Aotearoa New Zealand Association of Social Workers

Submission to the Law Commission

On

Abortion Law

8 April 2018

Contents

Aotearoa New Zealand Association of Social Workers 3
How the information was gathered 4
Social Worker Registration 4
Responses to the questions 5

Submission on the Abortion Law

Aotearoa New Zealand Association of Social Workers

Aotearoa New Zealand Association of Social Workers (ANZASW) is the professional body for a national collective of more than 3,200 social workers, who have day-to-day involvement with the most vulnerable people in our society. Our work is guided by a Code of Ethics that is aligned with the International Federation of Social Workers (IFSW) Statement of Ethical Principles.

Our members are employed in a wide variety of organisations across the social services sector including health, education, welfare, justice and social advocacy.

Members work across government and non-government settings including community organisations, iwi agencies, youth justice, child protection, mental health, addictions, disability and private practice. We are involved in research, training, education, professional development, competency assessment, data gathering, risk assessment, structural analysis, interagency protocols and the improvement of social policy.

ANZASW members are responding to the consequences of poverty on an almost daily basis.

The international definition of social work mandates the profession to engage in advocacy for social justice and human rights:

"*Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing*."

Social work is founded on principles of human rights and social justice and, in Aotearoa New Zealand, is guided by the Treaty of Waitangi and respects the equality, worth and dignity of all people. In accordance with the March 2012 IFSW Global Agenda[1] "we commit ourselves to supporting influencing and enabling structures and systems that positively address the root causes of oppression and inequality.

> *"We commit ourselves wholeheartedly and urgently to work together with people who use services and with others who share our objectives and aspirations, to create a more socially-just and fair world. We believe the overarching principles of social work are respect for the inherent worth and*

[1] International Federation of Social Workers, International Association of Schools of Social Work and International Council on Social Welfare (2012). 'The Global Agenda for Social Work and Social Development Commitment to Action'. Available at isw.sagepup.com (accessed 13 June 2012)

dignity of human beings, doing no harm, respect for diversity and upholding human rights and social justice."

Our mission is to enable people to develop their full potential; our skill-set is problem solving and facilitation of positive change in individuals, organisations, whānau and communities. We recognise people in our society can be both agents of change and victims of factors beyond their control. As a profession, we strive to alleviate poverty, foster social inclusion and liberate those who are vulnerable or oppressed. Our interventions involve the development of coping strategies, one-on-one counselling and therapy, family and group work, agency administration, community organisation, social action and social change and helping people to access services, resources and support systems within their community.

Social workers respond to crises and emergencies along with the personal or social problems that arise from experience of barriers, inequities and injustices within our society. We are also involved in statutory intervention when vulnerable children and adults are at risk of harm.

How the information was gathered

A questionnaire was developed in consultation with the Law Commission policy advisors. This was sent to the National District Health Board Social Work Leaders Council requesting that the questionnaire be circulated to social workers working in the field of abortion counselling and pregnancy counselling.

Reponses were received from 6 members.

The profile was:

- All respondents were registered social workers
- All respondents were employed by District Health Boards
- Two respondents were from a mixed urban / rural area
- Three respondents were from an urban area
- One respondent was from a rural area
- Five respondents were from North Island locations
- One response from a South Island location was from a team of eight social workers

Social Worker Registration

Social Workers are currently subject to a voluntary statutory regulation scheme under the provisions of the Social Workers Registration Act 2003. Under this scheme all District Health Boards require social workers to be registered with the Social Workers Registration Board.

The Social Workers Registration Legislation Bill currently before Parliament aims to make registration of all social workers mandatory. The Bill aims to increase the professionalism of the social work profession and protect the public from harm.

Responses to the questions

1. Under the CSA Act the Abortion Supervisory Committee is required to appoint suitably qualified people to provide counselling services for people considering having an abortion, and to approve agencies to provide counselling services. a. How does this work in practice?

Social workers at our DHB offer counselling, if they wish to have it. Any termination of pregnancy (TOP) post 13 weeks have to have counselling. For medical terminations counselling is optional.

There are three experienced social workers that provide counselling services at our DHB. We all completed a counselling component as part of our Bachelor of Social Work. We complete professional development to maintain our social work registration status. We keep up to date with the law/processes for having a pregnancy termination in our region. We are experienced in providing supportive counselling with patients on the inpatient wards and in providing counselling to women who are considering having an abortion or continue pregnancy.

The Abortion Supervisory Committee (ASC) gathers very sparse information about who is providing counselling at licenced abortion facilities. Usually how many staff, their qualifications and length of practice. The Standards of Practice for the Provision of Abortion Counselling 1998 document is long out-of-date and the requirements regarding who is suitable, what qualifications are required, and on-going training requirements are unclear. This differs from the requirements for medical and nursing staff providing abortion services, which are very prescriptive and clearly outlined in the Standards of Care for Women Requesting Induced abortion in New Zealand 2009 document. There is reference within the counselling standards[2] to 'lay-counsellors' but no definition of who this applies to nor what is required of 'lay counsellors". In practice all DHB's as licenced facilities employ either qualified social workers[3] or counsellors[4] to provide the abortion counselling service. Recent research identifies that appointment to this role is often from existing health social work staff who are generally working in the field of women's health; and this role is absorbed into their practice without additional resource i.e. funding or designated full-time equivalent hours. There is no national approved training programme for abortion counsellors to ensure consistency in practice and very little access to on-going training as is required of medical and nursing staff who provide abortion services.

There is no specific training for social workers who work in abortion counselling that I am aware of. Several years ago, there was a gathering in our region for those of us who practice in this field. This allowed us to look at our practice and to see and learn from what others were providing. The counselling service we offer at our DHB is learned on the job and from those who have previously held a counselling role. Social Workers need to research and source professional development opportunities to enhance competence in this field.

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[2] "Suitably trained lay counsellors may also be used where there are insufficient professional social workers" – Standards of Practice for the Provision of Counselling, Counselling Advisory Committee 1998 Appendix 1

[3] The Social Workers Registration Board has the responsibility for recognising educational qualifications for the purposes of the Social Workers Registration Act 2003. Recognised social work qualifications are listed in Schedules 1 and 2 of the Act. http://swrb.govt.nz/for-social-workers/new-registrations/nz-recognised-sw-qualifications/

[4] New Zealand Association of Counsellors is a self-regulating professional body. Members meeting the NZAC requirements may identify as "Registered with NZAC".
New Zealand Christian Counselling Association issues an 'Annual Certificate of Practice' once they have met the annual requirements for membership.

The Social Worker or counsellor should be:

- registered in their field of practice
- Have a minimum of 3 years work experience or practice
- Be familiar with the Law Training and orientation process provided on joining the service
- Participate in intensive/ In house training provided by social workers / counsellors working in the field
- Be receiving supervision consistent with policy requirements
- Access peer support
- Work with a Multidisciplinary team approach.

We are unsure what the current role is with ASC- our service has not had any recent contact or visit for some time. The social workers / counsellors in our area are the responsibility of the District Health Board.

All working in this field are registered social workers. There are very limited counselling services in the Community - Pregnancy Help tends to focus on offering practical and emotional support for women continuing a pregnancy. PATHS - focus on post abortion support and the trauma around having an abortion which can be beneficial for some women.

b. What is the appointment process?

The social worker rings and make a face to face appointment to see woman. Engagement includes discussion about options, screening for mental health, drug/alcohol and family violence issues. If woman brings a support person we always ask that person to leave at some stage in the session.

The job description for the position is titled pregnancy counsellors. This has meant that social workers, counsellors, or nurses meet the criteria to apply for the position. The DHB Manager and Professional Advisor Social Work are the two people that interview applicants and make the appointments.

Appointment to the abortion counselling role, as previously stated, is often sourced from existing health social work staff who either work in the field of women's health or who express an interest in this area. In some cases, recruitment occurs when appointing new staff to health social work roles with a specific focus of employing someone who is interested in this field of practice or has had experience in this field of practice. Social workers can apply the 'conscientious objection' rule to opt out of this field of practice - similar to medical/nursing staff.

Requirements nationally tend to include a social work qualification, social work registration and some health social work practice experience. This differs across DHB’s. The type of training staff received appointed to the role varies across DHB’s.

The Pregnancy Counselling Co-ordinator (PCC) work is a role within greater child and maternal health social work. In being appointed to the job I was asked numerous questions around my values and beliefs when it came to abortions.

During the interview process a social worker coming into the Social Work Women's team in will be asked if they are prepared to work in this area. There is also an expectation that they will work in this area. Our team is mindful that not all social workers coming in to work in this team will feel

comfortable due to personal circumstances, personal or religious beliefs. Over the last few years training has been very limited - with orientation to the Gynaecology Procedure Unit (GPU) and a lot of learning taking place on the job. Little training has been offered on a regional and national level. Networking and sharing of information and resources has been on the decline over the last 5-6 years.

2. What is the process for ensuring women have access to abortion counselling in your region?

Phone call to woman. Termination of pregnancy at 13 plus weeks will not occur unless a report from social worker is provided.

Its automatically built into the system for women to meet with one of the specialised social workers when they are considering a first or second trimester abortion. For women who live rurally, there is a system where they meet with the Certifying Consultants and social worker (pregnancy counsellor) on the same day. For second trimester abortions, women always meet with one of the specialised social workers.

All DHB's, as licenced facilities, must provide abortion counselling. Access to counselling differs across regions. The DHB at which I am employed has set up a new first trimester abortion service and counselling is offered to all clients referred to this service. Access to abortion counselling that is referred via GPs, health clinics for second trimester abortions varies and is very reliant on the referring service. It has not been well advertised on the DHB site but there is a plan for this to change.

All referrals go via the Sexual Health Clinic, a referral is then sent on to the social workers. The practice is to offer all women seeking a termination counselling. We then call or send a message to make an appointment time with to see a social worker. Obviously if a message is sent, it does not state what the appointment is for, just to call the number to make an appointment time. Normally we see women in our office, and I travel to the south of our region each week to see women who might otherwise not be able to see me in our main centre. Sometimes we will do a PCC over the phone if it is an issue for someone to see us.

The Clinic employs social workers/ counsellors that work specifically in this area. Currently there are 2 social workers and 1 counsellor working at the unit. There is vacancy for a full time SW/counsellor which has not been filled since the resignation of the staff member in February 2018.

The Clinic is an outpatient service at the DHB Hospital with a multidisciplinary team that consists of certifying and operating doctors, nurses, midwives, social workers and counsellors.

Our region covers a huge geographic area with many women having to travel a long way to access the service. A lot of the out of town women will not have seen a social worker/counsellor before their one-day procedure. We will see all of those women on the day. Women living in the metropolitan area will normally see a social worker and a first doctor before returning on another day for their procedure. There are some exceptions to this and if they are a here for the one day procedure they will also see a social worker first. There are a small number of women who decline to see social work. Women can also access a pre-decision counselling appointment - this maybe a referral from their GP or they can self-refer. We have women that travel from outlying rural communities for an appointment to see a social worker.

3. At what stage is counselling offered, in your experience?

Prior to appointment.

It is generally offered at the same time that a woman is referred to the Certifying Consultants. Social workers make sure that women know that they can always contact a social worker if they have any concerns leading up to when they are scheduled to have an abortion. Women may see a social worker post abortion on if this is necessary. We refer women on to ongoing counselling if they desire this support.

Prior to the setting up of the new first trimester abortion service at this DHB - it is very unclear how counselling is offered by GPs or health clinics. Referrals are often made only if the client requested it or was showing some signs of distress or ambivalence about her decision-making around pregnancy. Referral rates were low, so it is not possible to comment on whether GPs and health clinics consistently offered counselling or assume they or their practice nurses provided adequate counselling.

Since new service is being established all women referred to this service are offered counselling. In relation to second trimester abortion counselling the issues was the same as first trimester counselling referrals. There has since been a change in the booking process so now all second trimester bookings are done via the counsellor to ensure all women are offered counselling.

Generally, there have been consistent referrals for counselling in relation to abortion for foetal abnormalities.

Normally once a scan has been booked a counselling appointment is made as this saves women having to make several trips to the hospital. Tying it in with a scan also helps in knowing how far along they are and what procedure is available to them.

Counselling is offered at all stages of the process. Pre and Post and on the day of the procedure if required.

Usually when a woman goes to her GP or Family Planning or Sexual health doctor social work or counselling is offered.

4. What is the uptake of abortion counselling like in your region?

25% for those under 13 weeks. Post this 100%

Basically, all the women who are considering an abortion, see a social worker or counsellor. During the counselling session, we gauge on how much counselling support a woman desire. Counselling is not forced on women.

In my opinion the uptake for abortion counselling in my region has been low. I am not sure whether this is because counselling has not been offered or proactively promoted - or - client perceptions of what counselling is. Some clients have thought the counselling provided would be focused on changing their decision. Many are concerned they will be judged for their decision to terminate.

The region I work in has a high level of deprivation and many women who are choosing to terminate their pregnancies are living in situation with high and complex risks. I believe that supportive abortion/pregnancy counselling should be more proactively promoted. There is also a high Maori population so many seek the advice of whanau members regarding their pregnancy options.

I would estimate around 95% - as stated sometimes we will do a session over the phone if someone does not wish to meet face to face. Often women feel comforted in knowing they can speak about their situation in a non-judgemental environment.

99- 100% due to the clinic's policy.

Most women in our region will see a social worker at the GPU. Some women will present as very clear and well supported. Other women will be ambivalent or have no support and this is where the social work role becomes very important.

5. Is counselling a "de facto" requirement, i.e. must women access counselling, are women strongly encouraged to access counselling, or is it very much optional?

Counselling is encouraged but optional until 13 weeks. Counselling is mandatory post 13 weeks

It is a "de facto" requirement, although counselling session times can be long or short depending on how much a woman feels she needs assistance/support.

Counselling is definitely optional in this region. Although for second trimester abortions the opportunity for counselling support and preparation around the termination process is always encouraged, especially if women have to travel out of region to access the service. It is still optional, so women can decline. The surgeons who perform the second trimester terminations have a preference for counselling to occur however I am not sure if counselling is available on-the-day of surgery at their end.

We have had some issues with this in the past as doctors can sometimes undervalue counselling. Previously the PA who called women seeking a termination would just ask if they wanted to see a counsellor, many declined not understanding what is was that was on offer. However, we have worked to ensure that social workers contact all women who are seeking to have a termination. That way we get to explain what service we are offering, and how we can help. This has proved to be successful, hence the high uptake. It has also meant fewer referrals back to us, for grief and loss counselling, as a result of not having counselling initially. All counselling is optional, we offer, but someone can decline the offer, as is their right.

It is the policy at The Clinic to require all women presenting for consideration of a termination of pregnancy to have pre-abortion counselling. In addition, the team also provides:

- Pre-decision, individual and couple/whanau counselling
- support Pre-abortion day
- 1 support Further counselling support appointment if required Post abortion support

Seeing a social worker/having a counselling session is seen as part of the process.

6. Are there sufficient abortion counsellors/social workers throughout the country?

Yes Rural

Yes Urban

No Mixed rural & urban

Yes Mixed rural & urban

No Urban

No Urban

In your experience, what are the common reasons women have for seeking an abortion?

Reasons for seeking termination include:

- Mostly - unplanned pregnancy that was not expected nor welcome news. Wrong time,
- financial stress
- Sometimes, they can't financially afford to have another child
- Struggling financially,
- Script has run out due to financial constraints or busy/chaotic lives
- lack of financial resources/housing issues/focussed on career/
- Too many children combined with lack of financial stability i.e. unable to afford another child
- Family grown up, don't want to start again.
- Age - to young or to old.
- They feel they are too young or too old to have the baby
- to old/ family completed/
- too young/not ready /not prepared/emotionally and financially
- Complex and high-risk family situations i.e. women experiencing addictions, mental health, family violence, financial stressors, lack of supports, transience/homelessness - situations where there is poor or lack of control around pregnancies
- not in a relationship
- relationship instability,
- Relationship ended
- Lack of support from partner / relationship issues
- Family concerns
- Family violence
- They are not in a relationship with the father of the baby.
- They are in a new relationship, and not ready to be parents together
- Unstable relationship
- lack of family and other supports
- personal choice.
- Experiencing difficulty coping with life's stresses already.
- Emotionally, physically, financially /mentally could not handle it.
- History of depression/post-natal depression/high anxiety/low mood with pregnancy/stress
- They have mental illness and or drug addiction,
- They might have drunk alcohol or used drugs during their pregnancy.
- concerns re fetal abnormality
- Fetal abnormalities
- MFM (Maternal Fetal Medicine concerns)

- Hyperemesis / other medical conditions/on medication
- Medical history
- They are concerned that they physically can't cope with carrying the pregnancy or have previously experienced complications during labour.
- Erratic contraception usually missed pills/injections,
- failed contraception
- Failed contraception i.e. a form of contraception that does not work for the woman
- Cultural issues
- Cultural taboos and barriers
- Rape
- never wanted to have a child
- Not ready or prepared for parenting responsibilities.
- Not ready to be a parent, or already have a family and do not want to add to it,
- Not wanting to be a single parent.
- Simply don't want to carry the pregnancy.
- Pregnancies too close together i.e. women has an infant and has become pregnant within 3 months - 1 year of birth and doesn't feel able to cope with two babies
- The impact another child would have on the family and child or children they already have.
- They already have a child or children and feel that they can't emotionally cope with having more children.
- Unable at this time to give a child the life that they would want their child to have
- Unintended / unplanned / unwanted pregnancy
- completing study
- Non-resident/international student/international traveller

7. Are there any other medical procedures where patients are referred for counselling / social work as a matter of course?

- Women who have miscarried or experienced a still born are offered counselling at the hospital.
- Fetal loss e.g. miscarriages and still births
- Traumatic births
- Fetal abnormality terminations (these are seen to be business as usual for obstetrics and gynaecology.
- Decisions around end-of-life care for neo-nates/children
- After a stillbirth, miscarriage, death of a baby/child - those families are offered grief and loss counselling as a matter of support.
- Miscarriage
- Stillbirth fetal abnormality NICU
- Unexplained and non-accidental injuries
- Not aware
- No

If so, is that as a matter of:

All contributors cited “as a matter of practice”.

8. Do social workers play a role in ensuring that women give informed consent and are not pressured into decisions by family members or others?

All contributors answered yes

a. Are there any particular standards or guidelines for processes around this?

- Certainly, when women bring in support people, we also meet with women alone to ensure they are not pressured into a decision.
- There are guidelines around the management of fetal loss/stillbirth which includes offering social work services for support and counselling.
- Support/counselling in relation to end-of-life with neo-nates and children does not always have social worker involvement.
- Yes, see abortion supervisory committee standards of practice
- It is the clinic's protocol to see women initially on their own. It is only with the women's permission or request that partner's/ whanau /support persons are invited to join the session.
- The social work Code of Ethics and social work competencies guide practice

9a. In your opinion, what are the advantages of the support offered by a counsellor/social worker to a woman going through the abortion process?

- It allows woman a safe place to talk about their feelings and to unload the guilt.
- Often, they haven't told anyone else.
- For some woman is a clear-cut decision but for others it has been a really hard decision to make and they need support around this and to hear that this is an okay decision to make for themselves.
- Social workers and counsellors are trained in assisting women in dealing with this crisis and in helping them to explore their feelings and options (keeping baby, abortion, temporary guardianship, or adoption).
- Social workers and counsellors know about the different options and can assist women to explore what the options might look like.
- Social workers and counsellors also help with organising transportation and accommodation assistance for women who meet Ministry of Health National Travel Assistance criteria.
- Social workers and counsellors are familiar with WINZ supports and other community agency support.

I believe that all health practitioners involved in abortion services have some therapeutic support to offer. Medical staff may be able to talk with more authority/knowledge about the procedure and explore options in a generalised way.

What social workers bring to the table is:

- A holistic approach that view the client in their context
- Exploration of values and beliefs that underpin the women's decision-making process

- Assessment of their personal context i.e. cultural, religious, sexuality, familial, inter-personal and intra-personal circumstances
- Identification and management of social risk factors e.g. addictions, mental health and family violence
- Brokerage to further supportive services Counselling in relation to grief and loss
- Assessment of supports, decision-making capacity and ensuring decisions are not made under duress
- Assistance regarding meaning-making around the experience
- Emotional preparation in relation to the procedure they are undertaking

The benefit of social work involvement is that women are offered an unbiased, supportive approach to assist with clarity around decision-making and preparation for a process than many find emotionally/psychologically difficult. The counselling helps women to find a level of peace with their decision to terminate that reduces negative emotional/psychological impacts in the long term.

It allows her to feel listened to and validated, gives space to explore feelings and her situation in a safe environment. Helps in strategies to make a decision that is right for her.

The social worker/ counsellor supports a women's ability to make choices about her reproductive and sexual health and counselling assists an informed decision-making process. The role encompasses providing compassionate pregnancy option counselling and support to women, partners and whanau. Pregnancy option counselling is a therapeutic intervention which provides a woman with a private and safe space for her to discuss relevant thoughts and feelings regarding the pregnancy. The philosophy of the assessment is that a woman presenting for an abortion is sure of her decision. However, when there is ambivalence or conflict this need to be addressed. The support offered provides a safe space which is non-judgmental and unbiased.

Social work intervention:

- facilitates exploration religious, cultural, moral and spiritual aspects related to the abortion decision.
- Assists a client mange unfamiliar emotion.
- Check for support
- Screen for Intimate partner abuse.
- Provide accurate and clear information.
- Youth risk assessment for under the age of 18 years.
- Plan for post abortion coping
- Affirming
- Clarifying
- A safe place to talk
- An opportunity to disclose Family Violence
- Exploring any pressures to continue or not continue
- To offer ongoing support in what can be a very difficult decision

9b. In your opinion, what are the disadvantages of the support offered by a social worker or counsellor to a woman going through the abortion process?

We can only offer medical terminations at our DHB. Woman have to travel out of area for non-medical which adds cost and distress. These women also don't have the option to take the product home which I believe adds to the distress.

Essentially, since counselling is supposed to be optional, it is a shame that it is an automatic built in process for women to have to see a social worker. It can be time consuming for women to come see a counsellor. They are having to take time off work, study, or from whatever else they may be doing. If they are already comfortable and clear with their decision, it seems that it is a moot point for a counsellor/social worker to further discuss with them.

I would not like to see abortion counselling as something mandatory as I believe that it would be just viewed as a 'hoop to jump through', something to be endured in order to access a service women want or need. Some women will have discussed their decision with their partners/families/whanau and feel comfortable with their decision. I would consider it abusive if women were forced to attend counselling just to have an abortion. I do however, feel it abortion counselling should be promoted in a manner that encourages women to consider whether this may be helpful to them. Many women I see are clear about their decision to terminate but are experiencing some discomfort because their decision conflicts and or challenges their own personal beliefs. In these situations, the focus of counselling is not so much about exploring options but about meaning-making and reducing emotional discomfort and distress.

If supportive counselling is offered too late on the abortion care pathway it is also viewed as a distressing hurdle. The counselling process should be well embedded in the delivery of abortion services, funded and resourced appropriately and promoted alongside the supportive process offered by other health staff as part of the delivery model.

Social workers can hear how a woman may choose to have surgical procedure rather than a medical termination, as this is better for her emotional state. Social workers will advocate for this option, yet this can be overridden by the certifying doctor who thinks a medical termination is a better option, or cheaper because the woman maybe under 9 weeks Essentially social workers spend time with someone who trusts us to advocate for their needs and can be undermined on occasion.

If the support offered is biased or not offered in a non-judgemental environment it may be more harmful than beneficial. The information provided by the social worker or counsellor should be accurate and clear. The social worker should be familiar and knowledgeable about abortion and referral process.