Crisis Pregnancy Agency Report No. 3

Summary Report of the Consultation for the Strategy to Address the Issue of Crisis Pregnancy

RESEARCH

JULY 2004

crisispregnancyagency
Formulating & Implementing a National Strategy

TABLE OF CONTENTS

TABLE OF CONTENTS

Acknowledgements

The Agency takes this opportunity to thank sincerely all those individuals and groups who participated with such interest and so generously in the consultation process. Their contributions ensure that the Strategy is firmly grounded in reality and addresses identified need. The Agency also acknowledges with gratitude the organisations and voluntary groups whose staff members assisted in the planning and delivery of the consultation process. Without their inputs, the consultation would not have yielded such rich and pertinent information.

Special thanks are also paid to SIA Consultants, Patsy Carr and Maureen Gilbert for preparing this report.

1.0 Introduction

The Crisis Pregnancy Agency was established in 2001 with a specific mandate to prepare A Strategy to Address the Issue of Crisis Pregnancy. The Strategy was seen as providing for:

- a reduction in the number of crisis pregnancies by the provision of education, advice and contraceptive services;
- offering services and supports which make other options more attractive;
- the provision of counselling and medical services after crisis pregnancy.

The Agency's establishing legislation defines crisis pregnancy as "a pregnancy which is neither planned nor desired by the woman concerned, and which represents a personal crisis for her"[1]. 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 Crisis Pregnancy Agency published the Strategy to Address the Issue of Crisis Pregnancy (henceforth "the Strategy") in November 2003. This Strategy provides a framework for understanding the causes and consequences of crisis pregnancy and proposes realistic means of for tackling the many issues relating to it. To obtain a copy of the Strategy please phone the Agency's office on 01 814 6292.

1.1 The purpose of the consultation process

The Agency's remit requires it to work with appropriate partners to promote and co-ordinate the attainment of the objectives it sets. Effective consultation with service providers and the public is an essential part of that process. The Agency sees this kind of consultation as a cornerstone of developing a realistic and person-centred strategy.

The Agency used a broad consultation process in 2002-3 to assist it to develop its Strategy. The consultation aimed to gather opinion and to bring together knowledge about how strategic elements should be developed. The Agency defined the objectives of the consultation process as:

- following from the Women and Crisis Pregnancy Study[2], to find out what people thought were the main contributory factors leading to crisis pregnancy and to see to what extent these were similar to previous research findings
- to ascertain knowledge, experience and opinion on ways to address these contributory factors to help prevent, reduce and support crisis pregnancies
- to contribute to building a shared vision for the goals of a national strategy to address the issue of crisis pregnancy
- to consult with agencies on their services and how they relate to the issue of crisis pregnancy.
- to gather peoples knowledge, experience and opinion on ways to tackle and address contributory factors. This will help develop the most effective approaches to prevent crisis pregnancy and provide support to those who experience them.
- to contribute to developing a shared vision for the goals of a national strategy to address the issue of crisis pregnancy.
- to consult with other agencies and professional organisations on their services and how they relate to crisis pregnancy prevention and support.

[1] The Agency was established under Statutory Instrument No. 446 of 2001, Crisis Pregnancy Agency, Establishment Order, 2001. (available on www.crisispregnancy.ie and Government websites).
[2] Mahon, E., Conlon, C. and Dillon, L. (1998). Women and Crisis Pregnancy. The Stationery Office, Government Publications, Dublin.

This consultation aimed to build on consultations for the recent National Health Strategy (Quality and Fairness, Department of Health and Children 2002), the National Children's Strategy (Our Children: Their Lives, Department of Health and Children 2000) and the sexual health strategies currently being developed by several health boards.

The Agency's consultation process involved two phases:

- an open call for submissions on the theme of crisis pregnancy
- a targeted consultation with specific groups and organisations, based on the themes that emerged from public submissions

This document summarises the main outcomes of both phases.

1.2 The aim of this document

Following from the publication of the Strategy, the Agency has prepared this summary of the results of this consultation process in order to provide:

- a brief report of the process
- a snapshot of thinking in Ireland in 2002-3 on the subject of crisis pregnancy.

While this summary aims to reflect the overall consensus emerging from the consultation process it is not possible to include every point made. The Agency does not intend to imply any relative value to arguments advanced or points raised by those who contributed to the consultation process. All contributions were analysed and taken into account by the Agency in the process of developing the Strategy. Many polarised views were expressed, and this summary aims to present any contradictions without comment or implying relative values. The description key, applied to contributions, denotes seminal or frequently repeated points, and should not be taken as a denigration of other views.

1.3 How the consultation was conducted and analysed

1.3.1 Public consultation

In spring 2002 Government Departments, service providers and members of the public were invited to make submissions to the Agency. Responses were received from 246 individuals and organisations.

The vast majority of the submissions – almost 83% - were sent by individuals. Of these, 13 identified themselves as medical personnel, ten as religious and one as a public representative. The organisations which sent submissions included medical bodies, advocacy and campaign groups, service providers, support groups, a hospital and a health board. he full list of submissions received by the Agency can be found in Appendix 1, pg. 32.

Some 57 of the submissions used a pro forma, giving 189 which could be analysed in order to identify themes. This was done by coding respondents' views concerning:

- the problems to be addressed
- the causes of these problems
- proposed solutions to these problems

and then examining the results of this exercise thematically under each heading.
A summary of the results appears on pp. 6-9.

1.3.2 Targeted consultation

The Agency's targeted consultation took place in 2003 and explored in detail the issues and themes raised by those who took part in the public consultation. The Agency placed particular emphasis on finding out the views of individuals, groups and agencies which were:

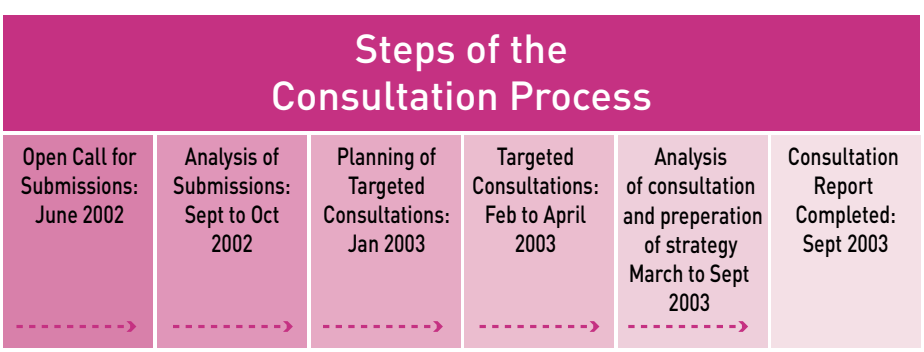
- not represented (or under-represented) in the public consultation
- considered either potential or actual consumers of services related to crisis pregnancy
- involved in the planning and/or delivery of relevant services

Participants in the targeted consultation included:

- individuals at risk of or with experience of crisis pregnancy and their immediate supports, such as:
  - women who had experienced crisis pregnancy and who had chosen abortion
  - women who had experienced crisis pregnancy and who had chosen to parent
  - women who had experienced crisis pregnancy and who had chosen to place their child for adoption
  - fathers, parents, grandparents and friends
- service providers, who were asked about such topics as:
  - immediate supports for people experiencing crisis pregnancy
  - how to prevent crisis pregnancy
  - the role of policy and practice in education, welfare, housing and adoption
  - the particular needs of groups such as Travellers, women using refuges, women with disabilities, older women etc
- policy makers, including:
  - Government Departments
  - health service managers
  - selected politicians
  - the Agency's own Consultative Committee.

In all, over 2,000 people took part in 60 targeted consultations held throughout the country. The consultations involved one-to-one interviews, focus groups, round-table discussions, questionnaires, workshops and e-mail. As with the public consultation, results were analysed thematically. A summary of the results of this process appears on pg. 10.

The consultations conducted are listed in Appendix 2.



1.4 Other factors in the Agency's consultation process

While the consultations were taking place the Agency's research programme undertook a number of related projects. It:

- looked at factors contributing to and potential solutions for crisis pregnancy
- looked into and built on ideas and opinions offered during the consultation process
- tried to fill gaps in the range of issues raised and potential solutions suggested by participants

The Agency used the results of the research to complement and back up the outcomes of the consultation process when the Strategy was being written.

The Agency found it hard to access some key groups. It was difficult, for example, to locate women who had placed their children for adoption or who had abortions and who were willing to discuss their experiences. The Agency will work to address these gaps through the lifetime of the Strategy.

The Agency published the Strategy after careful consideration of the full range of interests and opinions available to it through consultation and research. This document is intended to capture that range.

2.0 The findings of the public consultation process

As previously noted (pg. 4), some 189 submissions were analysed. The submissions were written in a variety of formats and addressed a broad spectrum of issues.

The Agency, therefore, used three questions to guide the analytic process and arrange the coded text. These questions were:

- What problems ought to be addressed?
- What are the perceived causes of these problems?
- What could solve these problems?

In terms of the analytic procedure, the text of each submission was systematically coded into themes. In all 500 catagories emerged from the analysis and these were arranged into a series of inter-related sets relating to the three main questions above.

Submissions were strongest in identifying problems concerning abortion, service provision and crisis pregnancy in general, and less clear in ascribing causes or identifying solutions. As previously noted (see pg. 4) many diverse views were expressed, so findings are frequently contradictory. Some topics (e.g. the issue of lone parent poverty) were interpreted as a cause, problem or solution in different contexts by different submissions.

The findings are presented here in summarised, bullet-pointed format in order to facilitate comparison with the themes and findings of the more detailed targeted consultation process (see pg. 10).

2.1 Problems

The submissions identified five main problems associated with crisis pregnancy:

1. The perceived incidence of crisis pregnancy and the necessity to reduce it.
2. The numbers of women who choose abortion, the perceived factors behind this choice and the need to ease those factors so as to make alternative choices more attractive to women. Not all submissions concerned with this issue named the incidence of abortion as a problem.
3. Ethical, religious and moral problems with respect to abortion and the perceived need to reduce and eliminate the numbers of women choosing this option.
4. A perceived lack of integrated, inter-agency services both during and after crisis pregnancy.
5. A perceived lack of accessible, available, affordable and confidential service provision.

2.2 Causes and related factors

The submissions identified a series of causes and factors related to the five main problems delineated above.

1. The submissions suggested the following causal factors associated with the high incidence of crisis pregnancy:
   - the lack of comprehensive sex education addressing the realities of teenage sexuality
   - the ever earlier onset of sexual activity
   - a perceived lack of knowledge and ability to negotiate the use of contraception
   - the combined problem of alcohol and sexual risk-taking
   - a perceived lack of information and knowledge among young people about sex, pregnancy and contraception
   - the lack of services and education programmes designed to meet the needs of men
   - the lack of targeted, affordable, locally-based information and services concerning sex and contraception
   - the teaching and promotion of contraception to prevent crisis pregnancy, sexually transmitted infections (STIs) and abortion.
2. The submissions suggested the following causal factors associated with the high prevalence of women who choose abortion:
   - rushed decision-making, partly due to lack of awareness of available supports
   - not seeking professional help before going to UK abortion clinics
   - perceived barriers to continuing in or accessing education
   - the expense and lack of availability of good childcare
   - the lack of affordable housing during and after crisis pregnancy
   - the poverty, isolation and stigma associated with lone motherhood
   - negative attitudes and lack of knowledge about adoption, particularly "open adoption" models.
3. The submissions suggested the following causal factors associated with the belief of some respondents that abortion is never a solution to any crisis pregnancy:
   - the belief that abortion is murder

- the belief that abortion contravenes Christian law.

4. The submissions identified the following issues related to the provision of crisis pregnancy counselling and other services:

- a perceived lack of information on supports for women experiencing crisis pregnancy
- a perceived lack of information on all options for women experiencing crisis pregnancy
- the lack of available and accessible non-directive pregnancy counselling services
- the lack of available and accessible post-abortion supports, both medical and psychological
- insufficient post-natal supports for women
- the lack of appropriate service provision for men
- funding difficulties experienced by service providers
- lack of co-ordination between service providers.

2.3 Solutions and recommendations for action

The submissions suggested a series of solutions for each problem.

1. The submissions identified the following ways to reduce the incidence of crisis pregnancy:

- primary prevention: postpone the onset of sexual activity by educating youth about the effects of early sex, e.g. regret, pregnancy, emotional issues
- secondary prevention: educate sexually active people about contraception, life skills, decision-making and building self-esteem
- introduce comprehensive sex education and address the realities of teenage sex
- address alcohol abuse via education and information campaigns, by banning alcohol advertisements and implementing a national alcohol policy
- provide comprehensive and accessible information at school and in the community on sex, contraception and available services
- address men in the Strategy, particularly with respect to education
- expand and improve service provision in the area of contraception and family planning
- replace current contraception strategies with the promotion of "abstinence alone" programmes similar to those running in the US.

2. The submissions identified the following ways to reduce the number of women choosing abortion by making alternative options more attractive:

- make information available immediately
- promote existing supports for women experiencing crisis pregnancy
- make sure that pregnant students can continue in education by introducing appropriate policies and guidelines and by creating incentives to encourage students experiencing crisis pregnancies to stay in education
- make educational institutions and workplaces more child-friendly
- use central planning to increase the capacity of locally-based, affordable childcare
- increase the availability of prenatal crisis accommodation and affordable

private and social housing by developing a coherent, progressive housing policy
- address the poverty experienced by lone parents via supportive fiscal policies
- initiate a public awareness campaign to explode the myths concerning young unmarried parents.

3. The submissions identified the following ways to reduce the numbers of women choosing abortion:

- promote adoption, including open models of adoption, to women (advertising campaigns were suggested as a way to change public attitudes)
- promote positive images of coping with motherhood
- use directive counselling techniques (these include: outlining the negative physical and psychological implications of abortion; encouraging women to think of pregnancy in "human" terms; funding only organisations that promote the life of the unborn)
- educate people, in schools and in the community, about the dangers of abortion, such as the increased risk of cancer etc
- the Crisis Pregnancy Agency should explicitly protect the life of the unborn in all policy and strategy documents
- reinforce the illegality of post-coital contraception ("the morning after pill")
- discourage the abortion of foetuses with disabilities by promoting equality between all people, disabled or non-disabled.

4. The submissions identified the following solutions for the problem of inadequate service provision:

- promote and thereby increase awareness of all supports available to women experiencing crisis pregnancy
- expand, improve and develop nationwide, non-directive pregnancy counselling support for women in crisis, to be provided by crisis pregnancy agencies and GPs
- develop, fund and promote post-abortion services
- develop a network of post-natal supports and services for women (these services were considered particularly important for young women and for the healthy development of their children)
- develop and implement standards to ensure that services are accessible, affordable and confidential
- provide adequate training for those who provide services to women experiencing crisis pregnancies
- set aside further resources and funding for development of services for women experiencing crisis pregnancies
- address the needs of men involved in crisis pregnancy situations.

2.4 Conclusion

Analysis of the written submissions provided the Agency with a feel for the range of views concerning how the issue of crisis pregnancy could be addressed. The submissions provided valuable information and direction for the Agency. Many of the themes raised were developed further in the targeted consultation, a summary of which appears in the next part of this document.

3.0 The findings of the targeted consultation process

As previously noted (see pg. 5), the Crisis Pregnancy Agency's targeted consultation process involved 2000 people in 60 separate sessions held throughout the country. All were wide-ranging in scope. The content of each session was recorded in the same way and analysed thematically under the major headings of:

- prevention of crisis pregnancy
- crisis pregnancy
- after crisis pregnancy.

Illustrative quotes from the contributions made by participants in the consultation sessions appear at the begining of many of the sections below. The type of person or organisation making the observation is given only when necessary for clarification.

3.1 Prevention of Crisis Pregnancy

3.1.1 Sex education

"Many adults, including teachers, find that they are culturally unable to impart the necessary information."

"My daughter came to me saying that she wanted to speak to our GP about going on the Pill. I said she couldn't possibly need it when she wasn't even in a relationship. She was pregnant two weeks later."

"Provide parents with the information and support necessary to guide their child through their social and sexual development"

"If the country is serious about prevention it must be serious about SPHE"

Sexuality education for both young people and adults was a key theme in the targeted consultation sessions. The lack of **comprehensive, consistent, well-delivered programmes** in both primary and secondary schools emerged as a serious issue. Many contributors praised the content of the Relationship and Sexuality Education (RSE) programme which is part of the Social, Personal and Health Education (SPHE) programme in schools but were critical of the way in which they are delivered. Not all schools have implemented the programmes. A minority of the population was said to be opposed to RSE.

Opinion was divided as to whether teachers or external supports were best placed to deliver RSE. Participants placed strong emphasis on the importnace of ensuring that the right person is selected and comprehensively trained to deliver both RSE and SPHE programmes.

Young people participating in the consultations, advocated the introduction of **peer education** into modules on personal responsibility and pregnancy prevention. Programmes should also be developed or adapted to suit people with particular educational needs, for example, people with intellectual disabilities or for whom English is not their first language.

The role of parents in their children's sexual education was seen as crucial, despite their own perceived lack of confidence and young people's view that they are out of touch. Contributors considered a positive relationship between parents and schools to be vital

in promoting positive sexual health, personal responsibility and decision-making skills among children and teenagers. **Parenting courses** were viewed as necessary to prepare parents and other influential figures, e.g. grandparents, to communicate comfortably and confidently with young people about intimate topics.

Key recommendations emerging from the consultations:

- The Government should review resources (time, training, funding) to enable the effective delivery of sex education programmes
- Specialist persons or teams should be trained to lead and deliver sex education programmes (for their own and/or other schools)
- Educational interventions should be developed, sensitive to the needs of persons in particular situations, e.g. people with disabilities, ethnic minorities etc.
- GPs should be proactive in promoting sex education for children of twelve years old and upwards
- GPs should use any opportunity offered to educate young people in sexual health
- Parents, schools and health service providers should establish closer links to ensure that sex education is not the responsibility solely of schools.
- Parenting courses dealing with all stages of children's development should be devised, promoted and made easily accessible to parents, grandparents and other carers.
- The Department of Health and Children should circulate leaflets and other materials to the parents of teenagers to help them to educate their children on sexual health.
- All sex education programmes should cover the teaching of decision-making skills and stress the issue of personal responsibility for both boys and girls.
- Youth workers' training should be revised so that attention is given to their roles in crisis pregnancy prevention.
- Sex education should be provided in out-of-school, training and community settings.

3.1.2 Alcohol

*"Let's face it: half the people wouldn't be ****ing if they weren't drunk" (young person)*

"Many women present not knowing if they have had sex, either consenting or forced, as they have totally blacked out because of their alcohol consumption" (GP)

"I had sex with a lad because I was drunk. I wouldn't have gone near him if I was sober" (young women)

The role of alcohol in crisis pregnancy emerged as a theme at all levels of the consultative process. It was deemed to be particularly relevant to teenagers and young adults. Service providers and young people themselves acknowledged that drinking alcohol is a key element of the social lives of teenagers and young adults. However, participants in the consultative process also stressed that misuse of alcohol is not confined to young people. **Alcohol lowers sexual inhibitions** and awareness of responsibilities, in turn giving rise to crisis pregnancies through unprotected sexual intercourse or the ineffective use of contraception.

Health providers noted the **conflict of interest** between social/health and economic governmental policies. Various health strategies are promoting healthier attitudes towards the intake of alcohol while, at the same time, the Government is ensuring a high tax return to the exchequer by allowing late pub opening hours, advertising alcohol in sport etc.

Contributors discussed the **glamorisation** of alcohol in advertisements. They also noted that parental attitudes and the pattern of parents' own drinking behaviours were significant in shaping young peoples attitudes and behaviours.

Key recommendations emerging from the consultations:

- Provide more non-alcohol-related recreational outlets for young people
- Advertise the adverse effects of alcohol, for example, on the backs of toilet doors and on prime time television
- Introduce legislation to regulate the advertising and sale of alcohol
- Include alcohol education in workplace health and safety programmes
- Dedicate money generated through the sale of alcohol to research the effects of alcohol and the relationship between alcohol and crisis pregnancy
- Integrate national policies on alcohol and drug abuse
- Examine critically the effects of alcohol advertising and promotion
- Develop peer alcohol education programmes by and for teenagers.

3.1.3 The role of the media

"In the soaps the pregnant girl/lone parent nearly always ends up in a more favourable position than she had before she had the baby" (young man)

"The media should tell what it's like having your whole life ruined by a baby" (young women)

Participant's felt **the media** plays a major role in relation to crisis pregnancy. They agreed that representations of sex, sexuality and sexual behaviours in the media militate against responsible sexual behaviour and the prevention of crisis pregnancy. This consensus view extended across all ages and both sexes.

Respondents stressed the need to challenge the portrayal of "choices without consequences" as portrayed in the media. In particular they noted that the media fails to offer young people the positive option of abstaining from sexual intercourse for personal wellbeing, sexual health and prevention of crisis pregnancy. The inaccurate portrayal of the long-term effects of unplanned teenage pregnancy was lamented throughout the consultations.

Key recommendations emerging from the consultations:

- Produce a series of prime time TV documentaries highlighting the reality of lone parenting, including its negative aspects
- Use teen-orientated media, including advertisements in teen magazines, to develop awareness of how to prevent crisis pregnancy
- Develop videos to demonstrate how the abuse of alcohol and drugs can create damaging sexual behaviours, leading to crisis pregnancy.

3.1.4 Information and education about fertility and contraception

"The youth of today are exceptionally naïve and very ignorant of the facts of life"

"Sometimes you come across leaflets on contraception in public places, such as libraries, which is really good, because you don't have to ask for it" (young man)

"The information given out with packets of condoms and the Pill is targeted at adults and is boring for young people to read, so they don't read the instructions" (young woman)

Contributors saw information and education about fertility and contraception as critical factors in the prevention of crisis pregnancy. Many felt that sexually active people, particularly teenagers and young adults, have **little knowledge about** their **fertility**. This lack of knowledge was also identified in women at the peri-menopausal stage. Changing patterns of fertility at this stage in a woman's life, along with the increased possibility of having a child with a disability, make accurate knowledge an important issue.

Information about the **effective use of contraception** was considered essential for the prevention of crisis pregnancy. Information and education on the use of condoms and post-coital contraception (also known as emergency contraception or MAP – "the morning after pill") were considered particularly relevant. Contributors noted the varying levels of information and knowledge about contraception among health professionals.

Contributors said that there is a significant level of **embarrassment** in seeking information about contraception, particularly among young people and women seeking post-coital contraception. This was shown to arise from fear of the perceived judgmental attitudes of health service providers.

In relation to **people with disabilities**, particularly those with intellectual disabilities, management of fertility has been ignored on the false premise that people with disabilities do not have, or ought not to have, sexual needs and the desire for intimate interpersonal relationships.

Service users and providers throughout the country reported a **wide variation in access to information** about fertility, contraception and related services. Variation was reported both between and within health boards. In addition, contributors reported a deficit in the provision of information on contraception in GP practices, as not all GPs provide information about every method of contraception. This was viewed as inequitable. The general consensus was that GPs should make clear the level of contraceptive information and services they provide by advertising this information in their waiting rooms.

Easy local access to information was seen to be very important. Contributors suggested that information should be age appropriate and should take account of varying levels of literacy, be culturally sensitive and made available in alternative formats.

Key recommendations emerging from the consultations:

- Promote body and fertility awareness through workshops and training
- Ensure consistency of service by all health board service providers
- Indicate on posters in GPs' waiting rooms which contraceptive services

are provided

- Disseminate contraceptive information in libraries and other easily accessed, privacy-protected locations
- Take into account varying degrees of literacy and cultural aspects when creating contraceptive information
- Take into account the age(s) of target groups when creating information accompanying contraceptives
- Provide links from teen/youth-oriented websites to others offering information on contraception and the prevention of crisis pregnancy
- Establish a "one-stop" information centre in every town to allow people to access information on contraception, crisis pregnancy prevention and counselling, without embarrassment.

3.1.5 Provision of contraception

"Boys do not usually buy condoms in a chemist's, and do not usually think of it until they are out for the night, if at all! However, they are usually easy enough to get from pubs, if you look old enough" (young man)

"Short term, it is perceived as cheaper to take risks" (health board)

"Emergency Contraception needs to be freely available and out there for anyone who needs it. A list of doctors who provide it and do so seven days a week is essential"

Contributors saw the provision of contraception as critical to the prevention of crisis pregnancy. Access to contraception was perceived as being hindered by:

- lack of provision in particular parts of the country
- the type of availability where there is provision
- lack of specialist contraception services
- the particular circumstances of:
  - women in abusive relationships
  - women misusing drugs
  - non-national women working in prostitution, for whom language and other difficulties can present significant barriers to accessing contraception.

As previously noted (see pg. 13), a particular disincentive to seeking methods of **contraception requiring medical prescriptions** is that not all GPs prescribe all methods of contraception, and some may not prescribe any. Contributors suggested that the situation could be remedied by operating a protocol under which non-prescribing doctors would automatically refer on people seeking contraception. Similarly, while it was recognised that some under-16s are sexually active, the prescribing of contraception for this group was described as potentially a legal minefield. Contributors also reported that some pharmacies refuse to stock post-coital contraception.

The forms of contraception of most interest to contributors in the targeted consultations were **condoms and post-coital contraception.** In relation to condoms, emphasis was placed on ease of access. With regard to post-coital contraception the dominant view was that this form of contraception should be made readily available. The issue of the abortion-inducing potential of post-coital contraception was raised by some contributors.

Contributors reported that contraceptive measures have been imposed on some people with disabilities (particularly those with intellectual disabilities) on the basis that "it is the best way" of dealing with their vulnerability to pregnancy through their own or imposed sexual behaviours. This imposition also applies to women working in prostitution,
of whom a significant number are given Depo-Provera.

Contributors felt that cost of contraception, especially the 21% VAT on condoms, ontributes to crisis pregnancy.

Responsibility for contraceptive use also emerged as an important issue. Some women felt that they should take responsibility for ensuring that they are protected, as they are the ones who become pregnant and, in general, have the responsibility for rearing children. On the other hand, there was a substantial view that men should be better informed about contraception and share the responsibility of using it. Participants also noted that women in prostitution are vulnerable to those men who prefer sexual intercourse without the use of barrier methods of contraception and who offer to pay more for this experience.

Key recommendations emerging from the consultations:

- Educate people about fertility and all methods of pregnancy prevention (see also pg. 11)
- Disseminate contraception information and promote the use of condoms and post-coital contraceptive, where appropriate
- Adapt information on contraception for those with difficulties in reading and/or understanding English or Irish
- Advertise services relating to women's health and contraception on the Internet
- Provide easily accessible, cheap or free condoms in places and at times when and where young people meet and recreate, e.g. in dispensing machines in clubs
- Provide post-coital contraception over the counter
- Address the cost of contraception
- Teach people the effective use of condoms and other forms of contraception
- Highlight the effect of alcohol and drugs on the effective use of contraception (see also pg. 12)
- Ensure that GPs are fully trained in the empathetic provision of contraceptive services
- Mandate that GPs who choose not to prescribe contraceptives refer their patients to those who do
- Provide training for GPs in the use of emergency contraception
- Encourage GPs to have a prompt on patients' charts, reminding them to ask patients aged 16-50 about their use of contraception
- Enable young women to access contraceptive services without having to attend their family doctors
- Ensure that services are gender-inclusive and accessible to men.

4.0 Crisis Pregnancy: what is a crisis pregnancy?

*"Your whole life is ****ed. You aren't free any more" (young person)*

"A means of escape, an opportunity to play a role, a rite of passage, a guarantee of love, an opportunity for attention. For young men it is often associated with virility, masculinity and image" (youth workers)

In the best of circumstances, bringing a child into the world, with the subsequent responsibilities that it entails, is fundamentally life-changing. Crisis pregnancies, for many women, are the most stressful experiences in their lives, fraught with personal difficulties – many of them resulting from, or exacerbated by, cultural and/or institutional responses to their situation.

What constitutes a crisis pregnancy varies from one person to the next, as do responses to the situation. Most participants in the consultative process saw crisis pregnancy as something that happens to teenagers and young adults, although some stressed that a crisis pregnancy can happen at any age. What is clear from research is that not all crisis pregnancies start in the same way: while some are the result of unprotected sexual intercourse, failed contraception or rape (within or outside marriages or partnerships), others become crises due to changes in the relationship with the birth father, or changed circumstances.'

As previously noted (see pg. 3) the Agency's establishing legislation defines crisis pregnancy as "a pregnancy which is neither planned nor desired by the woman concerned, and which represents a personal crisis for her". Pregnancy is experienced as "unplanned" or "undesired" for many reasons, including:

- It is the unsought result of having had unprotected sex or of failed contraception
- It occurs outside a committed relationship
- It occurs as a result of an extra-marital/partnered relationship
- It is a consequence of rape
- There are health complications for the pregnant mother and/or the baby
- There is an increased possibility (or actuality) of having a child with a disability
- The burden of childcare is considered too great
- It is incompatible with a current work or educational situation.

Participants asserted that the attitudes of family, friends and society have a significant impact on determining whether or not a woman experiences her pregnancy as a crisis. The majority of teenagers consulted did not view a teenage pregnancy as a crisis, a cause for shame or a stigma, despite the suffering caused to young and lone parents by negative labelling (e.g. "slappers", "no-hopers").

4.1 Access to information

People experiencing a crisis pregnancy have many information needs. They need information on:

- counselling and advisory services that are available locally
- available medical services
- financial supports
- social supports
- appropriate accommodation/refuge services

- the legal and welfare aspects of lone parenting
- adoption
- abortion.

Strong inter-agency co-operation is required to enable people experiencing crisis pregnancy to access this breadth of information quickly and in age-appropriate and targeted formats. In addition, information must be made available for women who "cannot search openly".

Many people experiencing crisis pregnancy were reported to look to their families and peers, rather than statutory service providers, for initial information. Suggested means and **locations for disseminating information** included libraries, social welfare and tax offices, CICs, leaflets distributed in schools, posters and trolleys in supermarkets, hand dryers in ladies' toilets and through crèches. Women who have been raped may be too traumatised to get past barriers to access help and services, after sexual assault.

Easy and discreet access to information about appropriate supports and services was considered important. Access to information needs to take into account all ages, literacy levels and cultural diversity. Information advertising the availability of non-directive, non-judgmental crisis counselling services was considered particularly crucial.

Key recommendations emerging from the consultations:

- The circulation of leaflets advertising crisis pregnancy counselling services in all public places
- The establishment of a confidential information phone line with trained personnel, operational 24 hours a day, with information on all options open to people experiencing crisis pregnancy.

4.2 Crisis pregnancy counselling service

Participants in the consultation process highlighted the need for counselling and support for women of all ages who experience crisis pregnancy. The attitudes and interpersonal skills of those currently providing services received both positive and negative comment.

The consultations identified a need for a dedicated crisis pregnancy counselling service, staffed by trained counsellors and widely available througho ut the country. Counsellors should have access to all of the information likely to be needed in situations of crisis pregnancy so that the service could function as a "one-stop shop" for information. Most importantly, counsellors should:

- work in a non-directive and non-judgmental manner
- discuss all options openly with clients
- communicate a positive regard and ongoing support for service users.

There should be "free consultation for men as well" because men, as fathers, have a need and a right to be considered and supported in situations of crisis pregnancy.

A number of those consulted referred to the particular difficulties of those who want to conceal their pregnancies. The need for strict confidentiality has implications for medical care, accommodation etc (see also pg. 24).

Participants suggested that a person who is continuing her pregnancy should be able to

continue to receive crisis pregnancy counselling support along with her antenatal care. Crisis pregnancy counselling support should also be available during the adoption process, if that option is chosen. After adoption birth parents, particularly birth mothers, need ongoing support (see also pg. 24). Where abortion is the chosen option, counselling should be available both up to and after the abortion for as long as the woman finds it helpful (see also pg. 22).

Key recommendations emerging from the consultations:

- Establish a national dedicated crisis pregnancy counselling service, available to both women and men
- The Crisis Pregnancy Agency should establish inter-agency networks to provide information and support for people experiencing crisis pregnancy.

4.3 Decision making in crisis pregnancy

As previously discussed girls and women who know that they are pregnant are faced with three options: to have abortions, to continue the pregnancy and keep their child or to continue the pregnancy and offer the child for adoption (or long-term foster care). The decision-making process may be very fraught, especially when the mother is traumatised by her situation. The consultation process underlined the importance of the person experiencing the crisis pregnancy being fully informed about the various options available. Contributors stressed that it is essential for girls and women to be made aware of the services that are in place to support them, whatever option they choose.

The role of fathers in decision making concerning crisis pregnancy elicited two opposing views:

- They are largely excluded
- They shirk their responsibilities.

The role of fathers is considered in more detail on pg. 26.

4.4 Decision to seek an abortion

"You can't tell a doctor that you are going to have an abortion" (young women)

A number of contributors considered the decision to seek an abortion, to be a valid option in the case of a crisis pregnancy. Others, did not see abortion as an option under any circumstances. A third group expressed the view that abortion should be available in Ireland under certain circumstances or that women should be facilitated in seeking abortion elsewhere.

Participants frequently noted that, in relation to young girls and teenagers, it is the parents who bring **pressure** to bear in favour of abortion. In such cases, it is not unusual for the girls to become pregnant again within a few years, often under similar circumstances. Partners may also exert pressure on girls and women to have abortions.

Contributors considered that it is difficult to get hold of information on abortion as an option in crisis pregnancy. Contributors reported that there is a level of social stigma attached to the option of abortion. People are generally unaware of the services provided by GPs, particularly in relation to abortion information, and are likely to bypass them in favour of attending centres specialising in women's health to source this information.

Participants reported that GPs may only allow older women to have **amniocentesis tests** if they have decided to have abortions upon finding foetal disabilities. This was considered unjust, in that it forces a woman to make a decision before she is in possession of the facts. Participant's also reported confusion regarding the 1995 Abortion Information Act.

Participants suggested that the **cost** of having an abortion influences this choice for many women, who also face financial hardship if they keep their babies. Women who are financially dependent on others find it difficult to travel for abortions. Some women take out loans in order to travel.

A number of those consulted, particularly those working with women who have experienced domestic violence, incest and/or rape, considered that the influence of the moral teaching of the Catholic Church in relation to contraception and abortion inhibited some women with crisis pregnancies from seeking abortions.

Key recommendations emerging from the consultations:

- Establish an anonymous telephone line to give information about abortion
- The Crisis Pregnancy Agency should provide a comprehensive counselling service to assist people making decisions about abortion
- The Crisis Pregnancy Agency should maintain a list of recommended abortion clinics
- Access to a genetic counsellor, should be available to persons experiencing crisis pregnancy.

4.5 Decision to continue the pregnancy

The decision to continue the pregnancy and have the baby, whether to keep it or to place it for adoption, gives rise to the need for further supports. Key related issues raised in the consultation process were:

- medical/obstetric services
- continuing in education
- choosing adoption.

4.6 Medical/obstetric services

Participants in the consultation process urged strongly that the emotional vulnerability of those experiencing crisis pregnancy should be taken into account in the delivery of related health services. Some lone parents, particularly those who were not in work, felt that hospital staff were disrespectful and "extremely patronising", scheduling short appointments, which did not allow enough time for questions.

Contributors reported that older women with crisis pregnancies, in particular, were reported to need extra time in antenatal clinics in order that both lifestyle issues and the risk of having a child with a disability might be addressed sympathetically. Women who themselves have disabilities face particular challenges during pregnancy and delivery and require special consideration.

Overall, contributors emphasised the importance of good **interpersonal skills** when providing antenatal care or other supports to those experiencing crisis pregnancy.

Key recommendations emerging from the consultations:

- Train healthcare workers in the interpersonal skills necessary for the management of crisis pregnancy
- Ensure privacy and adequate consultation time in clinics and healthcare facilities for those experiencing crisis pregnancy
- Crisis pregnancy counsellors should accompany young girls attending hospitals for antenatal care.

4.7 Continuing in education

Contributors in the consultation process emphasised the importance of enabling young women experiencing crisis pregnancy to continue in education both during and after their pregnancy. they saw this as vital to ensuring that the student gain skills which would assist her to develop her potential and escape the poverty trap often associated with lone parenthood. Many older women make substantial investments in adult and continuing education, and they too should be facilitated to remain.

A number of contributors referred to **difficulties in the school environment** for girls who become pregnant. Parents and school/college authorities were seen to have a key role in ensuring that it is possible to continue in education and that girls are "not victimised or excluded". Some lone parents said that they left college during the first year as a result of crisis pregnancy. In their view, there were no supports available to help them to stay in college, and information on coping with crisis pregnancy was unavailable.

Key recommendations emerging from the consultations:

- Schools should have a protocol to deal positively and sympathetically with crisis pregnancy
- Third-level colleges should provide information and support for college students to enable them continue their studies, both during and after crisis pregnancy
- Parenting courses should be offered to young mothers-to-be.

4.8 Choosing adoption

"Adoption services operated as and were seen as a service for childless couples, as opposed to a service for children" (women)

"There is a lot of bad press and it frustrates me"

"Adoption is only mentioned if it is mentioned to us" (social worker)

"Many women are in denial about their pregnancy and don't admit it to themselves or anybody else... Many of these women give their children up for adoption. As society was never aware of their pregnancy, there's no issue surrounding people or family questioning how they could give their child up for adoption" (GP).

The consensus view was that the ideal outcome for a mother who gives birth is to be able to keep her baby. Should that not be possible, however, it was recommended that the possibility of adoption be explored with her. The key finding from the targeted consultation process in relation to adoption was that it should be **offered as a positive option** in a crisis pregnancy situation. This differed from the open consultation process where the more active **promotion** of adoption was advocated.

A minority of respondents expressed the view that adoption is **never an ideal solution** to a crisis pregnancy and that other models, such as fostering, should be considered. Others considered fostering an inadequate solution for children, as in their view it lacks long-term stability. They advocated a change in legislation to enable more children in long-term fostering to be eligible for adoption by their foster families.

There was clear consensus, however, on the resoundingly **negative attitude** of both professionals and the general public to adoption as an outcome to crisis pregnancy. It was felt that Ireland's recent religious and social history, during which women were coerced into having their children adopted, contributed directly to these attitudes, which are reinforced by negative media images. Participants recognised, however, that despite the lack of standard practice, there have been positive changes in the adoption process in terms of:

- information for adopted children on their parentage and identity
- efforts to make the process child-centred
- contact procedures and open models of adoption
- patterns of inter-country adoption, all of which are soon to be reinforced by legislative change.

Participants felt that more **information** should be provided on adoption at the first point of contact for a girl or woman experiencing a crisis pregnancy, e.g. in GPs' waiting rooms or via other service providers. The options available to birth parents, such as "open adoption", in which the birth parent/s may continue a relationship with the child who has been adopted, should be explained.

Those who intend to place their children for adoption may need special living **accommodation** for the duration of the pregnancy. They also require special accommodation in the hospital environment at the time of delivery.

Key recommendations emerging from the consultations:

- Develop standards of best practice for adoption
- Standardise adoption practices
- Legislate for "open adoption"
- Fund the development of adoption services
- Offer the option of adoption in a positive context to those experiencing crisis pregnancy
- Provide secluded accommodation for those who need it
- Deliver a public awareness campaign on contemporary adoption practices, along with a specialised campaign for practitioners.

5.0 After crisis pregnancy

As previously noted (see p 3) the Crisis Pregnancy Agency's establishing legislation envisages that the Agency's Strategy will address "the provision of counselling and welfare services after crisis pregnancy". This part of the consultation process focused on the needs of girls and women after they have had babies (whether kept or placed for adoption) or after the pregnancy has been terminated. They may require some or all of the following:

- medical care
- appropriate counselling supports and other services provided to an agreed standard
- information regarding social welfare and other entitlements
- childcare facilities
- income support
- housing.

5.1 Supports after abortion

"The people in the UK were really lovely – they treated me like I was normal" (young woman)

"When I heard that somebody else other than me had an abortion I was so happy. It is definitely something that needs to be discussed and opened up" (young woman)

"I was terrified of bumping into somebody I know" (young woman)

"I got a brown envelope to bring to my GP to get an internal examination. I kept it in a drawer and worried that I might get something, but no way, I couldn't go to a GP" (young woman)

Consultations with women who have had abortions showed that the experience of travelling for abortion is fraught with difficulty. Having made the decision to terminate their pregnancy they found that:

- it is not easy to identify reliable sources of information about abortion and abortion clinics in the UK
- organising appointments and travel can pose problems, for example, in maintaining secrecy from family, friends and the workplace, and in accessing money to cover costs
- moral and/or emotional issues about abortion may trouble the individual or others who may know about her situation
- difficulties may arise with the father, should he be aware of the crisis pregnancy.

The decision to terminate the crisis pregnancy is often made quickly, but not lightly. However complex and difficult the experience, many concluded it to be "the right decision" for them. The majority of those consulted said that they had been accompanied on their journeys and that the clinics dealt with them positively and compassionately. An overriding factor in the experience was the imperative to maintain secrecy, and this need prevailed after the abortion.

A major issue for those who have had abortions relates to their **physical wellbeing**. Many cannot or do not take the time off work that they may need in order to recover fully after the abortion. None of the women consulted had sought or received a medical check-up when they returned home, even though they were advised to do so. Some thought that their abortions were illegal, so follow-up examinations would also be illegal. Conversely, the view was expressed that doctors should be provided with information from UK clinics, "particularly regarding medical or blood defects". This would require women to take medical information with them when they travel.

GPs who took part in the consultation confirmed that there is a "gap in follow-on counselling/referral" for people who have had abortions. Those who do present with physical symptoms often display "additional evidence of the lack of counselling" (see also page x). Consultation results indicate that there is a lack of awareness among women about post-abortion medical and counselling services. It was suggested that a directory of doctors providing post-abortion medical services should be compiled and disseminated.

The perceived social stigma attaching to those who have had abortions, combined with a culture of secrecy, inhibit many from seeking counselling support afterwards. Some contributors who had had abortions did not feel any need for counselling. Most, however, felt that *"good counselling"*, both during and after the event, was valuable, particularly in terms of reflection and validation.

Key recommendations emerging from the consultations:

- Develop relationships between Irish service providers and UK abortion clinics in order to encourage a greater number of women to have post-operative check-ups
- Provide a directory of doctors who offer non-judgmental post-termination health checks
- Evaluate the information packs given to women on discharge from UK clinics.
- Provide secure, confidential opportunities for women to discuss their abortion experiences
- Provide non-judgmental, non-directive counselling services, both before and after the operation, for those who terminate the pregnancy
- Develop information sources for abortion services
- Incorporate specific post-abortion information into existing or planned phone lines
- Legislate to make abortion available in Ireland.

5.2 Supports for those who choose adoption

"It's brilliant, the way they do it now" (woman)

"There's not a day goes by that she is not happy, and therefore I'm happy"

"Not a day goes by when I don't think about her... The thoughts won't go away, but it was the right decision"

"It's a lifelong process – it doesn't end when the papers are signed" (adoption worker)

As previously noted (see pp 20-21) there was general agreement that public attitudes toward adoption are negative and not informed by contemporary experience. Some

contributors felt that this has put pressure on women experiencing crisis pregnancy to keep their babies. **Secrecy**, therefore, continues to be a significant issue. The emotional trauma of crisis pregnancy is exacerbated by the burden of trying to maintain secrecy about plans for adoption. This impacts on the types of supports needed and on the way in which they are delivered. Long-term **counselling services** were viewed as essential for proper support of birth parents. Referrals to appropriate psychological support services may be needed for some women.

Adoption support services were considered by contributors to be seriously **under-resourced**, with insufficient social workers to cope with the workload. Consultation with service providers revealed **regional inconsistencies in the provision of adoption services.**

The prevailing focus on adoption in Ireland today appears to be on foreign adoption. Contributors suggested that the *"Irish perspective"* should be put on the agenda of social workers' in-service training.

The **role of the birth father** in the adoption process needs to be reviewed according to some contributors. Legislative reform should be considered to give the father his rightful role in relation to his child and the adoption process.

Key recommendations emerging from the consultations:

- Invest increased resources in adoption services
- Give service providers professional training in all issues relating to adoption
- Make psychological and counselling supports available to girls and women who place their babies for adoption, for as long as they are required
- Review the role of the father in the adoption process, and make appropriate legislative changes to reflect this role
- Research best practice in relation to adoption.

5.3 Supports for others who continue the pregnancy

Post-natal medical support:

"There's a lack of supports once you have the baby" (young woman)

"Supports may be needed as the woman can become isolated as the initial attention and support disappears" (young woman)

Contributors considered post-natal support is vital after crisis pregnancy, especially for those who miscarried and those whose children have disabilities. Post-natal check-ups are necessary for all mothers and babies but are considered particularly crucial after crisis pregnancy because of the **added stress** and its consequences. Contributors suggested that the check-ups should also explore how the new mothers were coping and should address the issue of post-natal depression, where appropriate.

The need for greater liaison between maternity hospital and the women's home was suggested. Contributors also stressed that more support from and resources for **public health nurses** were required. The relationship between the mother and public health nurse was seen to have the potential to offer valuable support, particularly in the situation of a first-time mother.

Post-natal medical and psychological support was viewed as critical for those whose crisis pregnancies ended in **miscarriage.** Similarly, for some, the crisis experience is at the time of birth or afterwards, perhaps when the mother is told that her child has a disability. The style and content of communication by doctors and hospital staff is considered crucial. Contributors suggested that hospital staff need training on the manifestations of various disabilities as "people are left in limbo after diagnosis, given a little knowledge rather than the full facts".

Key recommendations emerging from the consultations:

- Develop a policy for follow-up after discharge from hospital, to include medical, contraceptive and psychological supports for all who need them
- Resource an increased level of support from public health nurses and social workers
- Improve liaison between the hospital and the home.
- Make genetic counselling available to parents who could benefit
- Disseminate a post-birth support plan at antenatal classes.

5.4 Childcare

"My mother had to leave her job to look after my baby because there was no affordable childcare to take him at three months" (single parent)

Childcare featured to a large extent in the consultations. Easily accessible, affordable childcare of a high standard was considered crucial to the support of women. The inadequacy of childcare was highlighted by contributors.

Contributors reported that the high cost of childcare is resulting in women having to withdraw from the workplace. **Family-friendly workplaces** were seen to be critical for the support of lone parents. It was suggested that **tax relief** on childcare would be instrumental in reducing its cost.

Participants considered the current level of **provision of leave** to care for children when they are sick to be inadequate. They felt that the unpaid parental leave system was based on the assumption that one parent can rely on the financial support of the other, thus barring the single working parent from the possibility of availing of the scheme.

Contributors drew attention to the stresses involved in working full-time outside the home while also parenting and said that these stresses were more than doubled by the absence of a partner. Contributors said that from a purely **financial perspective** it was unclear how a woman on an average wage could possibly meet the costs of housing plus childcare in addition to the other costs of supporting both herself and her child. Single employed women are effectively driven out of the workplace and into state dependence, setting up a cycle which research indicates is likely to be continued in the next generation.

Childcare facilities are vital if mothers are to **continue their education, training or career.** Contributors reported that many crèches do not accept babies under six months of age. This leads to a reliance on "grannies" for the first six months of a baby's life, which was considered unjust.

Contributors identified a need for more **on-campus crèche facilities** at third-level institutions to enable students to continue their education (see also pg. 20). It was also suggested that second-level schools could share in the provision of a crèche as a crucial support to school-going parents.

Contributors advoacated the introduction of parenting courses for young mothers who experience crisis pregnancy. They felt that these would help to empower young women to develop the confidence, skills, capability and self-esteem required to care for themselves and their children. Parents, teachers and social workers all agreed that parenting courses would help to counteract the possibility of the young mother losing motivation to manage her situation and would help to deal with any negative social labelling or categorisation.

Key recommendations emerging from the consultations:

- Provide "one-stop-shops" with small flexible teams to co-ordinate support services in each county
- Provide accessible and affordable crèche facilities
- Provide more crèche facilities in third-level institutions
- Develop crèche facilities for school-going mothers
- Give tax relief on childcare costs
- Improve the provision of leave for taking care of children when they are sick
- Provide a leave entitlement for taking children for statutory check-ups etc.
- Legislate for and promote family-friendly policies in all sectors
- Collaborate with non-statutory agencies in the promotion and provision of parenting courses.

5.5 The role of fathers

"I see my shopkeeper more than my child" (father)

"The system enforces a situation whereby women are better off without men. This system also entraps women with no way out, as they will lose their allowances" (men's group)

"Family law should be updated to include the recognition of male input and equality of men. They should be allowed to take equal responsibility" (men's group)

"Instead of trying to push us apart they should be trying to help us be a family" (father)

A widely held view among boys and men consulted was that they are on the periphery of decisions related to crisis pregnancy and are largely excluded from exercising their roles as fathers after their children are born. It is perceived that fathers have "no rights, only responsibilities". Financial arrangements relating to lone parents were considered seriously detrimental to men's involvement in the care of their children.

The omission of fathers' names on the birth certificates of their children was considered a serious form of discrimination. Contributors felt that mothers often choose to omit the father's name because they believe that they will lose certain rights, particularly in relation to housing, if they include it. This situation should be clarified, and mothers reassured, it was suggested.

Other contributors criticised young men for shirking responsibility for the care and upbringing of their children. They suggested that men should be educated about the consequences of their actions. Overall, the view was expressed that girls and women experiencing crisis pregnancy, along with their families and statutory agencies, should try to include and support men in sharing responsibility for their children.

Key recommendations emerging from the consultations:

- Use education and create a national awareness campaign to promote men's responsibilities with regard to crisis pregnancy and its aftermath
- The Government should review the way in which lone parent social welfare excludes fathers from childrearing
- Update family law to reflect gender equity
- Clarify and publicise the situation concerning naming fathers on birth certificates
- Encourage boys to attend childcare courses in school.

5.6 The role of grandparents

"You always have your ma"

"A key member of the care team to children of single parents"

"Cushioning the reality of parenting"

"I didn't know where to turn or even what to look for or who to talk to" (grandmother)

Though unrecognised and unsupported by the State, the role of grandparents in the post-crisis pregnancy support of daughters and grandchildren is very important. Grandmothers sometimes renounce their own life plans in order to care for grandchildren. The role of primary supporter to the new family can be very stressful.

Lone parents' support groups, considered vital for post-crisis pregnancy mothers, were suggested as being very useful for grandmothers. **A helpline** for grandparents was also advocated.

Key recommendations emerging from the consultations:

- Recognise the childcare and other supportive roles played by grandparents
- Provide parenting courses for both parents and grandparents
- Establish a helpline for grandparents

5.7 Supports for lone parents

"When you work, you get nothing. When you're on the dole, you get everything"

A review of statutory services and supports for lone parents is long overdue, the consultation process revealed. Responsibility for policies, procedures, services and supports relating to lone parents, whether working or in receipt of welfare payments, is spread across several Government Departments. Improved co-ordination and nationwide implementation of policy are required.

Since reported figures on lone parents count only those in receipt of welfare payments, the working lone parent is effectively invisible. This is leading to the stigmatising misconception that all lone parents are dependent on the State, according to contributors.

Flexibility on the part of employers is an important ingredient in the decision to continue with a pregnancy. Lone parents generally can offer less flexibility in their working hours etc than those who share the tasks of parenting with another person. The tax credit available to single parents "goes no way" towards compensating for the additional financial burdens and is ill-publicised.

The predominant view among those lone parents consulted is that there is little encouragement for them to work or little support for them if they choose to do so. A housing officer reportedly told a grandmother, "the best thing would be for the lone mother to give up working".

Key recommendations emerging from the consultations:

- Review policies relating to welfare entitlements, education and work for lone parents
- Review the cut-off threshold of the means test for the One-Parent Family payment, increase it in line with inflation and index link it for the future
- Remove obstacles to lone parents' participation in employment
- Undertake research into the needs and supports required by lone parents in employment
- Provide services outside standard working hours to ensure that working lone parents can access information and support independently.

5.8 Information needs

Service users and service providers recognised the importance of both access to and the availability of information on welfare services after crisis pregnancy. There was agreement that information regarding welfare entitlements should be improved, and that better co-ordination between the different relevant agencies is required.

Single parents in employment also require information on such issues as parenting, legislation concerning lone parents, access, guardianship, maintenance, mediation services and more, as well as about employment legislation and financial supports. As previously noted, all information should be provided in formats targeted to diverse needs.

Key recommendations emerging from the consultations:

- Audit current information provision to identify information gaps relating to lone parents
- Establish inter-agency collaboration in the production of comprehensive information
- Ensure the accessibility of relevant information for grandparents and other key supporters of lone parents
- Circulate comprehensive information about benefits, supports and services with the welfare payment book

5.9 Housing and welfare

"Lone parents are offered housing in hell holes" (single parent)

"It may not be appropriate for teenage parents to have their own accommodation" (service provider)

Participants across the board highlighted a range of housing and welfare issues, including:

- access to and availability of information (see above)
- the availability of suitable housing
- cohabitation and its effect on welfare allowances
- the need for general recognition of diverse forms of family structure
- the need for changes in Government policy.

Accommodation is a critical issue for all lone parents, whatever their circumstances. For those who require assistance with housing, **bed and breakfast accommodation** is unsatisfactory because:

- it lacks 24-hour access to kitchens
- residents may be required to be out of the house during the day
- it militates against the father of the child remaining with the mother.

Privately rented accommodation can be satisfactory, but some landlords do not want to rent property to people with children. A participant suggested that landlords should be offered an inducement to make accommodation available to lone parents.

While mothers and their children are welcome, **refuge accommodation** is not designed to cope with mothers with children and babies. The lack of appropriate housing may "force the woman back" into the situation from which she came.

Key recommendations emerging from the consultations:

- Give priority to lone parents, particularly vulnerable groups such as those on low incomes
- Investigate the affordability of rented accommodation and the discriminatory attitudes of landlords
- Improve the quality of emergency accommodation for lone parents
- Lobby Government for integrated, as opposed to segregated, housing for lone parents

5.10 Supplementary welfare

"Someone from the welfare office basically interrogated my daughter and because her boyfriend was there that morning, her book was taken off her. She was so humiliated she has not claimed a penny since" (mother of a single parent)

"The system enforces a situation whereby women are better off without men"

"The community welfare officer either would not or could not help because I didn't fit into the box he had me in. His attitude was 'you got yourself into this mess, you can get yourself out of it" (single mother)

While contributors recognised that the supplementary welfare payment scheme is

discretionary and demand-led, they reported inconsistencies in its administration. The guidelines developed in 1995 should be updated and implemented. Social welfare rates have not increased in line with rental costs in recent years, and the way in which rental supplements are calculated is unclear to recipients.

Community welfare officers (CWOs) are key people in the lives of many of the lone parents who contributed to the consultation, having the power to give or withhold money. Not all are considered "approachable" and some previous recipients have stopped attending their local social welfare office because of this. Services and the attitudes of providers across the country are said to be inconsistent. Contributors considered regular updating on services, entitlements and interpersonal skills to be essential.

Key recommendations emerging from the consultations:

- Update guidelines for the administration and distribution of supplementary welfare payments in line with changing needs, and issue them to community welfare officers
- Train/update community welfare officers regularly on social welfare entitlements, benefits and interpersonal skills
- Increase family income supplements inline with inflation at budget time
- Reconsider the current rates for rent supplements in light of the increases in rent charges, especially in the greater Dublin area.

6.0 What the agency did with the findings

The consultation process revealed a rich diversity of views on how crisis pregnancy in Ireland can be addressed. The recommendations which emerged from the public and targeted consultations were grouped together under the following high-level themes:

- prevention
- decision-making in crisis pregnancy
- adoption
- after crisis pregnancy
- policy agenda.

The Agency categorised the recommendations under each heading by listing them according to five strategic dimensions:

- policy, standards and research development
- improving knowledge and skills
- building service capacity through partnerships
- influencing change in key areas (income supports, employment, training and education, childcare, accommodation) as they affect those who experience crisis pregnancies
- cultural change.

These strategic dimensions were later used to order the Strategy itself.

The Agency then divided the recommendations into what should be tackled by relevant Government Departments and other organisations, and what the Agency should do itself. It presented these findings to its own Consultative Committee and to each relevant organisation. The Department of Health and Children, the Department of Education and

Science and the Department of Social and Family Affairs, along with the Health Boards, the National Children's Office and the Family Support Agency, were provided with recommendations specific to their area. The Agency used the opinions expressed in these sessions to inform the development of its Strategy and its ongoing research programme.

During the sessions policy makers were asked to identify policy and legal recommendations for immediate attention. Their recommendations included the following:

- Crisis pregnancy as a subject should be placed in a specific area of the health services, in order to ensure that developments are driven
- Sex education should be developed further
- Choice of service provider should be offered for contraceptive services
- Crisis pregnancy should be addressed as part of a holistic approach to positive health
- Standardised training on crisis pregnancy counselling should be provided for health service personnel.

Policy makers also thought that:

- public policy often militates against the involvement of fathers
- asylum seekers and unaccompanied minors have specific needs in relation to sexual health and crisis pregnancy.

Policy makers also stressed the necessity to develop innovative demonstration projects and the importance of inter-agency links. After it had met all the organisations separately the Agency held an inter-Departmental meeting to encourage this co-ordination on matters related to crisis pregnancy.

The consultations undertaken to inform the development of its Strategy continue to be very important to the Crisis Pregnancy Agency. The findings are often used as an important resource in the Agency's everyday work.

The Agency's consultation process is ongoing. The Agency is committed to the practice and process of meaningful consultation in the long term. It appreciates the commitment and interest of all who take time to share their views on the subject of crisis pregnancy, and values every contribution.

Appendix 1: Submissions to the Crisis Pregnancy Agency Strategy

Report at 17th June 2002

A Kennedy
Agnes McCrane
Aileen Murphy
Alice Cahalan
Alistair McFarlane MB B
Alliance Centre for Sexual Health
AMEN
Angela Grealy
Anne Cuffe
Anne Doley
Anne Hourihan
Anne Kilday
Ann Shields
Anon
Antoinette Nolan
Aoife Thornton
Barbara Moriarty
Basics Rights Federation
Bernard James Nolan
Breandain O'Loinsigh
Brendan Mangan
Brendan McGann
Brendan O'Regan
Brian Beirne
Brid Lambe
Cabhair Womens Group
Care for Northern Ireland
Catherine McKeever
Catherine McMahon
Cherish
Christian Democrats
Christine Cott
Ciaran O'Shea
Cogar
Colm Mac Ionraic
Colm Walsh
Cora Sherlock
Cork North West Pro Life Campaign
Cuan Mhuire
Cunamh
Cura Anne Fallon
Dana Rosemary Scanlon
David Logan
David McCracken
Deirdre Keohane, Families of Beara Support Group
Deirdre Mac Ionraic
Derg Finn
Doctors for Life
Dolores Leonard
Donal Nunan
Dr Damian and Jennifer Mooney
Dr Derbhile Donnelly
Dr Helen Stokes
Dr Janina Lyons
Dr Mary P O'Carroll
Dr Michael Cuffe
Dr Miriam Brady
Dr O'Halpenny
Dr Olive Pierse
Dr Patrick J T Conway
Dr Phil Boyle
Eileen O'Doherty
Eilis Grealy
Eilis McNamara
Eimear Thornton
Elaine Wakley
Eleanor McFadden
Eoghan Casey
Etain Nic Cinngamhna
Evana Kirrane
Family and Life
Family Solidarity Ballyroan Branch
Family Solidarity National Executive
Felicity McCormack
Ferns Diocesan Youth Service
Fiona and Joe Aston
Fr Gerard McGreevy
Fr Phonsie Cullinan
Fr Ronald Neville PP
G I Moore
Galway for Life
Gearoid R O'Dubhtaigh
Gerard Hanley
Gerard O'Connell
Health Promotion Managers
Helen Leahy

Helen McGreavy
Helen Walsh
Human Life International
IFPA
Ireland for Life
Irish Civil Rights Association
Irish College General Practitioners
James Hope
Jim O'Sullivan
Joan Smyth
John and Adrianna O'Donnell
John and Maura Burke
John and Patricia Brown
John Moynihan
John Nash
Joseph Giblin
Joseph Keane
Josephine McHale
Kathleen Moloney
Kathleen O'Toole
Leo Macky
Letterkenny Womens Centre
Liam Kirwan
Life Ireland
Loretta O'Connor
M O'Droma
M. Durning
Maire B Morgan
Maire Bean Ui Bhaoill
Maire Gately
Maire Mhic Niaillan
Margaret D'Alton
Margaret Desbonnet
Margaret Roche
Mari Moynihan
Marian Glynn
Marie Dixon
Marie Kirwan
Martin Gleeson
Martin Mulroy
Martina Walsh
Mary Agar
Mary C Callinan
Mary Darcy
Mary Finlayson
Mary Gallagher
Mary Griffin
Mary M Plunkett
Mary Margaret McGread
Mary McMahon
Mary McManahan
Mary McMenamin
Mary Meade
Mary Morris
Mary O'Reilly
Mary O'Rourke
Mary T Smith
Matt Kerins
Maura Daly
Mayo for Life
Mayo General Hospital
Michael G Ahern
Mini Cashman
Miss L O'Connor
Mom and Tot Capital Rights Association
Mother and Child Campaign
Mr Joseph McCarroll
Mr Joseph Mullery
Mr Joseph Schutte
Mr Joseph Walsh
Mr Labhras White
Mr Liam de Paor
Mr Liam O'Cuire
Mr Michael Hanrahan
Mr Patrick Pye
Mr Shane O'Connor
Mrs B Flanagan
Mrs Celine Kelly
Mrs Ethna M Cotter
Mrs Irene Healy
Mrs Joan Murray
Mrs Julie Walsh Power
Mrs Kathleen Hennessy
Mrs Kathleen Lavin
Mrs Mary A Caulfield
Mrs Mary Stewart
Mrs Maura Minehane
Mrs Noirin Pye
Mrs Patricia Mannion
Mrs Rosemary Tindal

Mrs Sadie McCabe
Ms Ann Greene
Ms Eva O'Sullivan
Ms Frances Hannon
Ms Geraldine O'Connor
Ms Lelia O'Flaherty
Ms Margaret O'Connor
Ms Maria O'Grady
Ms Maura Gibbon
Ms Nora Burke
Ms Nora Newell Women's Centre
Ms Rosemary Watters
Ms Theresa Martin
Ms Una Joyce
NAOMI organisation
National Youth Council of Ireland
Neart
NEHB
Nessa M Lucey
Neville Butterly
Noelle McCarthy
Noreen Hanly
OPEN
Organisation
P O'Shea
Paddy O'Reilly
Patrick Carr
Patrick McCrane
Patrick Phillips
Pavee Point Travellers Centre
Peggy Connolly
Peggy Kelleher
Phil Brien
PP Donnellan
Pro- Life Campaign
Pro Life Sth Dublin Constituency
Prof Patricia Casey & Breda O'Brien
PS Cavanagh Neagh
R&S Education training SS for schools
Rhona Anne Kelly
Rita and Donald O'Driscoll
Rita McCrane
Robert Agar
Robert Pierse
Roisin Barr
Roisin McGarry
Ronan Cusack
Ronan Mullen
Royal College of Physicians in Ireland
Sarah O'Brien
Seamas O'Domhnaill
Seamus de Barra
Sean O'Domhnaill
Sean O'Farrell
Sheila Corless
Sheila Kilhain
Sheila O'Brien
Sinead Hewson
Siobhan Hannigan
Siobhan O'Haodha
Sligo Youth for Life
Southern Health Board
Sr Maire Ni Ghbeallain
Sr Margaret Collier
Sr Mary Magdalen
Sr. M. Brigid Horan
Sr. M. Elizabeth
Sr. Mary Patrice
Students for Life
Teresa Gillespie
Terry McMullen
The Counselling Centre Cork
The Loving
The Well Woman Centre
Theresa Croston
Thomas Coleman
Tom and Rose Geraghty
Tom O'Gorman
Treoir
V Rev Sean Moriarty PP
Waterford Student mothers group
Well Woman Centre
Womens Counselling Network
Yield Ireland

Appendix 2: List of Consultations undertaken by the CPA

These consultations were organised through contacts of the Agency. Some were facilitated by health boards through the Health Board Liaison Group and others were done on behalf of the Agency by Youth Reach workers.

Level 1	Level 2	Level 3
Your experience and recommendations for the future	More specific workshops for service providers, assign res--ponsibility to recommendations	Policy makers to prioritise and take responsibility for recommendations
Unemployed Men 18-40 – Mens Support Group	Adoption Service Providers	Health Service Managers
Disability – Concerns faced by those with a disability or caring for the disabled regarding all aspects of crisis pregnancy	Welfare and Housing – Crisis Pregnancy dimension of these issues	Board and Consultative Committee of the Crisis Pregnancy Agency
Bray Women's Refuge	Masters Students of Women's Health - RCSI	Government Dept's – Dept of Health and Children, Social and Family Affairs, Education and Science
Adopted children	SHB Sexual Health Forum - Recommendations on prevention, crisis pregnancy and post crisis pregnancy	Organisations funded by CPA; Pact, Life, IFPA, Well Woman, Cherish, Cura, Treoir
Birth Parents	Service Providers /Practitioners – Focus on recommendations regarding prevention	Politicians - round table discussion with women, elected representatives and the group who drafted the 5th Progress Report of the All Party Committee on Health and Children
Adoptive Parents	Midlands GPs, issues rural GPs are facing	National Children's Office
Drug Liaison Midwives	Dublin GPs, issues they are facing	Adoptive Board
Unemployed Women – 25-40, Larkin Centre for unemployed	SHB - Crisis Pregnancy regional focus	Family Support Agency
Lone Mothers	Sexual Health Promotion Officers – Prevention in settings of education, home, workplace and community	SPHE Management
Lone Fathers	Representatives from the Post Primary Parents Council	Teachers Unions

Lone Parents in the workplace – Questionnaire filled in	Youth Practitioners, role in sexual health promotion and prevention X 2	National Parents Council – parents view of crisis pregnancy and their role
Boys age 16/17 attending a youth club	Crisis Pregnancy and the Older Women	National Women's Council of Ireland - Rec's on prevention, crisis pregnancy and post cp
Girls age 16/17 attending a youth club	Women's Health Information Committee; Crisis Pregnancy regional focus	Health Promotion Managers
Travellers/Ethnic groups	SPHE Co-ordinators/Principals	
Rape Crisis Centre		
Rathmines Women's Refuge	Practitioners/ Social Workers – Prevention	
Grandparents		
Ruhama/ Women's Health Project	Prevention in settings of education, home, workplace and community	
Student Welfare Officer	Women's Health Development Officers - Rec's on prevention, crisis pregnancy and post cp	
Women who had abortions	Youthreach – role in crisis pregnancy and prevention	
People in employment	Workers Union	
	Post abortion counsellor	
Boys/Girls 16/17; Out of School	Inhouse staff consultation	