SUBMISSION TO

INQUIRY INTO TRANSPARENT ADVERTISING AND NOTIFICATION OF PREGNANCY COUNSELLING SERVICES BILL 2005

via an attached document to community.affairs.sen@aph.gov.au

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Dr Susie Allanson

BA (Hons), MA (Clinical Psychology), PhD, MAPS

Clinical Psychologist

The Fertility Control Clinic

&

Private Practice

118 Wellington Pde East Melbourne 3002

Ph: 9419 2922

Fax: 9417 6739

I am delighted to have the opportunity of writing in support of the Transparent Advertising and Notification of Pregnancy Counselling Services Bill 2005.

This submission details the following:

1. My qualifications and experience in this area;

2. The current problems with "false providers" of pregnancy counselling services, including anecdotal examples of (unwitting) users of these services;

3. A framework for professional and ethical problem pregnancy/abortion counselling, and;

4. Recommendations relevant to The Bill.

This submission draws from my paper, Pregnancy/abortion counselling: False providers, mandatory counselling, ultrasound and "cooling off", to be published later this year in the Australian *Women Against Violence Journal.*

Qualifications & Experience

I have been a clinical psychologist for more than 25 years working variously at the Royal Children's Hospital, Children's Court Clinic, schools, private practice, and teaching and supervising health professionals and students. I have been the clinical psychologist at the Fertility Control Clinic in Melbourne for the last 15 years. I served on the Board of Family Planning Victoria in the mid 1990's. My doctoral thesis, completed in 1999, was titled, The abortion decision: Fantasy, attachment and outcomes. I have publications on problem pregnancy decision making and abortion in peer reviewed journals (included in the References section of this submission) and I was a reviewer for the international Journal of Psychosomatic Obstetrics and Gynaecology from 1996 – 2002. I am regularly asked to speak about unplanned/ problem pregnancy counselling and abortion to various audiences. I was asked to contribute a literature review chapter on abortion and mental health, as part of a group of academics, primarily situated at the University of Melbourne Key Centre for Women's Health in Society, contracted to provide a Reproductive Health & Mental Health report for the World Health Organization (WHO). I am a member of the Reference Group for the ARC Linkage Grant Research, Understanding women's experience of unplanned pregnancy and abortion, being carried out jointly by the Royal Women's Hospital, Melbourne, and University of Melbourne Key Centre for Women's Health in Society.

The Fertility Control Clinic (FCC) is Victoria's largest free-standing private abortion providing clinic. It was originally set up in 1972 by the abortion rights campaigner, Dr. Bertram Wainer. The FCC is an accredited day procedure centre. FCC staff includes a counselling team, gynaecologist and other medical practitioners specialising in family planning, theatre and general nursing staff, a team of pathology scientists, reception and administrative staff, and a Chinese-Vietnamese interpreter. The FCC provides a crucial and vital health service to the people of metropolitan and regional Victoria, other Australian states (notably Tasmania), and women from other countries who are studying, holidaying or have migrated to Australia. The clinic has a

direct impact on decreasing maternal and peri-natal morbidity and mortality, and economic and socio-emotional impoverishment by:

(i) preventing unwanted pregnancy via contraceptive advice and treatment;

(ii) improving women's reproductive health via a wide range of screening and treatment (e.g. Pap test, colposcopy);

(iii) providing safe termination of problem pregnancies;

(iv) providing women-centred, evidence based, pro-choice counselling.

False Providers

The term "false providers" was used by the National Health & Medical Research Council (NH&MRC) in their report, *Services for the termination of pregnancy in Australia: A review. Draft Consultation Document – September 1995.* The NH&MRC used the term, false providers, to describe services publicly purporting to provide pregnancy or post-abortion counselling to women, but which are run by anti-choice organizations such as Right to Life or Pro Life. The unambiguous agenda of such organizations is to ensure that once conceived, a pregnancy is continued to term. That is, the continued development of the embryo or fetus takes precedence over the best interests and wellbeing of the woman concerned.

A woman contacts such services with the expectation that she is the service's client, that her welfare will be their primary concern, and that the service will make appropriate referrals according to her needs. However, the goal of anti-choice counselling is to ensure that a woman will continue her pregnancy and will not access abortion providing services. In this sense, the true client of such organizations is the pregnancy – the embryo or fetus - not the woman.

False providers attempt to achieve their goal by misleading the woman about their counselling agenda, by providing the woman with misinformation about pregnancy, abortion and other related matters, and by using their sympathetic counsellor role to falsely create the initial impression that the welfare of the woman is their primary concern. False providers thus violate a basic duty of care to their clientele - the women contacting their service.

Misinformation

Based on the false assertion that women are hurt by abortion, false providers argue that their anti-choice agenda is also in the best interests of women. False providers' claim that abortion harms women by, for example, causing infertility, breast cancer, and mental illness. All these claims contradict solid research over three decades (Allanson, 2006; Major, Cozzarelli, Cooper, Zubek, Richards, Wilhite & Gramzow, 2000; NH&MRC, 1996; Royal College of Obstetricians and Gynaecologists, 1991).

From my own clinical work at the FCC and from information from colleagues, I have been informed of false providers disseminating a range of false, misleading and fear-inducing information to individuals contacting their organization, health professionals and the general public. They invariably omit to mention their anti-choice links and agenda. Medical practitioners have unwittingly advertised a false provider by

displaying the false provider's poster or literature to patients, only to hurriedly remove it when feedback of that "service" suggests their patients have been upset or annoyed by their contact with it. Schools have also been targeted in a similarly ambiguous and mischievous manner.

Misrepresentation of Counselling Services.

Pregnancy Counselling Australia is a key example of how false providers mislead individuals, health professionals and the community. Pregnancy Counselling Australia sounds reputable and well credentialled. It advertises its phone service free of charge in the 24-hour emergency section of the White and Yellow pages and advertises elsewhere. It has mailed out eye-catching large posters to general practitioners to display in their waiting rooms. It may receive government funding. But in fact Pregnancy Counselling Australia is an anti-choice organization. This fact is difficult to find in their literature, and is apparently rarely mentioned when they are contacted by women hoping to receive ethical counselling. There are other similar organizations where their advertising makes no reference to their: anti-choice philosophy, refusal to provide accurate evidence based information, and refusal to refer for abortion.

Harm

Given the above it is to be expected that anti-choice "counselling services" can be harmful to women contacting them. There does not appear to be any rigorous research documenting the impact of this, but there is ample anecdotal evidence from women presenting to health professionals subsequent to their contact with a false provider, or from health providers themselves who have phoned the false provider to check on its counselling approach. Over the years I have been contacted by women and their families who have unwittingly contacted a false provider, and I have also been privy to many similar stories from my colleagues around Australia. Below I provide five case studies of women and their families who consulted me over the past year at the FCC, and four case studies provided by other FCC counsellors. We do not know the actual number of women contacting false providers each year, or the number who are assisted or unaffected, versus distressed, by their contact. For a number of reasons a woman who has contacted a false provider rarely pursues formal avenues of complaint against the false provider. She may be unsure where to turn to make a complaint and doing so may not be in her or her family's best interests - facing an unplanned/problem pregnancy usually is experienced as a crisis, women may be acutely sensitive to confidentiality and privacy issues given the continuing taboos around unplanned pregnancy and abortion, and generally women want to move on once the pregnancy crisis is resolved.

The number of examples included here does not reflect the actual number of women attending the FCC in a year who have expressed dismay that they unwittingly contacted a false provider. The cases below will hopefully provide the Committee with some appreciation of the quality, rather than the quantitative occurrence, of such contact:

CASE 1 A father from a regional area contacted me by phone. His 16-year old daughter was five weeks pregnant as the result of being raped. He and his wife were aware of counselling available about the sexual assault via the Centre Against Sexual Assault (CASA) and had arranged this for their daughter. But the father was phoning

to find out where they could get counselling for her around the pregnancy decision. As her father, he felt strongly that she should terminate the pregnancy, as did her local doctor. But, perhaps in part due to the pressure from these people to have an abortion, she now was saying she wanted to continue. He felt out of his depth and he wanted to make sure she had every opportunity to think it all through.

The local sexual assault unit (police) had looked up their list of services and given him Pregnancy Counselling Australia. So he phoned them. He was shocked and distressed by their comments. Once they heard that he favoured his daughter terminating her pregnancy, they called him a murderer. They seemed to have no sympathy for his situation let alone his daughter's. He hung up on them, in a very distressed frame of mind.

He phoned the clinic quite soon after, understandably very upset. After my talk with him, he commented at how much calmer he felt. I also did my homework in linking this father and his daughter into appropriate services. Such liaison with other services can be time consuming and require special knowledge and a good working relationship with other services. One of these services is Action Centre run by Family Planning Victoria (FPV). It provides a broad based and professional family planning service specifically for young people up to 25 years of age. Action Centre run a pregnancy phone counselling service. Unfortunately, FPV do not have the funds to run this as a 24 hour 7 days a week phone service, although they are most suitably qualified to run such a service – professional, ethical, knowledgeable and sensitive, with solid ongoing professional education and supervision.

I also phoned the police who had unwittingly put this father onto PCA. They were grateful for my call and shocked to hear that this service, which advertises in the 24-hour Emergency Service section of the phone book, was in fact anti-choice and so unprofessional and unethical. They substituted FPV and Action Centre details, but unfortunately, as mentioned, these services do not have the funds to provide a 24/7 phone service.

CASE 2 I received a distressed phone call from this 34-year old mother of one child. She had had an abortion at ten weeks gestation, one week ago. Mary had a very serious history of Post Natal Depression (PND) – she was hospitalised in the Mercy Mother Baby Unit for three months as soon as she returned home from giving birth. Her description of anxiety attacks, hearing screaming in her head, together with her hospital admission suggests her PND may have been psychotic in nature and severity.

When Mary found herself pregnant this time she understandably quickly started feeling like she was slipping back into her mental illness. She consulted her doctor and psychologist before attending FCC. She presented as clear in her abortion decision.

Following her early abortion Mary experienced "instantaneous relief" and so then began wondering whether she could have continued the pregnancy instead. She had hoped that one day she could have another baby and do so without the PND. Mary also began to have nightmares about screaming, underdeveloped babies and linked this to the anti-choice protesters' picketing at the clinic, and also to the way she had returned to work as if nothing had happened.

Late last night, with Mary starting to second guess herself and doubting her decision, she contacted Pregnancy Counselling Australia 24-hour phone service. Mary had read the "pregnancy alternatives and post abortion" part of the phone book listing, but did not take that to mean that they were "Pro-Life, ie. anti-choice – it doesn't say they were that", Mary said. "You think you're safe phoning because it's in the 24-hour section next to Life Line."

Mary described the phone call as "very traumatic". She reported that the "counsellor" spoke about the "baby being in pain and it will forgive me if I pray and I shouldn't have done what I've done and the clinic is just a money making business and if I phoned you, you wouldn't care." Mary said that in her frame of mind at that time "I sort of believed what they were saying." The false provider also said that Mary should never have sex again and she should be tested for sexually transmitted diseases. "She had me scared to contact you." The false provider also urged Mary to look up an anti-choice website. Thankfully Mary did not.

Mary and I spoke about all of this, and her situation in detail. I spoke of the unethical nature of this "service" and avenues of making a complaint, but I also encouraged Mary to focus on doing what she had to do get herself feeling better. We revisited the very serious context of Mary's decision and validated her decision, ascertained that her partner is very supportive, encouraged Mary to see her psychologist again, and I mailed out pertinent literature to Mary. We also spoke about what Mary could do if in the future she decides she does want to have another child – given her history she would need to see a psychiatrist specialising in pregnancy and depression before she conceives and work out a solid game plan. I provided her with contact details of such a psychiatrist. I invited Mary to recontact me at any stage, but I felt confident Mary had good support and now had reviewed and re-validated her decision.

Mary was very grateful and said that she felt much better. She said that after the call last night she had had to be very brave to contact us this morning. Mary said that she did not want other women to go through what she had with the false provider.

CASE 3 24-year old Karen and her husband presented to the clinic with an unplanned pregnancy. They had known about the pregnancy for six weeks and Karen's pregnancy was now eleven weeks gestation. They had delayed coming into the clinic for an abortion because they had initially contacted a phone pregnancy service to find out about having an abortion. Unbeknown to them this service was a false provider offering "counselling" from an anti-choice philosophy. Karen had been married only a short time, her husband had recently lost this job, Karen was concerned that medication she had been taking might adversely affect the pregnancy, and neither felt ready to become a parent. They contacted the false provider feeling fairly certain that terminating the pregnancy was the right decision for them and for any children they might have in the future. The phone service informed them that abortion was an extremely dangerous operation likely to cause infertility and mental illness. The service would not refer the couple elsewhere, and the couple was left feeling highly anxious and hopeless.

Finally, out of desperation, the couple spoke to a close friend who was able to provide them with more accurate information and referred them to us. By this stage, Karen had also lost her job through stress and their marital relationship had almost failed. Fortunately Karen was still able to have an early abortion. They were reassured by

receiving accurate, evidence-based information about abortion, and non-judgmental counselling. Karen proceeded uneventfully through theatre. Post-operatively both Karen and her husband were relieved and grateful.

CASE 4 Jane is a forty-year old married woman with three children and living in a Victorian regional centre. She initially travelled three hours to the clinic when her unplanned pregnancy was eight weeks gestation. Her history of depression included bouts of post-natal depression, one of which was a psychotic depression with suicidality. She was understandably and sensibly fearful about how she and her family would cope if she continued with this pregnancy. At 40 years of age, Jane also was very aware that her age meant that she faced a significantly increased risk of genetic and medical problems with the pregnancy and would require more than the usual ante-natal monitoring. This was a difficult decision for Jane, but she ultimately decided that terminating the pregnancy was best for herself and her family. Jane had her own regular psychologist, and was also aware that she could recontact me at the Clinic.

However, perhaps in part because of her isolated geographical location, she phoned a false provider some weeks following the abortion. Jane was seeking reassurance and validation that she had made the right decision. She reported to me later that she had been told that abortion was a sin, she had murdered a child, she would necessarily suffer serious depression and grief and that she would need to ask for forgiveness. For several days following that "counselling", Jane was suicidal and functioning poorly, before her husband insisted she recontact us. Provided with the factual information, bolstering and professional counselling she needed, Jane again felt relieved and optimistic about her future with her family, and was encouraged to continue to see her own psychologist. Some weeks later, Jane phoned the clinic to thank us and update us on her continued improvement.

CASE 5 A 16-year old woman from a rural area attended the clinic with her mother. She and her mother told of their attempt to access professional counselling at a Pregnancy Help clinic. The mother was initially concerned when the counsellor persisted in excluding the mother from the session even though her daughter wanted her mother with her for support. While the mother waited she became increasingly concerned by the material in the waiting room which appeared to be prolife/right to life. Her daughter emerged from the session visibly upset. The young woman reported that the "counsellor" had spoken glowingly about young women who had continued an unplanned pregnancy and how strong and wonderful they were. This made the young woman feel guilty for even raising the topic of abortion. Nonetheless, she did raise abortion as an option, and was told that they did not refer for abortion because it was harmful to women and she needed to think carefully about whether she ever wanted to have children because most women who have an abortion end up infertile and never get over it.

After some delay in knowing where to turn, the mother and her daughter eventually attended the FCC. The young woman was relieved to receive factual information, be listened to in a non-judgmental and empathic way, and benefited from having the opportunity to look at her options in a way which was respectful to her unique circumstances. Fortunately she was still very early in the pregnancy and had time to follow up on suggested homework to clarify whether to continue or terminate her pregnancy.

CASE 6 A woman in her early twenties attended the clinic for problem pregnancy counselling. She explained that she had an 8-month old baby and her partner had walked out on her when she had been 7-weeks pregnant with the current pregnancy. In desperation she had phoned a pregnancy phone counselling service. She spoke to a woman who told her that if she had an abortion she wouldn't be able to get pregnant again because a large percentage of women having abortions became infertile. The woman suggested that she should continue this pregnancy – at least then she would have two children rather than ending up with one. This single mother waited five weeks before a friend suggested she contact us and come in for counselling. She ultimately decided to terminate her pregnancy. Because of the delay her pregnancy was 12-13 weeks gestation at the time of abortion. Compared with the procedure for an early abortion, she had to undergo a procedure with a higher risk, and greater time and expense.

CASE 7 A young woman attending the clinic with her boyfriend told the counsellor: My boyfriend and I went to a pregnancy counselling service in [a country town]. They showed us a film that was really frightening showing the baby trying to get away from the instruments the doctor was using. Then they told us how bad it was to have an abortion and I would never be able to have any children. They said my boyfriend would leave me if I had an abortion. I said my parents would kill me and kick me out if they found out I was pregnant. They said they would give me baby clothes and somewhere to stay till I had the baby. I said I wanted to finish school and I had to get an abortion. I did not want to live with strangers or adopt the baby out. I was so furious and scared after seeing them.

CASE 8 A 40-year old woman attending the clinic told the counsellor: I am 40 years old and I have teenage children and I don't want another child. But I've made it all even worse because I was feeling really worried and so I phoned a service listed in the front of the phone book. This person was so obviously trying to talk me into going ahead with the pregnancy. When I mentioned that I knew there might be risks of Downe's Syndrome because I was older she said I had nothing to worry about. I knew this wasn't true and I feel they shouldn't be allowed to be telling people things that are not medically true.

CASE 9 A young woman attending our clinic told the counsellor: I rang a counselling line I found in the phone book. I thought I could discuss what I could do about being pregnant – what my options were. But this was not what happened. The woman told me if I had an abortion I would never be able to get pregnant again and that I could die. And she said that they cut the baby up. I was only about six weeks pregnant at the time, which I reckon means it's not a baby. But I was still really frightened by everything she said. But I knew I had to have an abortion because there is no way I could cope with having a baby at 17. My boyfriend is only 18 and he's just a student too. They shouldn't be allowed to scare people like that and tell lies.

Ethical, Professional Problem Pregnancy/Abortion Counselling

Many women confronted with an unintended pregnancy continue their pregnancy without ever considering abortion or needing recourse to any sort of pregnancy counselling. These women are not considered here. Rather, the discussion below concerns those women who seriously contemplate, or complete, an abortion for psychosocial reasons or because of serious medical reasons.

In Australia, approximately 96% of abortions are early terminations (prior to twelve weeks gestation; Adelson, Frommer & Weisberg, 1995). The very small percentage of abortions occurring at a much later gestation are more likely to be for medical reasons and can present the woman, her family, and health care professionals with a complex and sad situation. Early abortion is one of the safest, simplest and quickest operations and following an elective abortion for psychosocial reasons, the majority (at least 80-90%) of women experience relief and improved functioning (NH&MRC, 1996; Royal College of Obstetricians and Gynaecologists, 1991World Health Organization).

Every woman presenting to the FCC with an unplanned or problem pregnancy routinely sees one of the clinic counsellors. By the time women book to see us the majority of women presenting for abortion for psychosocial reasons present clear in their decision to have an abortion (they usually have already discussed their decision with their doctor or other health professional, partner, family or friends) and they are confident that they will adjust well afterwards. A clinic survey of 374 women presenting at their initial consultation in 1991 found that 90% of women had "no doubts" about their decision to have an abortion. Counselling for these women is generally straightforward, primarily involving respectful support and information exchange required for informed consent. Common law judgements have ensured that all patients are provided with information about the risks and benefits of medical procedures they are considering undertaking and alternative courses of treatment. Termination of pregnancy is a medical procedure and those providing it must comply with these requirements. In all States and Territories except for the ACT, the grey legal status of abortion requires health care providers to obtain information about a woman's state of mind and reasons for seeking an abortion to ensure compliance with the law.

A minority of women presenting for pregnancy/abortion counselling are unsure what to do and can require quite complex counselling. They may ultimately decide to continue their pregnancy or to terminate their pregnancy. At the FCC we expend a disproportionate amount of counselling resources trying to meet the needs of the approximately 10% of women who are uncertain what course to take but who are usually quite desperate and are seriously considering abortion. These women may require more in depth counselling and information to help them clarify their circumstances, support networks and other issues so that they can decide whether to terminate or continue their pregnancy. Ambivalent women may be provided with decision-making literature, asked to think further on their decision, referred to other health services and be referred on to me. An audit of a six-week period in October-November 2005, revealed that of 24 women consulting me about a problem pregnancy, ultimately 16 terminated their pregnancy, seven opted to continue their pregnancy, and the outcome of one was unknown.

If a woman remains ambivalent, then by default, she continues her pregnancy. Although most women understandably want to reach a clear decision either way, this "default" decision is a legitimate (although not ideal) way to make a problem pregnancy decision for the very small number of women who remain indecisive and for whom the decision is particularly complex. Post abortion counselling is required by a small minority.

Our clientele can include women from unremarkable backgrounds and also those with serious histories of mental illness, drug abuse, intellectual disability, psychosocial

deprivation, violence and/or reproductive traumas. In these complex cases, counsellors must have impeccable professional and ethical qualifications, be able to recognise risk factors and be able to access a professional network providing pertinent clinical experience and appropriate referral options.

Within any counselling setting, an unbiased, non-judgmental, respectful and evidence-based approach by the counsellor is ethically and professionally mandated. However, many counsellors are not covered by any legislative or professional body. Anyone can call themselves a counsellor and as long as they are not engaged in criminal activity, they are not answerable to any professional board or legislative body. In contrast, for example, only people fulfilling strict academic, professional and legislative criteria are entitled to call themselves psychologists, and transgression of ethical or professional guidelines can result in serious penalties.

Nonetheless, practitioners displaying the highest standards are required when counselling women facing an unintended or problem pregnancy, or women requesting post abortion counselling. Guidelines for such counselling have been set out by various reputable organizations (Abortion Supervisory Committee, 1998; NH&MRC, 1996; Royal Women's Hospital, 2005). The Australian Psychological Society has a more generic set of Ethical Guidelines for Psychological Practice with Women, which recommend that practitioners should "recognise and support a woman's capacity to define her own problems" (Australian Psychological Society, May, 2,003). They all agree that such counselling must be based on respect for the woman's autonomy to make decisions and on supporting the woman's decision free of judgement or coercion – her values should drive the decision. They also note that discussion of alternatives (continuing the pregnancy to parent or adopt) should not be required when the woman has clearly made her decision.

> "Counselling aims to provide a woman with an opportunity to talk about her pregnancy unconstrained by the hopes, fears or expectations of others…In the event that a woman is uncertain of her decision, non-directive, supportive counselling may be undertaken…consistent with her ethical values and beliefs, rather than directing, judging or arbitrating that decision."
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> (NH&MRC, 1996, p. 29)

Reputable counselling and medical services around pregnancy and abortion also routinely focus on women's ongoing reproductive health and wellbeing: women are screened for sexually transmitted infections, undergo a Pap test, and have their future contraceptive needs addressed. In the case of pregnancy continuation, the woman's antenatal care is addressed. In the case of pregnancy termination, her post operative care is addressed. No wonder that worldwide, where reproductive services include timely, accessible and affordable safe abortion, women's reproductive health improves and abortion rates generally decline.

Anti-choice rhetoric tries to equate "pro-choice" with "pro-abortion" as if pro-choice is about pressuring women to have an abortion. But this is incorrect. Pro-choice is exactly that – assisting a woman make a choice which she feels is right for her. It is not in anybody's best interests for a woman to go through theatre when this is not really what she considers is the best decision for her. Anti-choice propaganda is keen to push the idea that pro-choice organizations and abortion providing services do not

function like other health services in meeting their professional, legal and ethical duty of care to their patients. Such anti-choice sentiment is a nonsense and is insulting to the dedicated health professionals with whom I have the privilege of working.

Recommendations Related to The Bill

I welcome The Bill as a way of ensuring that the legal obligation on fee for service organizations to refrain from misleading advertising, is extended to fee-free pregnancy counselling services. The Bill would ensure that both anti-choice and pro-choice organizations clearly inform the public in their advertising about whether or not they will refer for abortion so that people are less likely to be misled and more aware of the type of service they are accessing.

I have been concerned for some years about the distress suffered by women and their families who have unwittingly contacted a variety of cost free pregnancy/abortion counselling agencies which are actually false providers. I have lobbied and met with, Sensis, the company responsible for the telephone directory listings, to ask that they refuse to list these organizations, or at least, ensure a listing which clearly states whether a service is right to life/prolife/ antichoice versus pro-choice. Sensis has been sympathetic to the situation but considers that until the law changes, they can do very little.

Given anti-choice organizations' dedication to their philosophy, it is surprising that they are so reluctant to clearly spell out their links and origins in their advertisements. One can surmise that they may be concerned that if their true agenda were clear to the public, then the public would not choose to contact them. Although only an impression from our day to day work, it appears that over the past few months women have become more aware of the problems with the listings in the phone book (perhaps due to the media exposure around Senator Stott DesPoja's campaign and The Bill) and have been less likely to contact such "services".

However, once false providers become more widely recognised, they may change their name. (For example, I understand that recently Australian Federation of Pregnancy Support Services, AFPSS, an umbrella anti-choice organization named in Parliament on several occasions by Senator Stott Despoja, has changed its name to Pregnancy Help.) Consequently, it can be very difficult to keep track of which organizations are, and which are not, providing anti-choice or pro-choice (woman-centred) counselling. The Bill's requirement for services to state whether they will or will not refer for abortion (Part 2, 6 (1) is crucial.

The Bill defines "non-directive" pregnancy counselling, and uses this as a descriptor for pro-choice, options pregnancy counselling encompassing support and referral for pregnancy continuation and termination. I have some concerns about using the term, "non-directive" given that in response to parliamentary questions by Senator Stott Despoja, it appears that The Federal Department of Health and Aging believes that AFPSS is providing "non-directional" pregnancy counselling. The Department's view raises the difficult issue of language and how anti-choice organizations may commandeer pro-choice language to hide their actual practice and philosophy. Because of the problem in discriminating between false providers versus pro-choice pregnancy counselling, pro-choice services have tried to more clearly articulate the concerns and differences between anti-choice and ethical counselling by emphasising

certain language such as “non-directional” , “woman-centred”, “options”, and “pro-choice”. Unfortunately, anti-choice rhetoric can subsequently claim this language as its own and the confusion for the public continues.

It would also appear that there must be a requirement on all pregnancy counselling services to provide evidence-based information and to provide professional and ethical counselling. Although this may be beyond the scope of The Bill, these matters need to be considered, especially when (a) services can be listed in the Emergency section of phone books where the public may mistakenly, though I think rightly, expect only properly credentialled services to be listed, and (b) where their capacity to provide such a “service” may be because of government funding.

It is respectfully recommended that to achieve transparency in advertising and notification of pregnancy counselling services, The Bill be accepted in its entirety with the additional provisos that :

(i) Appropriate and reputable organizations, such as the Pregnancy Advisory Service, Royal Women’s Hospital or Family Planning Australia, be encouraged with additional government funding to (a) provide a 24-hour pregnancy counselling phone service, and (b) set up best practice guidelines and accreditation for pregnancy/ abortion counselling services.

(ii) The requirement for telephone listings to include a “non-directional” that is, a pro-choice/options/woman-centred pregnancy counselling service (section 7), would also wisely stipulate that once pregnancy counselling accreditation is available, any pregnancy counselling service must be properly accredited before they can be listed in the Emergency section of any phone book.

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