

Family Planning and Adoption Promotion: New Proposals, Long-Standing Issues

By Cynthia Dailard

Within the last few months, a spate of bills has been introduced by long-standing opponents of family planning programs with the aim of promoting adoption in Title X family planning clinics and other federally funded health centers. Not surprisingly, these proposals are the source of significant concern within the family planning community. Individually, and especially taken together, they raise fundamental questions about the nature of adoption counseling that appropriately should be provided to pregnant women in government-funded programs and about the extent to which the nation's family planning program should assume functions historically performed by adoption agencies. At a time of severe budget constraints, they also raise a serious question about the extent to which family planning funds should be diverted for that purpose.

Of more immediate concern, however, is the fact that two of the proposed measures are directly aimed at denying women facing crisis pregnancies full information about their options—apparently on the basis of the notion that the best way to promote adoption is to prevent family planning providers from discussing abortion. One would revive the abortion “gag rule” imposed by the Reagan and Bush administrations; the other would go a step further to set up a program of direct federal subsidy to counseling organizations *on the condition* that the pregnancy-options information they provide is incomplete.

The Ethics of Informed Consent

Established in 1970, Title X of the Public Health Service Act is the only federal program devoted solely to

the provision of family planning services to low-income women, teenagers and others in need of care. As part of its mission to help low-income women avoid unintended pregnancy through high-quality contraceptive care, Title X supports a wide range of reproductive health services, including pelvic and breast examinations, Pap smears and screening and treatment for sexually transmitted diseases, as well as preg-

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nancy tests. Indeed, each year Title X clinics provide pregnancy tests to almost 1.3 million American women (almost 30% of Title X clients), or one in eight women obtaining a pregnancy test from a health care provider. With half of all pregnancies in this country unintended, many of the pregnancies detected at Title X clinics are unplanned.

Program guidelines that have been in place for almost two decades dictate that when a woman at a Title X clinic faces an unintended pregnancy and requests information about her options, she must receive information about *all* her options in a nonjudgmental manner. While by law Title X funds may not be used for abortion, the guidelines specify that a woman who requests information about her options must receive “nondirective counseling” on “prenatal care and delivery; infant care, foster care, or adoption; *and pregnancy termination*” (emphasis

added). Once she decides how to proceed, the counselor will refer her for the services requested, which may include additional counseling if so desired.

Pregnancy counseling does not—and should not—involve advocacy of any one option. Rather, counselors who work in family planning clinics are trained to provide short-term counseling designed to convey basic, factual information about all of the alternatives, so that women can explore all of their options and decide for themselves which is best for them, given their life circumstances, values and desires. According to the Title X guidelines, nondirective counseling should “help clients resolve uncertainty, ambivalence, and anxiety in relation to reproductive health and to enhance their capacity to arrive at a decision that reflects their considered self-interest.” Indeed, access to full information and freedom from coercion are cornerstones of the Title X program and fundamental to any notion of voluntarism.

The Title X standards for nondirective counseling are consistent with those promulgated by major medical organizations such as the American College of Obstetricians and Gynecologists. They also are consistent with a fundamental principle of modern medical ethics known as “informed consent”—that people can make an informed decision about medical care only after they have been given full information about their condition, the risks and benefits of proposed treatment and all possible alternatives. Moreover, a health care provider who does not obtain informed consent from a patient may be liable for medical malpractice.

Reviving the Antiabortion Gag

Abortion opponents, however, have long sought to prevent Title X providers from discussing abortion. Indeed, the Reagan administration

An Adoption Professional Talks About Counseling

In August, I spoke with Susan Badeau, a Kennedy Public Policy Fellow in the office of Sen. Jay Rockefeller (D-WV). An adoption advocate and child welfare professional for 20 years, and an adoptive parent herself, Badeau has worked extensively with birth families, foster families and adoptive families as a counselor, trainer and program supervisor.—CD

CD: There seems to be confusion over what exactly adoption counseling entails, as well as who should provide it and when. So, first, is there a difference for you between the counseling around adoption that should be provided to a woman in the context of pregnancy-options counseling and the counseling that would be appropriate for a woman after she has decided to carry a pregnancy to term?

SB: There are important differences in both the amount and type of counseling that should be provided. There are three basic, early messages that a woman should receive about adoption when she has just found out that she is pregnant and asks for information about her options. First, she needs to know that adoption is an option for her—but that she doesn't need to make a final decision until after the baby is born. Second, she needs to know that there are a range of adoption options—that she could opt for an open adoption and be involved in the process of selecting and meeting the parents, and even maintain contact with the child, or she could opt for a closed adoption and have less-intimate, or even minimal, involvement. Third, she must be told that the biological father will need to be identified, notified or involved in the adoption process—the specifics will vary depending on state law.

CD: Should the counselor give her much information beyond that?

SB: The counselor should be able to answer basic questions, but beyond that, the client should be referred to an adoption agency. Remember, the point of talking about adoption at this point is so the woman can factor that possibility into her decision about whether or not to carry her pregnancy to term. You don't want to overload her with too much information, because she needs time to process the fact that she's pregnant.

CD: What about the kind of counseling that should be provided once a woman has decided to carry her pregnancy to term and is contemplating adoption?

SB: It should be far more sophisticated and in-depth than anything offered when a woman first discovers she is pregnant. In fact, a good adoption counselor should provide a woman considering adoption with at least four lengthy counseling sessions—often more.

First, the counselor must ensure that her client is well-informed about both her rights and her responsibilities as a birth parent, as well as explore a variety of emotional and practical issues such as how the client handles loss and grief and the extent of her support system.

The counselor should also help her client understand that there will be times when adoption-related emotions are intensely felt and other times when they are more in the background—and that as she reaches other milestones in her life, some of the feelings and issues associated with the adoption may surface in new ways.

The counselor also needs to help the client explore what she plans to do in her own life after the adoption. And finally, the counselor and client need to explore how the adoption might affect her relationship to others, such as the child's biological father or grandparents, her other children or her friends.

CD: What do you think is the appropriate role of family planning clinic personnel in the provision of adoption services, and what kind of training do they need?

SB: Obviously, pregnancy-options counselors in family planning clinics must be equipped to provide high-quality, nondirective counseling to women facing an unintended pregnancy. That means they must be sufficiently knowledgeable about adoption to provide the kind of information I described earlier, but they also must have enough training to be comfortable speaking *positively* about that option—something they must do in all conversations about adoption they have. As for the more extensive counseling that's appropriate for women who have decided to carry their pregnancies to term, that to my mind should be handled by very highly trained personnel in a licensed adoption agency. And while there's no reason in theory that a family planning clinic couldn't equip itself to provide full adoption services, the resources required would be considerable. We're talking about a very different and specialized service set—not just a simple add-on.

in 1987 promulgated regulations, quickly dubbed the “gag rule,” that specifically barred counselors in Title X clinics from discussing abortion as one of the alternatives available to women facing an unplanned pregnancy and from referring women to a provider of abortion services—even when such information or referrals were directly requested. At the same time, counselors were required to give *all* patients referrals for prenatal care and delivery services.

The gag rule was opposed by 78 national organizations, including the American Medical Association and the American College of Obstetricians and Gynecologists, as well as 36 state health departments,

Title X opponents have adopted new strategies for denying women information about abortion.

on the basis that it violated Title X providers’ First Amendment right to free speech and interfered with the doctor-patient relationship. The U.S. Supreme Court, however, rejected these arguments in 1991, when it voted 5–4 in *Rust v. Sullivan* to uphold the regulations as a permissible exercise of executive power.

When Congress passed legislation the following year to repeal the regulations, it fell 10 votes short of the two-thirds vote necessary to override President Bush’s veto. It was not until the Clinton administration suspended the regulations in January 1993 that Title X providers were once again free to provide women with full information about all of their options.

While the Reagan administration took an overt approach to gagging Title X providers, some family planning opponents are now proposing a different—albeit more stealthy—approach to achieve the same end. The Adoption Awareness Act—intro-

duced in July by Reps. Jim DeMitt (R-SC) and Tom Bliley (R-VA), chairman of the House committee charged with oversight of Title X—would redefine nondirective counseling in a way that undermines the very meaning of the term. Instead of requiring family planning providers to disclose all options available to family planning clients facing an unintended pregnancy, the legislation explicitly limits nondirective counseling to information about “prenatal care and delivery; infant care; foster care; and adoption”—a list that echoes word-for-word the definition of nondirective counseling contained in the Title X guidelines, *minus* any mention of abortion.

The Women and Children’s Resources Act, introduced in September by Rep. Joseph Pitts (R-PA)—known for his unsuccessful attempts two years running to entirely defund U.S. international family planning assistance—and Sen. Rick Santorum (R-PA), goes a step further. The bill would provide \$85 million to the states for grants to pregnancy counseling centers as long as they do not provide any counseling about or referrals for abortions. Moreover, funds for any services related to *contraception* would be expressly prohibited under this “alternatives to abortion” program.

Title X and Adoption

The Reagan gag rule was motivated by the belief—still shared by many antiabortion, anti-family planning advocates—that Title X clinics “promote” abortion by encouraging women to terminate unplanned pregnancies and by either not providing any counseling about adoption or not portraying that option in a sufficiently positive light. In response, the Adoption Awareness Act, even as it reimposes the gag rule, would provide \$7 million in federal funds to a national adoption organization for the purpose of training Title X and other federally supported health care providers in how to better “promote” adoption.

The extent to which counselors in Title X clinics need additional training in counseling around adoption—and what the nature of that training should be—is questionable. Family planning providers already are required to discuss adoption in the course of routine nondirective counseling. Still, Frank Bonati, president and chief executive officer of the Family Health Council of Western Pennsylvania, the only Title X grantee in the nation that also is a licensed adoption agency, suggests that family planning counselors could benefit from training in adoption counseling. “Is there a need for family planning providers to be better versed in adoption? Certainly there is room, just as there is room for some family planning providers to have a greater appreciation of the nuances involved in delivering prenatal care and abortion. Knowledge of adoption should certainly be part of a counselor’s routine tool bag.” But Bonati rejects the notion that adoption should be emphasized any more than other options. “Should we be training family planning providers in adoption any more than other options? No.”

Moreover, experts in the field of adoption distinguish between what is appropriate for a family planning provider to discuss in the course of nondirective counseling of a woman who has just had a positive pregnancy test and the counseling about adoption that should be provided to a woman who has decided to carry a pregnancy to term and is contemplating whether or not to choose adoption (see box). “An options counselor must provide the woman with enough information for her to make a rational, informed decision about how to proceed with a pregnancy,” explains Bonati. “Once she has made that choice, family planning providers shouldn’t be required to discuss adoption in any greater depth than if the woman had selected abortion or prenatal care with the intention of keeping the baby.” All of these cases require referrals, Bonati asserts, to appropri-

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ate specialists who can discuss a potential course of action in far greater detail.

The Federal Adoption Services Act, introduced in July by Reps. Sue Myrick (R-NC) and Cliff Stearns (R-FL), offers a much more direct approach to adoption promotion under Title X—and in doing so, it raises the notion that family planning clinics ought to be providing fewer services related to contraception and more services related to adoption. Authorizing no new funds for the program, it specifically authorizes diverting Title X funds from the program's core historic mission of providing low-income Americans with high-quality contraceptive services to the provision of adoption services. This is proposed at a time when Title X providers face tremendous financial difficulties just

in meeting existing demand for contraceptives among those in need of subsidized services (*TGR*, Vol. 2, No. 2, April 1999).

Adoption experts distinguish between what is appropriate for a family planning provider to discuss in the course of nondirective pregnancy counseling and counseling that should be provided to a woman who has decided to carry a pregnancy to term.

The immediate prospects for these bills are uncertain, but it is clear that they constitute a serious threat to the future viability of federally funded family planning programs. Key principles should guide the family planning community's response. First and foremost, adoption should

not be promoted at the cost of gagging doctors and violating principles of informed consent. Second, family planning providers do, indeed, have a clear and vitally important role to play in providing high-quality counseling, including counseling about adoption, to women facing unintended pregnancies—and they should be trained accordingly. At the same time, any effort to require Title X providers to become experts on adoption and to provide larger scale adoption services, at a minimum, would require a substantial infusion of additional funding and resources, in order to ensure that the program's ability to fulfill its responsibilities to the millions of low-income Americans in need of contraceptive care not be compromised. The latter point is critical because, ultimately, the provision of high-quality family planning services must remain a centerpiece of any serious national effort to reduce rates of unintended pregnancy and abortion. ⊕