: the biotechnology industry, scientists, research advocates and patients themselves who may exercise influence—even if well meaning—in the hope of future treatments."[12]

Exploitation of Women

As far back as the 1980's, radical feminists such as Renata Klein warned that fertility drugs used by reproductive technology industry could be dangerous. Their concerns lead them to found an international network which they called *Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRAGE).*[13] Around 1988, Robyn Rowland and Renate Klein "exposed the severe health hazards for both the women and the resulting children by the hormonal cocktail of Pergonal and clomiphene citrate

administered in IVF." Anita Direcks linked clomiphene citrate to DES, another drug given to women which was later found to have caused health problems including cancer.[14]

Despite the odds and the enormous power of the reproductive technology industry, resistance is growing to egg donation. And it is not all coming from the "religious right." New groups like *Hands Off Our Ovaries*[15] and *the Alliance for Humane Biotechnology* are emerging to warn women of the dangers. Members of the Alliance are a diverse group and include the *Centre for Genetics and Society*, the *Pro-Choice Alliance for Responsible Research, Our Bodies Ourselves*, *California NOW*, *Breast Cancer Found*, *AAUW*. Last year, they successfully campaigned for a new Californian law which requires a warning about the health risks posed by the procedure to accompany advertisements offering cash to egg donors.[16]

Given that no-one knows the long-term dangers for women exposed to superovulatory drugs, we should not be putting more women at risk by paying them to donate their eggs. We can only hope that resistance will continue to grow. As Ms George puts it, "Egg harvesting has significant health, ethical and social policy repercussions for the status and treatment of women, yet it offers no health benefits to the supplier herself. The expectation is that the disproportionate burdens of contentious scientific research will be born by women: collateral damage along the biotechnology superhighway."[17]

ENDNOTES

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Marcia Riordan, B.Sci (La Trobe), M.Bioethics (JPII Melb) is the Executive Officer of the Life, Marriage and Family Office, Melbourne.

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Marcia Riordan ✠

Caroline Chisholm Centre for Health Ethics

Suite 47, 141 Grey Street, East Melbourne Vic 3002

Tel (03) 9928 6681 Fax (03) 9928 6682 Email: ccche@stvmph.org.au
www.chisholm.healthethics.com.au

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Director/Editor: *Rev. Kevin McGovern Dip Ap Sc (Optom) (QIT), STL (Weston Jesuit School of Theology)*

Research Officers: *Mrs. Kerri Anne Brussen BApp Sci (RMIT), Grad Dip Health Ed (La Trobe)*

Administrative Assistant/Layout/Sub-editor: *Josette Varga*