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Reproductive Decision Making Is Important to Client Well-Being: A Call to Action

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As practicing social workers, we tend to witness and appreciate the daily struggles of our clients. I have seen firsthand the consequences of a lack of adequate reproductive health knowledge and access to family planning and a general lack of attention to the reproductive health of people who are the most marginalized. I have also witnessed policies that put ideology before outcome. The result can be felt in economics, health, and overall well-being. However, I also realize that as social workers we have a lot of fires to put out and are often overwhelmed. Being a social worker can be emotionally exhausting; taking on yet another task may seem daunting. I think a metaphor used within dialectical behavior therapy can be applied here: teaching skills to clients can feel like putting up a tent in a hurricane (Linehan, 2014). Addressing RDM may also feel that way with some clients. Even when it is clear that addressing reproductive health would be useful, there can be so many needs and much suffering to attend to. I am hoping that this chapter speaks to the challenges that we see as social workers and allows us to begin to think about the barriers that we may be facing individually or as a profession in helping clients with RDM. Once we understand the barriers, we will be better able to address them.

Understanding how RDM is relevant to social work practice can help us take the first step to help our clients prevent unintended pregnancy. This chapter will describe the current situation and explain why, as social work clinicians, we are especially well placed to make a difference. You will read about (a) rates of unintended, poorly timed, and adolescent pregnancy, particularly among populations who are already involved with social services; (b) our professional responsibility to provide family planning information; and (c) how we can serve our clients by helping to fill the gaps in the provision of family planning information. The appendix provides a tool to measure your strengths and identify areas where you may need additional resources to fully help clients with RDM.

Throughout the book, we hope to give you information and tools that will demonstrate that social workers can make a difference by helping clients with RDM. Helping clients make their own decisions about reproductive health meets our professional obligation to affirm client self-determination (NASW, 2017) and fits into a reproductive justice framework. Also, helping a client make an informed decision about when to have children can have a significant positive impact on the client's economic situation and overall well-being (Mollborn, 2010) and improve maternal and child health (Brown & Eisenberg, 1995).

Scenario 1: Margaret and Sofia

Margaret, a social worker who has worked at a Texas women and children's homeless shelter for more than 10 years, believes that she could do more. She has been feeling frustrated with situations among her residents that are allowed to get worse when someone might have stepped in to prevent them. One common thread she has witnessed among the women she sees is a lack of reproductive services, which contributes to unintended pregnancy. Some of the residents occasionally see a medical professional, but many see only their social service providers. Several of her clients also struggle with long-term mental health problems. One woman in particular, Sofia, stands out to Margaret. Sofia has been diagnosed with bipolar disorder and has struggled to maintain stable housing. She has been in and out of treatment and spent a short time incarcerated. Sofia recently told Margaret, "With four kids and not enough money, I feel overwhelmed. And when I get down, I feel like there is nothing I can do. I feel so hopeless." Margaret referred Sofia for

treatment but believes her mental health is fragile. Sofia's first child was born when she was 15 years old. Her youngest three children were born while Sofia was receiving mental health treatment and were unintended pregnancies. Sophia has told Margaret, "I love my kids, but I wish God would stop sending me so many babies. I pray that he won't send any more to me, but they still keep coming." It is clear to Margaret that Sofia has very little knowledge about contraception and will likely have difficulties using methods that require her to remember how and when to use them. She wants to intervene, but she is not sure how. She recognizes that she should help Sofia find out about her reproductive options so Sofia can make her own decisions, but she is not sure where to start, especially since her agency does not address reproductive health. Margaret is not comfortable talking about contraception because she does not believe she knows enough about it, and she does not know where to turn for reliable and medically accurate information or referral services. She also feels overwhelmed by how many problems she encounters every day.

There are many reasons social workers, and others who could be allies, can and should support improved RDM, more broadly, and a reduction in unintended pregnancy, more specifically. Unintended, poorly timed, and adolescent births often have negative effects on the lives of those involved. Children of unintended pregnancies are less likely to receive adequate and timely prenatal care, are more likely to die as newborns, and are more likely to suffer abuse (Gipson, Koenig, & Hindin, 2008). Women who did not intend to get pregnant may be more likely to use illicit drugs or cigarettes before and during pregnancy (Dott, Rasmussen, Hogue, & Reefhuis, 2010) and more likely to experience depression during the pregnancy and postpartum (Najman, Morrison, Williams, Andersen, & Keeping, 1991). Socioeconomically disadvantaged teenagers who become pregnant face further hurdles to overcoming poverty if they become young parents (Mollborn, 2010). Unintended pregnancies are also expensive for society. Trussell (2007) estimated the direct medical cost of unintended pregnancies in the United States to be $5 billion, based on the average cost of all births. This cost estimate did not include costs due to loss of educational or employment opportunities or the cost of additional treatment that may become necessary for mothers who do not receive timely and adequate

prenatal care. The amount saved by contraception during the same time period was about $19.3 billion (Trussell, 2007). These savings can be used for other social services and human welfare needs, such as education and housing. Unintended births also have an impact on public health by increasing population growth and resource consumption, especially in a high resource-consumption country like the United States. According to Darryl Holman, professor of biological anthropology at the University of Washington, "as long as the growth rate remains positive, our species will eventually reach numbers and densities where technological solutions cannot ameliorate resource scarcity" (quoted in McNamee, 2014, para. 19). Limiting exposure to communicable disease, providing waste management, and ensuring adequate food, clean water, and clean air all become more difficult as the population increases. A greater demand for resources makes it even more difficult to absorb the effects of global climate change, such as displaced populations of people and disruption to agriculture (McNamee, 2014). Increased competition for resources can lead to violence and civil unrest, affecting the vulnerable the most. Clearly, the issue of reproductive health, along with high rates of resource consumption, needs to be addressed domestically and internationally. As social workers, we should empower clients by discussing reproductive decisions with them. We can also work with coalitions outside of social work on behalf of our clients.

UNINTENDED PREGNANCY RATES IN THE UNITED STATES

The staggering rates of unintended pregnancy and adolescent pregnancy within the United States present major challenges. Although the rate of unintended pregnancies in women ages 17 to 44 in the United States went down between 2008 and 2011 (Finer & Zolna, 2016), the United States still has higher numbers than most industrialized nations (Sedgh, Singh, & Hussain 2014). Among 15- to 19-year-old adolescents in 21 developed countries, the United States has the highest pregnancy rate (Sedgh, Finer, Bankole, Eilers, & Singh, 2015).

Comparing the whole United States with other countries does not reveal as much information as looking at individual states. Some states have adolescent pregnancy rates as low as those of progressive liberal countries, while others have rates as high as those in developing countries.

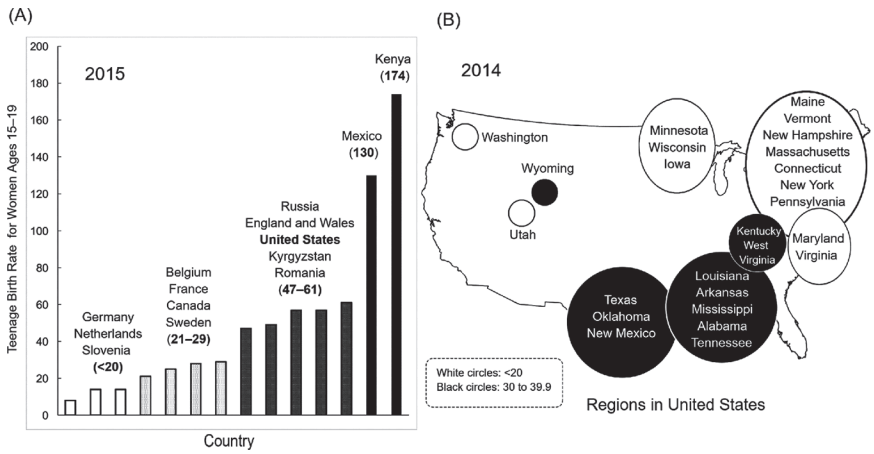
For example, the adolescent pregnancy rate in 2014 for Arkansas (39.5 per 1,000 adolescent females) was similar to that of Haiti (39 per 1,000 adolescent females). However, New Hampshire's rate (11 per 1,000 adolescent females) was similar to that of the European Union (10 per 1,000 adolescent females) (Hamilton, Martin, Osterman, Curtin, & Mathews, 2015; United Nations Population Division, n.d.). Please see Figure 1.1 for more information on rates of adolescent pregnancy.

As surprising as those statistics may be, the numbers for women whom we see most often as social workers—women with mental health issues, those who have been in child protective services or the criminal justice system, and individuals who are homeless or recently immigrated—are often even higher. By providing guidance for RDM, we can empower more women to take control of their fertility.

CLIENTS AT INCREASED RISK OF UNINTENDED PREGNANCY

To decrease the number of unintended pregnancies in the United States and secure the reproductive health of our citizens, we must take action.

FIGURE 1.1 Adolescent Pregnancy Rates per 1,000 Adolescent Women



Adapted from Hamilton et al. (2015) and United Nations Population Division (n.d.).

Both social workers and medical professionals have the opportunity to provide clients with reproductive planning information. However, social workers are more likely to see people living in situations associated with unintended and adolescent pregnancy and to see them more frequently (Barrett, Ju, Katsiyannis, & Zhang, 2015; Boonstra, 2011; Hillis et al., 2004).

Many social workers regularly see clients receiving mental health treatment, like Sofia in the scenario at the beginning of this chapter. Women and girls who have a psychiatric diagnosis have an increased risk of unintended pregnancy. Researchers in 2014 found that adolescent girls with psychotic, bipolar, or major depressive disorder were three times more likely than girls without a psychiatric diagnosis to have been pregnant (Vigod et al., 2014). In addition, women who reported feeling stressed and depressed were more likely to say they were not using their contraception properly. A group of 18- to 20-year-old women in a 2013 study, all moderately or severely depressed, said they were less likely to use long-acting contraceptive methods. Instead, they often chose less reliable methods or no method at all. For this reason, routine screening to identify women with mental health issues who are at risk for not using contraception effectively may be helpful (Hall, Moreau, Trussell, & Baber, 2013). Social workers could play an integral part in that screening.

Women who have been a part of child protective services or the criminal justice system have a higher risk of adolescent pregnancy and have more contact with social workers and so represent an opportunity for intervention. According to a 2005 study, almost half of adolescent girls who were involved in child protective services reported a pregnancy by age 19, compared with only 20 percent of their peers (Courtney et al., 2005). Girls who had been arrested were 3.5 times more likely to become adolescent parents than girls who had never been arrested (Barrett et al., 2015). And adolescent and pre-adolescent mothers are more likely to get pregnant again soon after having their first child. A study by Raneri and Wiemann (2007) found that 42 percent of adolescent mothers became pregnant again within two years of giving birth. Students in education programs designed to accommodate educational, social, or behavioral problems also tend to have higher rates of risky sexual behavior and unintended pregnancy than students in regular schools. Markham, Tortolero, Escobar-Chaves, Parcel, and

Addy (2003) found that 29 percent of students in alternative education settings reported having been pregnant or having made a partner pregnant.

Another often overlooked population of women who experience high rates of unintended and adolescent pregnancy are homeless women. A 2011 study found that young homeless women ages 16 to 19 became pregnant at a rate five times greater than 18- to 19-year-olds in the general U.S. population (Crawford, Trotter, Sittner Hartshorn, & Whitbeck, 2011). An earlier study found that nearly three-fourths of pregnancies among homeless women were unintended (Gelberg et al., 2001).

Poor women and immigrant women also have higher rates of unintended pregnancy. As with homeless women, many factors contribute to this outcome, such as lack of access to regular reproductive health care (Salganicoff, Ranji, & Wyn, 2005) and lower rates of contraceptive use (Finer & Henshaw, 2006). Between 1994 and 2001, the rate of unintended pregnancy rose 29 percent among U.S. women with incomes below the poverty level and dropped 20 percent among those with incomes double the poverty level or higher (Finer & Henshaw, 2006). Data from 2001 and 2006 confirmed the gap between rich and poor, showing that the rate of unintended pregnancy went down among women with the highest incomes but went up among women living in poverty (Finer & Zolna, 2011). Also, in a study of U.S. women ages 35 to 44, the likelihood of not using contraceptives was four times greater for women born outside the United States compared with those born in the United States (Upson, Reed, Prager, & Schiff, 2010).

There is also a disparity in contraceptive knowledge and rates of teen pregnancy related to ethnicity and race. Latina women exhibited lower levels of knowledge than either white or black women, and Latina women born in the United States were more knowledgeable than Latina women who immigrated to the United States. Latina women born outside of the United States were more likely to see pregnancy as something that "just happens" than white non-Latina women when they experienced an unintended pregnancy (Kendall et al., 2005). In terms of adolescent pregnancy, black and Latina females have twice the rates of pregnancy and birth as their white peers (National Campaign to Prevent Teen and Unplanned Pregnancy, 2016). As clinicians, it is helpful to be aware of these disparities in rates and knowledge to better

address specific needs. More information about rates of unintended pregnancy related to ethnicity and age, as well as how your state ranks in adolescent pregnancy and birth rate, can be found at the National Campaign to Prevent Teen and Unplanned Pregnancy Web site.

PROFESSIONAL RESPONSIBILITY

As you read in the case study, Margaret recognized that as a social worker, she could have an impact on the reproductive health access of her residents. Social workers, along with nurses and doctors, have long been primary gatekeepers of reproductive planning information. In the early 1970s, social workers displayed the greatest willingness of the three professions to become involved in birth control in their professional role (Werley, Ager, Rosen, & Shea, 1973). The NASW (2017) *Code of Ethics* continues to uphold the right to access family planning as consistent with the principles of self-determination, empowerment, and dignity that are at the core of the social work profession. NASW (2018) policy statements add, "It is vital that the social work profession keep abreast of the constantly changing policy landscape of reproductive issues and take an ethical and evidence-based position on behalf of our clients and communities" (p. 265). NASW further outlines its adherence to various national and international goals on its Web site under the Reproductive Health and Family Planning section.

In addition to our duty to individual clients, human service providers, including social workers, have been asked by HHS to increase contraception use within the community as part of national public health efforts. HHS has identified quality reproductive care as a crucial component of a strong public health agenda. Healthy People 2020 is a national 10-year health initiative that promotes reproductive care and family planning objectives. Healthy People 2020 also works with governmental agencies at the local, state, and federal levels, as well as with private and public health agencies, to provide wellness and prevention programs that focus on reproductive care. Some of the reproductive health goals of Healthy People 2020 (cited verbatim) are to

- increase the proportion of sexually experienced persons who received reproductive health services,

- increase the proportion of females in need of publicly supported contraceptive services and supplies who receive those services and supplies,
- increase the proportion of pregnancies that are intended,
- increase the proportion of females and their partners at risk of unintended pregnancies who use contraception, and
- reduce the proportion of females experiencing pregnancy despite use of a reversible contraceptive method. (HHS, 2010)

International social work organizations also support access to family planning. The International Federation of Social Workers (IFSW) has 116 members countries, including the United States. In 2014, IFSW released a policy statement that affirms the organization's support for the promotion of gender equality and the empowerment of women. IFSW states the belief that "attending to the well-being of women and girls is essential to social and economic development worldwide" (International Federation of Social Workers, 2014). Family planning is included as part of the comprehensive goals that IFSW lists in this 2014 policy statement. IFSW specifically supports access to a full range of reproductive health services in its organizational policies regarding women and cross-border reproductive services.

GAPS IN RDM INTERVENTIONS

For children and adolescents, parents are often the primary source of information about sexuality. When parents are knowledgeable, prepared to share information, and provide that information early enough, adolescents benefit from discussions with them about RDM (Santa Maria, Markham, Bluethmann, & Mullen, 2015). Research shows that when mothers talk to their children about sexuality, it both delays sexual intercourse and increases contraceptive use (Commendador, 2010). Yet, talking about sexuality and sexual health can often be difficult for parents. In a 2002 study, McNeely et al. found that many mothers feel too uncomfortable to discuss sex with their children. As a result, more than 40 percent of young adults have sex before they have had any discussion about contraception (Beckett et al., 2010). By the age of 16, about a third of young people have had sexual intercourse. And when you consider that adolescents who begin having sex at younger ages take

longer to begin using contraception, it is clear that early intervention is needed (Finer & Philbin, 2013).

If parents do decide to talk to their adolescent children about sex and birth control, the quality and amount of information they provide, as well as their beliefs and perspectives, have a significant influence on whether those young people seek reproductive health care services. A study by Hall, Moreau, and Trussell (2012) suggests that girls whose parents give them comprehensive reproductive health information are more likely to seek reproductive services than those who receive abstinence-only information. But the information must be timely and accurate. Many parents are not well versed on medical information related to different types of contraception. As a result, studies find that they underestimate the effectiveness of birth control methods and overestimate failure rates (M. E. Eisenberg, Bearinger, Sieving, Swain, & Resnick, 2004). Families need help discussing issues of sexuality and reproduction. Because many social workers meet with families, we can be at the forefront of helping parents discuss healthy relationships and RDM with their children.

Clinicians, including primary care physicians (PCPs) and practice nurses, are also first points of contact when it comes to issues of RDM, but medical doctors and nurses are often reluctant to talk about sexually related issues. General physicians and nurses may see discussing issues related to sexual health as complicating the care they are already trying to cover (Gott, Galena, Hinchliff, & Elford, 2004). Some of the specific barriers that medical professionals in the United States have cited include time constraints, lack of training and knowledge about contraception, low level of comfort, lack of monetary reimbursement, and belief that providing contraceptive services will not have an impact on unintended pregnancy (Ashton et al., 2002; Chuang et al., 2012; Henry-Reid et al., 2010). Another drawback of relying on PCPs and nurses to provide sexual education is that most adolescent girls will not seek contraceptive services if their parents must be told and do not always know their confidentiality rights (Reddy, Fleming, & Swain 2002). Confidentiality must be assured and explicit, especially for adolescents.

A 2014 study of what physicians and adolescents discussed during annual checkups found that only two-thirds of them talked about sexuality, and among those who did, the discussions averaged only 36 seconds. Every time, it was the physicians who brought up the topic.

Adolescent girls were over twice as likely to talk about sexuality than adolescent boys. Adolescents who explicitly asked to speak with their physician privately were 4.3 times more likely to talk about sexuality (Alexander et al., 2014).

Schools also have the potential to provide high-quality comprehensive sexuality education. But the quality and focus of U.S. programs for sex education vary significantly, mostly due to federal funding for abstinence-only programs. The U.S. government began funding abstinence programs in 1981, with a significant increase in federal support in 1996 (Lindberg, Santelli, & Singh, 2006), reaching $176 million annually by 2006 (Trenholm et al., 2007). When federal funding for abstinence-only education expired in 2009, an appropriations bill with $114 million marked for evidence-based adolescent pregnancy reduction was set for fiscal year 2010. However, Congress restored abstinence-only funding for 2010 and beyond, despite evidence against its effectiveness (Santelli et al., 2006; Stanger-Hall & Hall, 2011; Trenholm et al., 2007). Under President Obama, abstinence-only funding dropped again, in favor of more comprehensive sex education (Donovan, 2017), but the budget proposal from President Trump released May 22, 2017, called for $277 million to extend abstinence-only education between 2018 and 2024 (U.S. Office of Management and Budget, 2017).

Another reason sex education varies greatly is that states have very different policies. Twenty-four states and the District of Columbia mandate sex education. Of those states, only 13 require that sex education be medically accurate, and only two prohibit sex education programs from promoting religion (Guttmacher Institute, 2017). It is interesting to note that in states with policies that support abstinence-only education, the majority of parents prefer comprehensive sex education for their children (M. E. Eisenberg, Bernat, Bearinger, & Resnick, 2008; Ito et al., 2006). If sex education is provided, 18 states and the District of Columbia require that it include information on contraception, with 37 states requiring information on abstinence. Of the 37 states requiring abstinence information, 26 also require that abstinence be stressed (Guttmacher Institute, 2017). Clearly, state-level policies differ greatly within the United States regarding abstinence-only and comprehensive sex education. It cannot be assumed that clients know about reproductive health, even if they have taken a sex education course.

Abstinence-only education is not effective in reducing adolescent pregnancy. A 2008 study found that adolescents who had participated in

comprehensive sexuality education were less likely to report adolescent pregnancy than their peers who received abstinence-only education or did not receive any formal sex education (Kohler, Manhart, & Lafferty, 2008). Furthermore, a 2011 study found that those who received abstinence-only education had higher rates of adolescent pregnancy and births, even when taking into account socioeconomic status, student educational attainment, and ethnicity (Stanger-Hall & Hall, 2011). It is not surprising that NASW (2018) supports school-based sexuality and reproductive health education that includes information on reproductive health services and contraceptive methods. As social workers, in addition to filling in the gaps of knowledge for our clients, we may be able to help by advocating for research-based sexuality education programs.

Given the importance of RDM and the gaps in services, you might expect social workers to receive undergraduate, graduate, and continuing education and training in the area of contraception. Unfortunately, most of us do not. Despite NASW (2018) advocating for the inclusion of information on reproductive and sexual coercion, evidence-based risks of pregnancy, contraception, and abortion and reproductive justice in social work education, very few undergraduate and graduate school courses for social workers provide such training (Zastrow, 2014). It is unsurprising, then, that few BSW students report feeling adequately prepared to discuss issues related to sexuality with their clients (Laverman & Skiba, 2012).

Of 197 social workers who responded to M. Bell's (2015) research survey to say they were working directly with clients of reproductive age, only 9 percent had received three or more family planning trainings. Another 24 percent had received one or two trainings. Some reported that their social work education lacked attention to family planning issues. One respondent wrote that there had been "no education on this subject in grad school. I should have at least some continuing education on this subject but wouldn't know where to find it" (M. Bell, 2015, p. 291). The same research found that those who had attended at least one training were less uncomfortable providing family planning information than those who had not. This was true even for self-identified politically conservative respondents who reported feeling more uncomfortable generally with providing family planning information. In addition, open-ended responses indicated that at least some social workers with training felt that they needed additional information to remain current with reproductive technology and policies. For

example, one respondent wrote, "I have worked as a pregnancy options counselor . . . but that was 15-plus years ago and my knowledge is not as current as it could be" (M. Bell, 2015, pp. 290–291). Only about one-third of the respondents claimed to be knowledgeable about contraception. About two-thirds said that the field of social work does not provide adequate continuing education for family planning. Only 20 percent of respondents said that their social work education prepared them to discuss family planning. And only 25 percent were aware of the NASW position in support of access to family planning. It is probably not surprising, then, that only 9 percent of respondents strongly agreed with the statement "I frequently discuss family planning information with my clients" (M. Bell, 2015).

SOCIAL WORKERS' IMPACT

In the scenario at the beginning of the chapter, Margaret wants Sofia to have reliable contraceptive information so she can make informed decisions, but she does not know what to say to Sofia or where to find the information she needs. Many social workers and their clients encounter this challenging situation. The good news is that as social workers, we have an opportunity to help the people most at risk of unintended pregnancy. Research has shown that contraception counseling and access increases contraceptive use (Upson et al., 2010), and increased contraception use contributes to a decrease in unintended pregnancies, especially with teenagers (Santelli, Lindberg, Finer, & Singh, 2007). Early intervention, especially providing contraceptive counseling and providing access, can equip people with the resources they need to make informed decisions about their reproductive health. As we work with clients, it is necessary to devise individual strategies for them by considering the relationship between reproductive health and their unique backgrounds, behaviors, and beliefs. We also have to consider the historical bias and oppression that have limited personal empowerment related to family planning. As social work professionals, we are uniquely prepared to take into consideration clients' beliefs, behaviors, and social context, as well as their mental and physical state, when providing information on reproductive health. Yet we may still have personal barriers to this work or gaps in our knowledge that could be worked on, once we have identified them.

REPRODUCTIVE COUNSELING OBSTACLE SCALE

The Reproductive Counseling Obstacle Scale (RCOS; see the appendix) is intended for clinicians, administrators, teachers, and researchers to identify barriers that clinicians may be facing. A clinician can use it to self-identify areas in need of attention, or an administrator can use it to gauge the need for agencywide trainings. It can also be used to measure the effectiveness of a family planning training or to measure potential areas for further education within a classroom. The RCOS (M. M. Bell & Newhill, 2017) has been shown to have good reliability and validity. These results also show that items in the RCOS clustered around two primary areas. One area involved respondent interest in providing family planning information, respondent perception of the relevance of RDM to social work clients, respondent desire for self-efficacy in providing family planning information, and the perceived presence or abscense of workplace incentives for the respondent to discuss RDM. The other area reflected respondent views of moral concerns and their understanding of professional responsibility in discussing RDM. In chapter 2, we will discuss a model for understanding clients' decision making that you can use in working with your clients and in future chapters we will provide further strategies and skills for providing reproductive counseling. Before reading the following chapters, though, it can be useful to understand your own barriers, so that you can address them in an effort to better help your clients.

ADDITIONAL RESOURCES

Healthy People 2020, Reproductive Health and Family Planning
https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning

International Federation of Social Workers, Policies
http://ifsw.org/policies/

National Association of Social Workers, Reproductive Health and Family Planning
https://www.socialworkers.org/practice/intl/issues/reproductive.asp

National Campaign to Prevent Teen and Unplanned Pregnancy
https://thenationalcampaign.org/

There's No Place Like Home . . . for Sex Education
http://www.advocatesforyouth.org/publications/publications-a-z/589-theres-no-place-like-home-for-sex-education

Trends in Teen Pregnancy and Childbearing: Teen Births
https://www.hhs.gov/ash/oah/adolescent-development/reproductive-health-and-teen-pregnancy/teen-pregnancy-and-childbearing/trends/index.html

United Nations Population Division, World Population Prospects
https://data.worldbank.org/indicator/SP.ADO.TFRT