Crisis Pregnancy Agency Report No. 4

Crisis Pregnancy Counselling in Ireland

A summary of research conducted by Drs. S. Nic Gabhainn & V. Batt on crisis pregnancy counselling, to inform the development of The Strategy to Address the Issue of Crisis Pregnancy

RESEARCH

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crisispregnancyagency
Formulating & Implementing a National Strategy

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The following report is a synopsis of a detailed research report written by Dr. Saoirse Nic Gabhainn, Centre For Health Promotion Studies & Dr. Vivienne Batt, Women's Studies Centre, National University of Ireland, Galway.

The views expressed in this report are those of the authors and do not necessarily reflect the views or policies of the sponsors

1.0 Background

The Crisis Pregnancy Agency (the Agency) was set up in 2001 in direct response to the Fifth Progress Report of the All-Party Oireachtas Committee on the Constitution (2000), which dealt with the subject of abortion. Recognising "an urgent need to take measures to reduce the number of crisis pregnancies" the Committee recommended the establishment of an agency specifically charged with responsibility to develop a strategy to reduce the number of crisis pregnancies and to ensure that women faced with crisis pregnancy are offered "real and positive alternatives" (ibid).

Once established, the Agency began the task of preparing the strategy, using the definition of crisis pregnancy laid out in its establishing legislation: "a pregnancy which is neither planned nor desired by the woman concerned, and which represents a personal crisis for her" (Statutory Instrument No. 446 of 2001). The Agency understands this definition to include the experience of those women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances.

The Agency, as a government body involved in strategy, planning and co-ordination, works with all relevant statutory and voluntary organisations, while keeping the woman at risk of or experiencing crisis pregnancy at the centre of its concerns at all times. It takes an approach which ensures that its work:

- is based on partnership with relevant organisations
- makes a contribution to the development of public policy
- is accountable
- adds value to the existing range of statutory and voluntary services
- is innovative and courageous in the creation of new kinds of solutions
- improves quality in order to develop best practice.

As one of the many actions taken by the Agency in order to inform the development of its Strategy, a programme of research was begun in June 2002. An important element of this research programme comprised a review of crisis pregnancy counselling provisions and practice. This was undertaken between September 2002 and September 2003 by Dr. Saoirse Nic Gabhainn and Dr. Vivienne Batt of the Centre for Health Promotion Studies and the Women's Studies Centre, National University of Ireland, Galway. Their study, entitled *Crisis Pregnancy Counselling in Ireland: Current Practice and Future Vision* (available on request from the Crisis Pregnancy Agency), was instrumental in assisting the Agency to formulate its strategy in relation to crisis pregnancy counselling.

The findings of the research were used to inform the content relating to this aspect of the Agency's *Strategy to Address the Issue of Crisis Pregnancy*, which was published in 2003. In particular, the research highlighted issues requiring further consideration:

- better information for existing and potential users of crisis pregnancy counselling and for professional groups and organisations which refer women to crisis pregnancy counselling services
- equality of access
- access to high-quality training
- standards for crisis pregnancy counselling
- guidelines and protocols for service providers

- opportunities for developing formal links with other organisations that have contact with women and their families
- the issue of "rogue"* crisis pregnancy counselling agencies.

1.1 Strategic commitments and recommendations

The research also assisted in informing the Agency as it developed the commitments and recommendations on crisis pregnancy counselling included in the Strategy.

At present (July 2004) Agency-funded research documenting the experiences of women who have used crisis pregnancy counselling services is nearing completion. In addition, over the lifetime of the Strategy the Agency plans to:

- support crisis pregnancy counselling agencies to expand their services
- develop and implement additional training in crisis pregnancy counselling in order to ensure that, in the shortest possible timeframe, all state-funded crisis pregnancy counsellors are adequately trained. The aim is to upskill crisis pregnancy counsellors, to standardise delivery and to promote best practice in the field
- develop standards and protocols for crisis pregnancy counselling (ibid).

With regard to information about crisis pregnancy counselling, over the lifetime of the Strategy the Agency aims to ensure that prospective users of such services:

- know where and how to access crisis pregnancy services
- understand what services and information are provided, and by whom
- are assured of an agreed standard of information
- can avail of information about further support services through "key communicators" such as healthcare staff and GPs (ibid).

It aims to do this through further development of the *Positive Options* campaign and by providing materials and supports to "key communicators" (ibid).

1.2 Conclusion

The Agency is grateful to Drs. Nic Gabhainn and Batt for their important contribution to its thinking and strategic direction. This remainder of this document summarises the main findings and recommendations of their research.

2.0 Introduction

2.1 Scope of the research

Between September 2002 and September 2003 Dr. Saoirse Nic Gabhainn and Dr. Vivienne Batt of the Centre for Health Promotion Studies and the Women's Studies Centre, National University of Ireland, Galway conducted research on behalf of the Crisis Pregnancy Agency into the provision and practice of crisis pregnancy counselling. Their study, entitled *Crisis Pregnancy Counselling in Ireland: Current Practice and Future Vision*, aimed to:

- explore and describe current practice in crisis pregnancy counselling
- identify gaps or areas that require development and/or improvement

*Counsellors in all agencies reported their experiences with women who have been traumatised through contact with irregular service providers. These agencies are reported to use manipulative techniques to try and persuade women not to choose abortion. These are called "rogue" agencies.

- provide information to allow for the identification of standards in relation to crisis pregnancy counselling.

Among the issues addressed were:

- exploration of key competencies required
- characteristics of good practice
- recommendations for the development of a training module for crisis pregnancy counselling.

The findings of the research were instrumental in assisting the Agency to formulate its strategy in relation to crisis pregnancy counselling.

2.2 Defining crisis pregnancy

In research, policy and clinical practice terms such as intended, planned and wanted – and, by extension, *unintended, unplanned and unwanted* – have often been used interchangeably in relation to pregnancy. They can, however, refer to substantially different concepts – for example, an unplanned pregnancy may still be wanted (Rosenfeld and Everett 1996). The term *crisis pregnancy*, however, has come to be the accepted term for "a pregnancy which is neither planned nor desired by the woman concerned, and which represents a personal crisis for her" (Statutory Instrument, op cit). The Agency understands this definition to include the experience of those women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances.

2.3 The role of crisis pregnancy counselling in making decisions in relation to crisis pregnancy

Women experiencing crisis pregnancy in Ireland are faced with three options:

- continue the pregnancy and parent the child
- continue the pregnancy and place the child for adoption
- travel to the UK for an abortion.

Estimates for 2001 suggest that the majority of women experiencing crisis pregnancy continue to term and parent the child, many becoming lone parents. Consistently, the highest abortion rate (per 1,000 live births) is among women between the ages of 20 and 24. Up to 20% of conceptions within this age group ends in abortion, while, 0.45% of non-marital births result in children being placed for adoption (see: O'keeffe, 2004).

In order to assist women experiencing crisis pregnancy to come to an informed decision about their distressing circumstances a number of agencies offer crisis pregnancy counselling. This is intended to provide women, couples or families with the opportunity to discuss their situation in a supportive and confidential atmosphere. Counselling is aimed at helping clients to consider the options before them and to choose the course of action with which they can be most comfortable.

Research literature suggests that ideally, crisis pregnancy counsellors act as "sounding boards" for their clients, helping them to identify areas of conflict, rather than attempting to influence or guide their decision-making or coping processes. Crisis pregnancy counsellors may help their clients to explore the various options and may also assist them to identify what factors are contributing to their distress and their

decision-making process. The goals of crisis pregnancy counselling outlined in counselling literature (e.g. Davidson, 2000) can be summarised as:

- to enable clients to reach informed decisions that they will not regret, by providing them with information about options
- to lessen the risk of emotional disturbance, whatever decision is reached, by providing the opportunity for clients to work through the decision-making process and by assisting them in clarifying their feelings
- to advise the client about the abortion procedure, the morbidity and mortality rates associated with it and the possible after-effects, if abortion is chosen
- to lessen the risk of further unwanted pregnancy by providing contraceptive counselling and, in some circumstances, psychosexual counselling.

The situation with regard to the provision of information relating to abortion within the context of crisis pregnancy counselling is complex. The terms of the Regulation of Information Act, 1995, prohibit direct referral for abortion (by outlawing advocacy). Information about abortion can be given only in the context of counselling, face-to-face and in tandem with information about other options. Crisis pregnancy counsellors are not obliged to give information about how to get an abortion, however, of the six state-funded agencies only four – the Irish Family Planning Association (IFPA), Cherish[1], the Well Woman Centres and PACT – do so. As a result they are sometimes referred to as providing "three-option counselling". The other two agencies – Life and Cura – do not provide information on how to get an abortion and are therefore sometimes said to provide "two-option counselling".

2.4 Methodology

The data contained in this summary report was derived from three separate data collection exercises:

- factual information taken from publications of the six state-funded crisis pregnancy counselling agencies, including annual reports, brochures, leaflets and websites
- interviews with the directors of the six state-funded agencies, along with eleven of their counsellors (one counsellor interviewed worked for two agencies)
- submissions on the subject of current and best practice in crisis pregnancy counselling, invited from 21 organisations identified by the Crisis Pregnancy Agency and the researchers
- Interviews with a random selection of course directors of university counselling courses were conducted. A nominee from the CPA consultative committee was also interviewed, as was a nominee of the director of Youthreach. The directors of three separate voluntary groups were interviewed; the Cork Alliance, the Oasis Counselling Centre and the Cork Counselling Centre.

2.5 Presentation of results

Factual information on the six state-funded agencies is summarised in Table 1 (see next page). Data collected through the interview and submissions process is divided into three sections, dealing separately with current practice, skills and future developments. Quotes from interviewees appear in italics within quotation marks. Discussion and recommendations follow the presentation of data.

[1] The organisation 'Cherish' subsequently changed its name to 'One Family'.

	Cherish	Cura	IFPA	Life	Pact	Well Woman
Location of pregnancy counselling	Dublin based	Centres in Athlone, Castlebar, Cork, , Dublin, Dundalk, Ennis, Galway, Killkenny, Letterkenny Limerick, Monaghan, Sligo, Thurles, Tralee, Waterford,Wexford	Dublin (2), Cork, Limerick and Galway	Centres in Cork, Dublin, Galway, Letterkenny, Tallaght, Thurles, Tullamore	Dublin based. Sessional social workers may be availed of for counselling in other parts of the country	Dublin based
No. staff in pregnancy counselling	2 staff	380-400 volunteers 4 full-time and 3 part-time staff involved in counselling 5 social workers and 1 accredited psychotherapist	Part-time counsellors in all 5 locations	70 volunteer counsellors & committee members	2 social workers (1 part-time) 1 professional public relations and fundraising officer (part-time) Administration staff, shared with other services in the agency	3 counsellors
Funding	Health board grants	Health board grants, Episcopal Conference of Ireland	Health board grants	Health boards grants, Fundraising and subscriptions	Health board grants, some church funding	Health board grants
Pregnancy Services	• Post-abortion counselling • Information service • Non-directive pregnancy counselling	• Pregnancy testing • Pregnancy counselling • Post-abortion counselling • Access to social welfare information, medical facilities & spiritual counselling • Help with prenatal care and supervised accommodation • Referral to adoption and fostering services • Follow-up support and counselling (in some areas only)	• Pregnancy counselling • Post- abortion medical care • Post- abortion counselling • Women's Health and family planning • Family- planning courses for doctors and nurses • Education services	• Pregnancy testing • Pregnancy counselling • Legal and social welfare advice • Help with accommodation before and after birth, if needed • Post-abortion counselling • After-care service (Galway)	• Pregnancy counselling • Post-adoption counselling • Post-abortion counselling • Support for mothers • Adoption service • Search and reunion service	• Pregnancy counselling • Post-abortion and other counselling • Post-termination medical check-up • Contraception • A variety of other primary healthcare services to men and women

3.0 Current practice

3.1 Ethos, terminology and models

Although the term crisis pregnancy is now widely understood, it is not used by every agency working in the area. Research findings suggest that the reasons for this range from perceptions of the term, to the fact that the agency's clients may be more familiar with other terms, such as *unplanned or unwanted pregnancy*. In defining what constitutes a crisis pregnancy, respondents tended to the view that a pregnancy was a crisis if the woman experienced it that way (eg *"any pregnancy that has become a problem for that woman"*). Participants reported that clients rarely use the term *crisis pregnancy* and often, depending on their history and circumstances, avoid words such as *pregnancy* and *baby* altogether, requiring counsellors to choose their own language with care.

Some organisations reported a very strict (*"punctillious"*) interpretation of the Regulation of Information Act, 1995 (see page 5), while in others the approach appeared to be more flexible.

Directors of counselling agencies stated that the ethos of each individual organisation is outlined explicitly to potential employees and/or volunteers during the recruitment process and initial training. Transmission of ethos to clients usually comprises assuring them of confidentiality and a non-judgmental approach, along with clarifying what information will be made available to them.

Counsellors generally described the models of counselling that they use with clients experiencing crisis pregnancy as Rogerian, humanistic or person-centred, although some were more vague and others supplemented these approaches. Apparent lack of clarity concerning approach was not related to any particular type or level of service or service provider.

3.2 Procedures

The research revealed that up to 85% of clients attending the six state-funded agencies for crisis pregnancy counselling are self-referrals, with the rest being referred by a wide range of professionals and statutory and voluntary organisations. The agencies, in turn, frequently refer clients on to ante-natal services, but also sometimes for in-depth therapy or other support services appropriate to their circumstances. Although counsellors generally respected clients' right to confidentiality, certain situations, such as when a client was perceived to be in danger or to be a danger to themselves, were potentially problematic in this regard.

While some agencies, particularly those offering two-option counselling, operate drop-in and/or telephone services, in others waiting lists can be up to three weeks long. Clients are sometimes referred to other crisis pregnancy counselling agencies in such circumstances.

Telephone and e-mail contact with clients is not usually described as counselling, and counsellors reported particular challenges in using these technologies, which require them to forego the advantages of using non-verbal cues from clients. Telephone services are in any case limited if abortion is to be discussed as an option: *"If it's about crisis pregnancy it's always face-to-face and because we give information on abortion…there's no way we could legally do it any other way."* Moreover, not all counsellors are equipped with

computers. One agency reported increasing e-mail contact, particularly from women who are deaf or who have other disabilities. Another felt that some clients preferred the anonymity of e-mail and was *"wondering about sort of opening a chat room [so] that there would be somebody there for them to talk to"*. Specific difficulties were identified in relation to telephone and e-mail contact: *"You don't know who's phoning and you have to be very careful about giving out any information over the telephone."* There were also issues relating to clients' money or credit running out. Some counsellors considered counselling via the telephone or e-mail *"very dangerous".*

While none of the main crisis pregnancy counselling agencies charges for its services, indirect costs to the client – travel, loss of wages, childcare etc – can be substantial. One agency has access to an emergency fund to assist potential clients. By contrast, generic counselling services charge up to €50 per session for crisis pregnancy counselling. The opportunity costs to the state-funded agencies can be substantial, too: *"If we turned the counselling rooms into doctors' rooms, our revenue would be a lot more stable and secure…it costs us to offer it, and there's a constant debate internally as to whether we can afford to continue to do it, and whether for the sake of what we do, we could afford not to do it…women look to us."*

The provision of crisis pregnancy counselling is concentrated in urban areas, with three-option counselling being very limited outside Dublin. Some agencies saw this as an advantage in some circumstances: *"It's really an issue of anonymity – there is a comfort in coming up to Dublin."*

Those agencies with more than one location strive to offer similar services in each. Clients are seen only infrequently in locations other than dedicated counselling rooms, although "*we would always go absolutely as far as we can to meet the need"*, including the provision of services outside official opening hours. Exceptions on location are made where there are access issues for women with physical impairments.

Finding suggest a session of crisis pregnancy counselling is normally scheduled for one hour, although one (two-option counselling) agency reported sessions of 15-20 minutes. If clients travel long distances to attend crisis pregnancy counselling, longer sessions may be allocated *"depending on the work that would need to be done"*, although there is also a view that it is not effective to go beyond an hour with someone who is in crisis.

Most service providers expect that only one session will be required, although in practice the number of sessions will be determined by the client and can often depend on the extent of other supports available to her: *"What we find is that if they can talk to somebody, whether it's a close friend or a member of the family, and support kicks in, they don't really need our service. It's where there is an absence of support – that's the person you're inclined to see more often."* The number of sessions may also depend on the option chosen, with those choosing adoption more likely to return. Conversely, there can be organisational reasons for keeping things short: *"I would find it very very easy to see women several times…[but] you are taking away crisis spaces from other women who need them and the whole thing just isn't funded to that level."* Agencies try to ensure that returning clients are seen by the same counsellor.

Crisis pregnancy counselling is usually conducted on an individual basis, rather than in groups, but members of a client's social network – particularly partners and, in the case

of young women, parents – are welcomed by some, but not all, agencies. Access might depend on the strength of the relationship, client demand etc, as well as on organisational protocol or counsellor preference. Differences on this point were not related to any particular type or level of service or service provider, although one counsellor said that *"I have to have either the parent or the guardian with me in the room while I give the information to an under-eighteen".*

Most service providers do not follow specific protocols with particular client groups, although people with particular medical or mental health issues, along with those experiencing violence or abuse, are often referred on to specialist organisations. Under-sixteens are generally seen either with parents or dealt with by reference to the Gillick Principles[2]. Some agencies reported language and cultural barriers to effective working with clients whose first language is not English. Some three-option agencies liaise with specialist organisations, particularly in relation to identifying appropriate translators and procedures for obtaining permission for asylum seekers to travel out of the country. Some are considering providing information in languages other than English.

All the state-funded agencies offer post-abortion counselling. This is open to all women and is not limited to those clients who they have seen for crisis pregnancy counselling. Anyone considering termination is encouraged to return. Waiting lists are considerably shorter than those for crisis pregnancy counselling and more counselling hours are scheduled per client.

3.3 Client contact

Most clients' initial contact with the main crisis pregnancy counselling agencies is by telephone, where their call is taken by trained receptionists or helpline operators. These calls are perceived as very important for both the client and the service. The objectives of the agencies in taking these calls are generally to put callers at their ease - *"to calm her down so she is not in a panic"; "to engage with the person and explain the services that we provide"* - and to encourage them to come in to the agency to meet a counsellor.

It was found that in the agencies' view knowledge and understanding among the general public of the 1995 Regulation of Information legislation is relatively poor. While some clients were described as needing *"just somebody to listen to them really, just to get over that awful shock...get a space to take in the fact that they are pregnant"* and others *"are quite au fait with what we do"* many were described as being vague and apprehensive in relation to their expectations of the services available. Two agencies said that while they do not provide information on abortion they assure clients that they are willing to discuss the issue. Some agencies reported having had dealings with clients who had been traumatised by their contact with so-called "rogue" crisis pregnancy services.

While all crisis pregnancy counsellors reported that they are willing to discuss parenting, adoption and abortion with clients, the detail in which the topics are

[2] The Gillick Principles refer to the outcome of Gillick v West Norfolk and Wisbech Area Health Authority (1985). This court hearing made a judgment on the competence of children to make decisions relating to medical treatment which may be contrary to their parents' or guardians' wishes. It ruled that *"as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to enable him to understand fully what is proposed."*
This ruling is referred to as "Gillick competence" and is used as a measure of whether a child below the age of 16 should be able to make important decisions. Since this ruling, laws in the UK increasingly reflect the notion that the ability to understand and make informed decisions is more important than chronological age.

discussed depends on the client's perspective and interest. One counsellor asserted that *"life would never be the same no matter what option she chooses"*. Clients occasionally seek information or help that agencies cannot provide, mostly regarding finance. Counsellors reported that they are usually referred on to other service providers.

Findings suggest that crisis pregnancy counsellors focus on the support clients perceive that they have (*"It's important to know if anyone else knows…so that you know how much of a strain a woman has to go through after this"*). Counsellors also try to gauge the woman's emotional state by assessing their presentation and responses to specific questions. Emotional issues are generally construed as cues to which counsellors respond with reassurance and appropriate information. They are less likely to attempt to assess clients' financial or mental health status or to ask about any previous pregnancies (*"You don't really ask things, it's what they tell you."*), although some do try to ascertain these facts by asking about medical cards or if clients are on medication. The findings identified as much variation between counsellors as between services on these issues.

The specific content of any individual crisis pregnancy counselling session depends largely on the client's context, her previous experience of pregnancy, the language she employs and her emotional state, as well as her expressed intentions and/or fears. In general, counsellors try to assess clients' coping skills and tailor the information they provide to match their perceived ability to assimilate it. One counsellor said, *"Even though they may come here because of the same issue, how they perceive it and how they interpret it is completely different. One can be quite strong and take everything in her stride and another could be totally felled by the same situation".*

None of the main agencies reported to use video or other "props" during crisis pregnancy counselling sessions. Most, however, provide written information on issues that have been discussed during sessions. The Treoir booklet was mentioned and information from the British Pregnancy Advisory Service (BPAS) was disseminated by three of the agencies, when deemed appropriate. Some agencies supply pre-prepared information packs after sessions. Two counsellors mentioned an in-house form that clients are asked to sign at the end of a session to confirm that all options have been discussed. In addition, agencies stock leaflets on a wide range of related issues for clients to take away.

3.4 Standards

Most of the main agencies providing crisis pregnancy counselling use standard recruitment procedures and require all new staff involved in such services to have undertaken professional training courses and to be registered with, but not necessarily accredited by, a professional organisation such as the Irish Association of Counselling and Psychotherapy (IACP). This gives rise to some difficulties, as experience of crisis pregnancy counselling alone is insufficient to gain accreditation.

Both of the two-option counselling services recruit volunteers as well as paid staff. Volunteers are not required to have undertaken professional counselling training, although all volunteers received in-house training. Both organisations are moving towards increasing the professionalism of their crisis pregnancy counselling services.

While all agencies agree that on-going training is beneficial, most said that they lacked the resources to support their counsellors in accessing it. All provide some degree of in-house training, free of charge, although there is substantial variation between agencies in the length and depth of such training. Counsellors working in the area longest are least likely to have gone through initial in-house training.

Findings suggest that supervision varies substantially between agencies, and sometimes within them. What counsellors understand to be "supervision" also varies. Some counsellors have group supervision, others individual; some have internal supervision, some external; some are paid for, some have to pay for themselves; a few reported that they have no supervision. Those working in three-option agencies were more likely than others to report that they had external supervision which they funded themselves, while those in two-option agencies were more likely to report group or peer supervision, provided free of charge.

Supervision was regarded as the main source of appraisal or discipline, as well as the primary location for the maintenance of standards within organisations. All the main agencies have formal procedures for dealing with complaints but there were no reports of these ever having been used in relation to crisis pregnancy counselling. Standards were perceived to be associated with administrative management rather than the process of crisis pregnancy counselling.

Outcome criteria or goals for the services are focused on the crisis pregnancy counselling process and not pregnancy outcome: *"To give people a sense that they have time, to diminish the crisis"; "To provide a good quality service and then give the woman whatever she needs"; "To bring her to a space where she would actually be able to make decisions and the best decision for her, whatever that might be"; "Giving the appropriate information, giving the space, giving the support and listening to her and hoping to have been able to allay whatever fear she might have".*

In summary, the stated aim of all the agencies is to enable women to come to their own decisions and to feel that they have been provided with all the information necessary to facilitate them in making their choice. In the end the pregnancy outcome is the individual's decision: *("I've done my best and she goes…it's her decision")* according to participants.

4.0 Skills

All respondents identified listening and being empathic as the key skills of crisis pregnancy counselling. They also stressed the importance of putting clients at their ease, being non-judgmental and allowing sufficient time. Focusing on clients' demeanour, especially through non-verbal clues, was seen to be another key skill: *"I saw some kind of relief on her face, either she smiled or there was something in the way she looked at me…like it was right for her"*. The absence of these cues renders telephone counselling particularly difficult. In this instance tone of voice and cadence become more salient, whereas cues in e-mail communication centre on sub-texts and sentence construction: "*You're trying to come across as warm, like you're trying to give warmth, and it's very hard to do."*

Crisis pregnancy counsellors come from a variety of backgrounds, primarily from the health and social care professions, and generally have received training both before and

during their time with specialised agencies. While previous training was deemed to be important, nearly all respondents identified the source of their specific skills in crisis pregnancy counselling as stemming from in-service training and practice. One added, *"I think in some ways the skills are yourself"*.

5.0 Future developments

There was considerable agreement between the six state-funded agencies in relation to the future of crisis pregnancy counselling. Concerns about staffing levels and internal organisation notwithstanding, most are interested in extending their services: *"I think we have to provide decent and structured and reasonable support in a dignified manner to everyone who wants it"*. Some mentioned the desirability of providing a holistic service, offering services for the whole woman, with sexual health as one aspect (*"I feel that we're not going anywhere if we don't look at the bigger picture"*), while most focused on the prevention of crisis pregnancy and providing supports for pregnant women and, when a baby is born, the family unit. Three-option agencies laid particular emphasis on prevention, while the importance of supports during pregnancy was stressed by two-option counselling services. One counsellor commented that *"you can do all the counselling in the world, but where is the point at the end of the day?...There are no services."*

All respondents considered it important to provide information on crisis pregnancy counselling to other professionals as well as to prospective clients. Three-option agencies laid emphasis on the necessity to ensure that women were fully informed as to the services and information available from the complete range of service providers. Equality of access to services and information for all women in the country emerged as a key theme. Similarly, all the state-funded agencies called for the regulation of crisis pregnancy counselling through standards and training provision, particularly to ensure that those experiencing crisis pregnancy are not traumatised through contact with "rogue" service providers. One added, *"The very best training in the world isn't going to matter a damn if there isn't regulation and enforcement as to what is good counselling and what is bad counselling".*

Counsellors working with two-option agencies requested more appropriate supervision, while those from three-option agencies were more likely to report a sense of isolation in their work. All identified a need for further training in crisis pregnancy counselling, as well as more generic counselling issues. They also sought more opportunity for *"space"* to reflect on their work.

The Crisis Pregnancy Agency was perceived by respondents to have an important role in widening access to information on crisis pregnancy counselling and other relevant supports, and in improving the quality and accuracy of that information, as well as supporting activities aimed at prevention and improving supports for the parenting option. The Agency was also seen to be the appropriate body to address the regulation of service providers and to ensure the provision of standards for crisis pregnancy counselling.

The research found that reaction to the idea of a national telephone helpline was mixed. Respondents felt that there would be benefits in terms of ease of access and improving services to clients but had concerns with regard to overlap with existing helplines. They

stressed that all helpline operators should be professionally trained and that automated telephone services would be inappropriate. Concerns were expressed that the agencies might be unable to take on the extra work a national helpline might generate.

All the state-funded agencies expressed willingness to collaborate in the development of a training module on crisis pregnancy counselling, despite concerns from directors of agencies relating to the structure and flexibility of such a module. Issues were also raised by directors of agencies concerning the extent to which funding might become contingent on the extent to which agencies participate. Counsellors themselves were enthusiastic: *"Brilliant!"; "It would be super"; "I don't think anyone will lose out from attending a course if they are going to work in this area".*

Discussion of the module raised debate among participants on the differences between crisis pregnancy counselling and other, more generic, forms of counselling, specifically because of the short-term and information-giving nature of crisis pregnancy counselling. Some participants felt that in this context, the very word "counselling" could be seen to be inappropriate, misleading or off-putting to clients.

In summary, all the main service providers expressed willingness to work collaboratively with the Agency on these developmental issues (*"We all need to work together"*), especially, as previously noted, on a training module, so long as the ethos of individual service providers was respected.

6.0 Discussion

The research revealed that in Ireland crisis pregnancy counselling is perceived as a high-quality service, offered by dedicated staff. There is evidence of good practice throughout. Nevertheless the researchers argue that there is scope for considerable improvement in a number of closely-linked areas, outlined in brief below.

The following observations (6.1-6.5) were made by the research team in their reports.

6.1 Awareness-raising and dissemination of information

The research found that gaps exist in relation to the provision of information to prospective clients, to groups and organisations which refer women for crisis pregnancy counselling and to health professionals who have contact with women experiencing crisis pregnancy, especially to GPs, who constitute the second most important referral path after self-referral. It is important to note that research has established that a substantial proportion of women giving Irish addresses and attending abortion facilities in the UK have not been counselled in Ireland.

6.2 Improving access to services, ensuring equality of access

In common with other aspects of health and medical services (Byrne 1991) crisis pregnancy counselling services were found to be generally centralised and confined to the main urban areas. It is essential to improve the geographical spread of services. It may be possible for the state-funded agencies to network with accredited counsellors throughout the country in order to widen service provision. This scenario would require the agencies, perhaps in conjunction with the Crisis Pregnancy Agency, to provide in-service skills training and to develop standards for outreach work. Two of the agencies already operate a version of this approach, one with selected social workers and the other with GPs.

Variations of opinion and approach suggest the need to develop protocols regarding the conditions under which clients would be seen out of hours and/or outside agency premises.

Generic counsellors and private counselling organisations currently charge for crisis pregnancy counselling, while the state-funded agencies provide services free of charge. The advent of specific crisis pregnancy counselling training may offer opportunities to "approve" counsellors who undergo the training, subsequently enabling them to offer free crisis pregnancy and post-abortion counselling. This would help to alleviate pressure on the main agencies. Alternatively, people experiencing crisis pregnancy and who contact other service providers should be informed, as a matter of course, that free services are available elsewhere. The state-funded providers should be resourced adequately to meet this demand.

While telephone services are regarded with some apprehension by the main agencies (see pages 7-8) they offer significant convenience to many clients; telephone services extend access to a wider section of the public who would otherwise, for geographic or socio-economic reasons, find it difficult to use crisis pregnancy counselling services (Bartlam and McLeod 2000). Moreover, the immediacy of the communication is usually identified by the caller as a benefit (Coleman, 1997). Telephone helplines have an active listening and supportive focus alongside providing factual information (Rosenfield, 1996), using a process similar to that used in brief therapy although, since helpline operators are not working as trained counsellors, "brief support work" might be a more accurate term. Concerns raised by agencies concerning duplication and professional standards suggest the need to develop such services in conjunction with existing providers.

Issues concerning telephone counselling (as opposed to the "brief support work" outlined above) require careful consideration. Specific skills would be needed for this work.

6.3 Service management and organisation, development of protocols

Client management

The researchers argue that waiting lists of up to three weeks are unacceptable and unofficial drop-in services and/or relying on receptionists to prioritise distressed clients does not guarantee equality of access. Three-option agencies generally operate strict appointment systems, while two-option agencies offer official drop-in services and/or immediate access to crisis pregnancy counsellors. The practice of requiring clients to confirm appointments eases the pressure somewhat, but requiring them to make a minimum of two telephone calls before receiving a service, and not following up on those who do not confirm, could be considered a barrier to access.

Confidentiality

As well as differences across and within agencies concerning the maintenance of client confidentiality, there is some potential for conflict between the assurances given to clients and the conditions under which crisis pregnancy counsellors report that they would break such confidentiality. The researchers suggest that each agency should develop guidelines on this issue which should form part of written organisational policy, to be communicated to counsellors during training and supervision. Guidelines should also be accessible to clients and monitored by the agencies themselves.

Crisis pregnancy counsellors reported that they took notes during sessions, writing them up or completing a pro-forma following each session. The status of these documents should be clarified in the context of the Freedom of Information Act, 1997 and the Data Protection (Amendment) Act, 2003.

Protocol development

The research found that there is currently a dearth of protocols relating to certain specific groups of clients, including those for whom English is not their first language, people with disabilities, young women and those from cultural backgrounds with which crisis pregnancy counsellors are unfamiliar. In order to ensure best-quality services that are accurately responsive to client need, such protocols should be developed in the context of consultation and liaison with representative groups. There is a need to introduce diversity- and/or cultural-sensitivity training for service providers.

Information concerning other support services is particularly important for young women experiencing crisis pregnancy. Including parents provides an opportunity to address family issues in relation to the pregnancy, but can also be detrimental to the young women themselves. The many issues relating to abortion services and follow-up for young women are complex. The main agencies differ regarding the age of clients that they will counsel, and whether or not they require parents and/or guardians to be present. The National Children's Office and the Children's Rights Alliance could be asked to assist in developing appropriate protocols.

Some respondents stated that they would not take on clients who were under the care of psychiatrists or who were in abusive situations. The researchers argue that this is a restriction of access. In conjunction with appropriate professional and service-user groups, crisis pregnancy counselling agencies should develop, adopt and implement referral policies that operate in the best interests of clients, with optimum potential to meet their needs.

Referral procedures

Respondents reported that clients sometimes ask for services that they cannot provide. While some of these requests could be avoided by increasing awareness of actual service provision, to improve client perception of service quality it is also necessary to develop appropriate referral protocols. One of the main agencies suggested that files of relevant national and local statutory and voluntary services should be maintained, in order to improve referral procedures. Referral protocols should address such issues as when a referral should be made, how clients should be informed about onward referral, the assessment of quality of services referred to, ensuring equality of access to other services and appropriate levels of support to be provided to clients who are referred on.

Partners and families

Findings suggest that the involvement of partners, family and friends in the crisis pregnancy counselling process varies within and between agencies. In general, these issues require further attention. Best practice would suggest that each client have the opportunity to be seen alone, in order to explore options freely with the crisis pregnancy counsellor. It is also appropriate to offer services to members of a family or network who are affected by the pregnancy. It should be made clear to clients which agencies are in a position to do this.

Employing male counsellors

None of the main agencies employs male counsellors and many thought that it would be difficult to do so. This may be a matter for the Equality Authority to explore. In ideal circumstances, clients should be offered a choice of crisis pregnancy counsellor, including men. Respondents suggested that very few women would feel comfortable with a male counsellor in this context, so it may be an inappropriate deployment of agency resources. By contrast, respondents felt that male counsellors may be desirable for working with partners and families, and further consideration could usefully be given to this development.

Goals of crisis pregnancy counselling

The researchers note that some clients of crisis pregnancy counselling services are repeat clients. They suggest this is a matter of concern, (from a prevention point of view) as it may illustrate the degree to which the process of crisis pregnancy counselling is divorced from other issues of sexual health and behaviour. In other jurisdictions, albeit in different cultural contexts, prevention of further crisis pregnancy is a stated goal of crisis pregnancy counselling (e.g. Lane, 1974). The adoption of such goals here could be a very positive move, although it would require the allocation of extra resources, particularly for training.

A number of respondents reported advocating for clients with other service providers in a manner not usually considered to be part of the brief of a counsellor. While this may coincide with the ethos of an organisation the researchers suggest it is not related to the provision of information on crisis pregnancy and may not be in the best interests of empowering clients. The researchers argue that such advocacy services may be more appropriately situated within a holistic service for women, especially those who choose to continue their pregnancy, rather than in a crisis pregnancy counselling context per se.

Interpretation of legislation

While some of the main agencies appear to use strict guidelines on the interpretation of the 1995 Regulation of Information legislation, others appear to be less certain. A truly client-centred service may require flexibility of interpretation. In a number of cases Directors reported that they relied on crisis pregnancy counsellors in their organisations to work within the law. There is a need for agencies to clarify their positions and to ensure compliance with the legislation.

Complaints procedures

Not all crisis pregnancy counsellors appear to be aware of their organisations' complaints procedures, although all the agencies have them. They should be communicated explicitly to all employees and volunteers, especially those who have direct contact with clients (who should also be made aware of them). One agency reported that it also has procedures in place for following up complaints about abortion facilities in the UK, an instance of potentially good practice that deserves replication, although its effectiveness should be investigated.

Financial planning

The researchers suggest that planning for the maintenance and development of crisis pregnancy counselling services is essential. Confusion over budgets and continuity of funding militates against this. Allocating funding over longer timeframes and receiving longer notice of ensuing budgets would facilitate co-ordination and planning within and between agencies.

Post abortion counselling

Only a very small proportion of clients choosing abortion return for post-abortion counselling, despite being encouraged to do so. Women who go on to parent or who choose adoption are more likely to return for further sessions. Resource restrictions may prevent some crisis pregnancy counselling agencies from encouraging return visits. Cross-training of counsellors providing post-abortion counselling, and the formalisation of referral between the main agencies, could assist in improving access to services.

6.4 Training, accreditation and skills development

Skills development

Many of the improvements suggested in the course of the research require on-going training. At present wide variations were reported in training levels both within and between agencies. While crisis pregnancy counsellors working in three-option agencies are more likely than others to have received professional pre-service training, two-option agencies tend to have more extensive in-service training. The longest serving crisis pregnancy counsellors generally have the least in-service training.

All counsellors acknowledged the importance of on-going training and skills development, and reported substantial levels of self-directed learning and self-development. Those with experience in crisis pregnancy counselling have valuable knowledge, which should be passed on to new recruits.

Ethos

Where the ethos of specific agencies is a key aspect of their identity, working on how ethos fits or informs practice may help to deepen understanding within and between state funded agencies. It could also be used to assist the public to distinguish between the roles and approaches taken by the various organisations. Drawing a clear distinction between organisational induction (including ethos transmission) and training in specific counselling skills, may improve the appropriateness and usefulness of a training module in crisis pregnancy counselling.

Definition of service

The term "counselling", when applied to services for clients experiencing crisis pregnancy, caused difficulties for some respondents. There was concern that use of the term excluded some people, both potential clients and those working in the field of crisis pregnancy. Given that information-giving constitutes an important part of sessions, crisis pregnancy counselling may not strictly be "counselling" as it is generally understood. Such confusion also gives rise to a lack of recognition of the contribution made in this area by doctors, nurses and other health and social care professionals, none of whom might typically be described as "counsellors".

While the Director of one of the state-funded agencies explicitly reported that it did not "*do therapy*", counsellors in the same organisation did not all agree. In addition, while almost all respondents described their approach as person or client-centred, there was some confusion about counselling models, with not all respondents able to identify what, if any, theoretical approach or model they used. Training may help to clarify this issue.

Key skills

There was agreement about key skills among all respondents. A specific training module for crisis pregnancy counsellors should assist in the development of a range of skills, including active listening, becoming non-judgmental and empathic, responding to client needs and requests, offering time and space to clients, assisting clients to feel relaxed and safe, observing and interpreting non-verbal behaviours and emotional responses, observing the dynamics of relationships, distinguishing between the perceptions of the pregnant woman and her partner, family or friends and detecting pressure from others. Other skills include maintaining confidentiality, teamwork, developing self-awareness and ability to work to a client's agenda. Specifically in relation to telephone work, crisis pregnancy counsellors should be trained to manage the intensity of the interaction, to manage silence and to listen for what is not being said.

Training module in crisis pregnancy counselling

While all groups were in favour of this, and indicated their willingness to co-operate to bring it about, some reservations were expressed, notably concerning the length of the programme and its financial and resource implications. Service directors expressed concerns about the extent to which funding might become contingent on the participation of all counsellors, while counsellors themselves felt that any forthcoming module should build on existing training.

The issue of accommodating the range of organisational perspectives was raised, along with the need to respect agencies' specific ethos. It was suggested that the module should be made available to all professionals working in the fields of health and social care and that it should assist participants to identify and deal with their own perspectives on pregnancy, parenting, adoption and abortion. One contributor suggested that the module should take the form of a generic model, to be adapted by various services and professions to suit their needs. Another questioned the appropriateness of advocating a model that placed the emphasis on an issue, rather than on the client.

Respondents suggested a wide range of topics for inclusion in the proposed module. These include: theoretical approaches to counselling and how they relate to practice, sexuality and sexual health, psychosexual counselling, crisis counselling, spiritual counselling, moral and ethical issues, medical ethics, sensitivity to language, social contexts of crisis pregnancy, developmental issues, IVF, abortion, adoption, relationships, cultural issues, biology, parenting, contraception, the distinction between generic and single-session counselling, practical information on available services, finance, legislation, respecting the client and non-discriminatory practice, as well as the key skills listed above.

The module could also suggest practical tools for use in sessions, such as the checklist approach used by one agency to ensure that all appropriate issues are explored or raised with clients. Assuming it is fully integrated into crisis pregnancy counselling sessions, and is also flexible in its application, this approach could be replicated by other agencies in the interests of good practice.

The researchers suggest that an appropriately structured module in crisis pregnancy counselling should be of benefit to all those who work in this field (e.g. counsellors, social workers etc.). These benefits would be strengthened if all interested parties participate in its development.

Terminology

As previously discussed (see page 8), clients rarely use the term "crisis pregnancy" and a variety of other terms are employed by crisis pregnancy counsellors and clients alike. All respondents recognised the need for sensitivity to language, although few had received specific training in this aspect of their work. Language sensitivity should be covered in the proposed training module (see above).

Psychosocial status of clients

There is a tension between the relatively short time available for client contact and the number of issues to be explored. This can result in some counsellors being unable to determine whether clients have been pregnant before, their financial situation and/or their mental health status. Crisis pregnancy counsellors may be inferring the degree of clients' access to practical and emotional support, and their general psychological and/or mental health, from their exploration of social support and coping skills, although this was not reported explicitly by any respondent. Some counsellors reported that they tailor sessions in response to the perceived emotional status and coping skills of the client. This requires considerable skill and should be addressed in any new training module.

Around 10% of women who have abortions are reported to experience mild to severe emotional difficulties following abortion (RCOG, 2001). Excluding cases of medical or genetic indication, and also women with previous mental health difficulties, those most at risk of post-abortion distress are those who express ambivalence about the decision or who were coerced into it (Allanson and Astbury 1995). Coleman and Nelson (1998) stress the need for extended research to determine what constitutes a normal psychological reaction to abortion, should one exist. Greater understanding of typical levels of emotional reaction will enable the counselling of women choosing abortion to include information regarding what to expect in the period after a termination. Such matters are of importance in the decision-making process and have relevance to long-term outcomes. Assessing risk factors for poor post-abortion outcome should be covered in the proposed training module.

Accreditation

If counsellors must be members of specific organisations in order to hold their posts, support, including financial help, should be given to them to gain and hold that membership.

It is difficult for newly-trained crisis pregnancy counsellors to gain accreditation, as crisis pregnancy counselling is not considered an appropriate context in which to accumulate practice hours, possibly because of its specific and short-term nature. A more flexible approach should be explored with IACP or another accrediting body, perhaps with a view to creating a specific category of accreditation for crisis pregnancy counsellors.

6.5 Setting and monitoring standards, regulating services

The research findings indicate widespread support for the Crisis Pregnancy Agency to take the lead in setting and maintaining standards and regulation relating to a number of issues. The main agencies, while concerned about possible increased administration, over-regulation and duplication of work, would like to see the Agency work towards an integrated plan for crisis pregnancy counselling. Maintaining clear and transparent lines of communication with the agencies will assist in dispelling concerns and fears.

The researchers argue that the Agency's workplan should address sexuality and contraceptive education, and should aim to reduce the stigma surrounding crisis pregnancy and single parenthood, among other topics. Its central role should involve it in ensuring the highest quality service for those experiencing crisis pregnancy. The Agency should strive to achieve this by facilitating equality of access for all who need it throughout the country, by assisting service providers with planning and budgetary management, by regularising training structures, by monitoring service provision (particularly the accuracy of information given to clients of crisis pregnancy counselling services) and by developing social and financial supports for all clients who need them, especially those who decide to continue with their pregnancies.

Provision of information

All agencies report that they discuss all options with clients (although two-option counsellors do not provide information on how to obtain an abortion as a solution to their crisis pregnancy). At the same time, they say that they adapt sessions to suit the wishes and interests of their clients. While this has clear benefits, it may also have implications for the provision of information, as the interests of the client may be best served in this instance by thorough consideration of all available options. This is required by three-option agencies. So, for example, in the context of abortion referral if a woman is clear that she does not want to consider adoption and does not want to discuss it, and therefore it is not discussed, there is a question as to whether the conditions for abortion referral have been met. This may extend to the provision of written information, as some agencies report that they provide written information only on those topics which have been discussed in the session and/or limit information provision to specific aspects of a particular option. As most clients attend for only one session this may represent a lost opportunity to inform them on available choices, which may (inadvertently) influence decision making.

Adoption as an outcome of crisis pregnancy featured little in this study and is the option least likely to be considered by clients or highlighted for future service development by agencies. An accurate portrayal of modern adoption practice should be widely disseminated. The Crisis Pregnancy Agency should liaise on this issue with relevant NGOs and statutory organisations, as well as adoption service providers.

Agencies vary in the degree to which they discuss abortion and post-abortion issues. While, as previously noted, all agencies are willing to discuss the topic, some two-option counsellors do not discuss the actual procedure and others say that they focus on how clients could be affected by abortion. This second approach raises issues which should be tackled at the level of the organisation. Counsellors should be sufficiently skilled to respond sensitively to clients and should be equipped with up-to-date and accurate information, having explored their own issues on the topic during their training. While there is no evidence to suggest that counsellors lack sensitivity, procedures should be monitored to ensure a consistent standard of service-provision. Support from the Crisis Pregnancy Agency may help to develop culturally appropriate monitoring mechanisms which respect the ethos of organisations.

There are substantial variations in the written information provided for clients. Much material, such as that produced by Treoir and the BPAS, is disseminated by several services and is of high quality, while other written materials could be improved. Easy-to-read versions are required for clients with low levels of literacy or for whom English is not their first language, and versions in other languages are also required.

There are also issues of quality associated with the claims and suggestions contained in some written information. If the information is scientific or evaluative in nature it should be accurate, up-to-date and representative, as well as timely and relevant to the Irish context.

If clients are to make their own autonomous decisions they must have access to full information about the various options. It is arguable that crisis pregnancy counsellors, in choosing which topics to raise with clients at any given time, may influence the decision-making procedure (Sarangi and Clarke 2001). It is therefore important to consider how information can be given in a neutral way, without leading clients to specific outcomes.

Standards and supervision

While counsellors in all the main agencies reported that their work is reviewed or monitored and that they had the opportunity to express their concerns and opinions about their work, they appeared to be unclear as to how standards are maintained. This situation could be remedied if the Crisis Pregnancy Agency were to work with agencies to develop mechanisms for developing, implementing and monitoring standards.

According to the researchers, the significant range of supervisory arrangements currently in place renders quality control an important consideration. This is not so much to do with the quality of supervisors and the supervisory process (although this is obviously relevant) but relates primarily to the level of variation both between and within agencies. Rationalisation and a single standard are required.

Internal supervision is available free to many crisis pregnancy counsellors, although not everyone identified this as best practice. The distinction between internal supervision and appraisal is not always clear, although the two should serve different functions. Internal supervision can assist in the maintenance of standards, monitor trends to aid planning and ensure the transmission of ethos, and is most useful when it is accompanied by high-quality external supervision.

Given that most service providers aim for full accreditation with IACP, it may be appropriate to adopt its guidelines on supervision. Financial support should be given to counsellors to enable them to achieve this.

Regulation

In order to protect women experiencing crisis pregnancy, the reported abuses of so-called "rogue" agencies need to be addressed. The CPA could productively take a role in tackling this issue. The CPA, in collaboration with six state-funded agencies, could work towards documenting instances of abuse that come to their attention and work with relevant authorities to combat the problem of "rogue" counselling agencies.

Training

All agencies recognise the need for good-quality initial and on-going training, but the level of support given to staff varies by agency and financial status. This does not allow for the provision of a coherent, quality service. All crisis pregnancy counsellors require equal access to high-quality in-service training, whether provided internally by agencies or externally by others. They should be encouraged to maintain and develop their professional skills and should be given the opportunity to use those skills in subsequent practice. Expansion of training across agencies may assist in this.

Both two-option crisis pregnancy counselling services are moving towards greater professionalisation of their services and are exploring how best to ensure that their counsellors are most appropriately trained and accredited. These developments should be acknowledged and supported.

Future developments

There is widespread agreement among the main crisis pregnancy counselling agencies concerning the way forward. Service quality and development and the importance of linking with health professionals across the board were identified as important, along with regulation and the provision of information.

Participant's discussed the need to expand services. However findings suggest there were differences in emphasis between 3 option counselling and 2 option counselling services. Those from 2 option counselling services were more emphatic in relation to the provision of supports for pregnancy and aftercare services for mothers and children, while the prevention of crisis pregnancy and the need for more information on available services was highlighted to a greater degree by those from 3 option counselling services. Improving service accessibility, particularly geographical accessibility was raised by all groups.

7.0 Recommendations

The authors of the research report, Drs. S. Nic Gaghainn & V. Batt, made a series of practice and policy recommendations in their report. The final section of this summary report aims to list each of these recommendations under the following headings:

- Awareness
- Access
- Service management
- Standards
- Training
- Protocol development

Awareness

- The supply of information to potential clients, primary care providers and other health and social care professionals should be improved. The information should explain which agencies provide which services and how they can be accessed. The policy of the Irish Council of General Practitioners in this area, specifically in relation to training and the provision of information, should be supported.
- Advertising of crisis pregnancy and post-abortion counselling services should be rationalised and maximised. This could include a higher profile and more detail in the Golden Pages box advertisement of the Northern Area Health Board. Mailshots could be rationalised by including information on a range of service providers in one envelope.
- Methods of awareness-raising should be creative and innovative in order to reach young women and disadvantaged or marginalised groups.

Access

- Using the key principle of equality of access, every effort should be made to reduce the indirect costs of accessing the full range of crisis pregnancy counselling services. Dublin-based services could build on their outreach

network of social workers or other practitioners to develop a further network of appropriately trained and accredited or approved counsellors in private practice, primary care or statutory services

- Telephone services should be developed, using professionally trained operators suitably skilled in this work. Clients could then be referred to accredited or approved "information-givers" or other services as appropriate. The degree to which telephone counselling followed by face-to-face information provision would meet the legal requirements should be clarified.
- Consideration should be given to improving access by funding women to travel to urban centres for crisis pregnancy counselling.
- Counselling centres which currently charge for crisis pregnancy counselling could be supported to make these services available free of charge, or should ensure that clients are made aware of the existence of free counselling from other agencies. If these centres are to be funded they must be subject to the same standards and monitoring procedures as other crisis pregnancy counselling agencies.

Service management

- Agencies should be encouraged to identify clearly whether the prevention of crisis pregnancy in the future is an explicit goal of their crisis pregnancy counselling services. This development should be supported as best practice, and training provided if necessary.
- Agencies should be explicit about their expectations of crisis pregnancy counsellors in relation to the provision of information under the terms of the 1995 legislation. Clear guidelines informed by legal opinion should be provided to all who have contact with clients, as to the degree to which the three possible options should be discussed in order to fulfil the requirements of the Act.
- Post-abortion counsellors in the state-funded agencies who do not at present provide crisis pregnancy counselling should be encouraged to cross-skill in order to do so, as a way of helping to increase capacity and reduce waiting lists.
- Appraisal, complaints and disciplinary procedures should be clarified and made available to all agency personnel. All complaints made should be documented and followed up.
- Agencies providing unofficial drop-in services should consider formalising this mode of access.
- Counsellors should be supported financially to become accredited members of approved professional organisations.
- Counsellors with experience of post-abortion or other group work approaches should be encouraged to write them up for the benefit of all practitioners.
- Access to counselling services for partners and family members of women experiencing crisis pregnancy should be included as part of any planned service expansion. Information on such services should be disseminated.
- Agencies should be resourced to a level sufficient to meet client need with high-quality services. The employment and/or retraining of counsellors, the development of telephone services and links with other service providers should be funded, along with other forms of service expansion.
- Agencies should strive to meet the needs of those clients who would benefit

from several sessions of crisis pregnancy counselling. Where resources do not permit this, clients should be referred on to other accredited or approved counsellors or psychotherapists.

- All women presenting for crisis pregnancy counselling should be seen alone, except when the client is unable to understand the process fully or when interpretation is needed.
- The status of notes taken during crisis pregnancy counselling sessions should be clarified in relation to the Freedom of Information Act, 1997 and the Data Protection (Amendment) Act, 2003. Due care should be taken to preserve client confidentiality.
- Agency managers should be supported in relation to recruitment, staff management and organisational development.
- Operating budgets should be made available to agencies for longer periods and with a lead-in period of at least nine months.

Standards

- Counsellors should be supported to access relevant on-going training, standardised within and between agencies.
- Ideally clients should be offered a choice of crisis pregnancy counsellor.
- Cultural-sensitivity training should be offered to all agency staff who have contact with clients.
- Since the term "counselling" as applied to working with clients experiencing crisis pregnancy may constitute an unnecessary barrier for clients and agencies alike, the use of other terms, such as *help-giving*, support and *facilitation* should be considered. Clients who require psychotherapy should be referred on to other services or therapists.
- The issue of "rogue" agencies should be swiftly addressed with all appropriate partners and organisations. The main agencies should be encouraged to document instances of abusive interactions reported by clients.
- All written material given to clients should be accurate, accessible and balanced and should refer to all available options. It should be reviewed by the National Adult Literacy Association (for accessibility of language) and by the Crisis Pregnancy Agency (for accuracy and balance). Translation into other languages should be funded and co-ordinated across agencies.
- Agency staff who have contact with clients should have access to the most up-to-date material in relation to the consequences of pregnancy outcomes, legal requirements and available services. The Crisis Pregnancy Agency could make this available in e-format.
- A single standard for external supervision should be adopted across all agencies, based on IACP standards. Supervision is especially important initially for counsellors who are not professionally trained and/or accredited.

Training

- Particular attention should be paid to honouring the ethos of the various agencies when developing a training module on crisis pregnancy counselling.
- All agencies and counsellors should be offered the opportunity and facility to participate in the development of the training module.
- The training module should include core counselling skills as well as training

in issues specific to crisis pregnancy. It should be provided as flexibly as possible, employing up-to-date delivery methods. It should also be adaptable, to facilitate its use by other professions.

Protocol development

- All development of policy and procedures should be undertaken in consultation with appropriate representative consumer groups.
- Protocols should be developed to guide the provision of crisis pregnancy counselling for particular groups of clients, including:
  - those for whom English is not their first language
  - those from other cultural backgrounds
  - under-18s
  - people with HIV or AIDS
  - pregnant women whose tests have revealed foetal abnormality
  - people with disabilities
  - Travellers
  - women experiencing domestic abuse
  - women who have been raped
  - adoptees
  - women with medical problems or mental health difficulties
  - women who have had abortions in the past
  - those whose children have been adopted or fostered.
- Internal protocols should be developed by each agency with regard to:
  - locations for counselling clients experiencing crisis pregnancy
  - client confidentiality, the conditions under which this may be broken and how clients will be informed of this policy
  - the role of the service in advocating and mediating for clients, if any
  - conditions for referral on to other services and the maintenance of referral files
  - seeing clients with partners, family members and friends
  - services specifically for partners, family members and friends
  - exploring the risk factors for post-abortion trauma
  - provision of written materials and monitoring them for accuracy and accessibility.

Internal protocols should be developed with agency personnel and made available to the public.

Finally, the authors of the report recommend that The CPA needs to advocate on behalf of women in order to prevent crisis pregnancies and reduce the likelihood that a pregnancy will be seen as a crisis. The authors suggest that these objectives can be met by: supporting young parents and the parents of young children; reducing the stigma of unmarried parenthood and promoting healthy sexual development.

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