

Out of Compliance? Implementing the Infant Adoption Awareness Act

Legislation enacted in 2000 authorizes funding to support training for Title X family planning and other federally funded health care providers in how to provide information about adoption to women facing an unintended pregnancy “on an equal basis with all other courses of action included in nondirective counseling.” However, the experience of some family planning providers and a conversation with an adoption expert suggest that the training conducted to date and the national curriculum that was developed to support it often do not comport with best practices in either family planning or adoption—or with the training program’s statutory requirements.

By Cynthia Dailard

For a long time, some professionals in the adoption field have expressed concerns that pregnancy options counselors in publicly supported family planning clinics may not sufficiently present adoption as a realistic option for women facing an unintended pregnancy. Many anti-choice adoption proponents, who feel that adoption should be presented as the preferred option—even over parenting—for teens and unmarried women, go further. They charge that pregnancy counselors either fail to raise adoption altogether or provide women with information that is incomplete or inaccurate. As a result, they say that family planning clinics directly or indirectly “steer” women toward abortion. This presumed proabortion, antiadoption bias has spurred a long-standing campaign to prevent family planning providers from discussing abortion with women facing a crisis pregnancy and compel pregnancy counselors to actively promote adoption instead.

In 1981, Congress enacted the Adolescent Family Life Act (AFLA) to promote “chastity and self-discipline” among unmarried teens and adoption among teens who

become pregnant. Funding under the law—which remains in effect today—can only go to groups that do not “advocate, promote or encourage abortion.” Then, in 1988, the Reagan administration promulgated regulations that specifically barred counselors in family planning clinics supported by Title X of the Public Health Service Act from providing women facing an unintended pregnancy with information about abortion or a referral to an abortion provider, even in response to a direct request for such information. At the same time, counselors were required to give all patients referrals for prenatal care and delivery services. Although this “gag rule” was upheld by the U.S. Supreme Court in 1991 in a 5–4 decision, President Clinton suspended the regulation as one of his first acts in office.

The issue, however, did not go away. In 1999, Reps. Tom Bliley (R-VA), then chairman of the House committee charged with oversight of Title X, and Jim DeMint (R-SC) introduced legislation designed to essentially combine the operative provisions of the gag rule and AFLA. The legislation enumerated the various options that family planning providers would be required to discuss with clients facing an unintended pregnancy, specifically excluding abortion. At the same time, it authorized funds for a grant to a “national adoption organization” for the purpose of training Title X and other federally supported health care providers in how to “promote” adoption (“Family Planning and Adoption Promotion: New Proposals, Long-Standing Issues,” *TGR*, October 1999, page 1). From the start, the bill’s language appeared geared to support the National Council for Adoption (NCFCA), an organization that takes credit for having played a key role in developing the legislation and shares the conservative views of the bill’s sponsors.

The legislation—ultimately titled the Infant Adoption Awareness Act (IAAA)—was signed into law in 2000, but only after undergoing considerable changes in the legislative process. Gone entirely was the prohibition on discussing abortion. Instead of funding a single organization to promote adoption, the law authorized grants to national, regional or local adoption organizations to train family planning and other federally funded health care providers to provide “adoption information and referrals to pregnant women *on an equal basis with other courses of action included in nondirective counseling*” (emphasis added). In other words, the law dictates that the training comport with long-standing Title X requirements that family planning providers offer information about all the legal options available to pregnant women in a factual, nonjudgmental manner (see box).

The IAAA also required the Department of Health and Human Services (DHHS) to convene a panel of experts from a wide range of disciplines (including family plan-

ning providers) to craft best-practices guidelines that would guide the development and implementation of IAAA training and a training curriculum. These guidelines, issued in 2001, identify training goals such as imparting accurate information about the various types of adoption, state law, the role of fathers and other family members in the decision-making process, adoption services within the community and the psychological and emotional elements associated with resolving an unintended pregnancy. The guidelines also stress that training should improve counselors' basic skills in presenting "the adoption option in an objective, non-biased manner," treating clients with respect and providing "non-directive counseling to ensure that adoption information and information about other pregnancy options is presented objectively, without bias or judgment."

Implementation Issues

Following the development of these guidelines, DHHS in October 2001 announced the release of \$8.6 million to four adoption organizations. As expected, NCFCA received the lion's share of the money—\$6.1 million—to develop a national program curriculum consistent

Federal and Professional Standards for Nondirective Options Counseling

Federal regulations for the Title X family planning program require pregnancy counselors to "offer pregnant women the opportunity to be provided information and counseling regarding each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination." If such information and counseling is requested, counselors must "provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling." DHHS also elaborates that "nondirective" means that counselors "may not steer or direct clients toward selecting any option."

The Title X standards are consistent with those promulgated by major medical organizations. For example, the American College of Obstetricians and Gynecologists explains that "the best counsel will permit the involved parties to explore their options fully and make a decision that arises out of their own beliefs, values, needs and circumstances." They are also consistent with a fundamental principle of modern medical ethics known as "informed consent"—that people can make an informed decision about medical care only after they have been given full information about their condition, the risks and benefits of proposed treatments, and all possible alternatives.

with the best-practices guidelines and implement a national training program based on that curriculum. Three much smaller grants supported curricula development and statewide projects in Arizona and Michigan, and a regional project based in Tennessee. All of the curricula developed under these grants were required to receive DHHS approval prior to implementation.

Interviews conducted by The Alan Guttmacher Institute between September 2003 and July 2004 with more than 20 family planning providers located in 15 states about their IAAA training reflect decidedly mixed experiences. Many reported an overall positive experience or praised their trainers. For example, one provider was pleased with the trainers' "evenhanded approach" in discussing all the options available to pregnant women. According to Jan Lundquist, vice president of education of Planned Parenthood Centers of West Michigan, the "trainers really hammered on nonjudgmental language." Similarly, Johnny Wilson, vice president of education, Planned Parenthood of New Mexico, noted that those who conducted his training "acknowledged abortion as an option during any options counseling discussion and spoke to the importance of supporting pregnant women in whatever choice they might make."

Others expressed satisfaction with specific components of the training or with the networking opportunity it presented. Some family planning providers seemed to particularly welcome the legal session, in which adoption lawyers discussed the legal aspects of adoption and helped participants gain a better understanding of state law. Also valued was the "moving and honest" presentation of a birth mother who chose adoption, which one participant described as critically important in "bringing home the realities and emotions of making this decision—and how wonderful it can be for some families." Some attendees, moreover, simply appreciated the opportunity to build relationships with other service providers in their community, such as local adoption program directors. Marilyn Preston, director of education and outreach, InterMountain Planned Parenthood in Billings, Montana, said that the training afforded her the ability "to share information with other attendees concerning our clinic services, Title X requirements and emergency contraception."

However, the majority of family planning providers interviewed reported a far more negative training experience. The range of experiences reported may reflect the different approaches or techniques employed by the trainers. Collectively, however, the dissatisfaction expressed raises significant concerns about the implementation of the infant adoption awareness training program by NCFCA. In many respects, it also mirrors key concerns raised by an adoption expert familiar with NCFCA's training curriculum (see box, page 12).

An Adoption Expert Discusses Implementation of The Infant Adoption Awareness Act

In July, I spoke with Adam Pertman, executive director of the Evan B. Donaldson Adoption Institute and author of the book Adoption Nation, about the Infant Adoption Awareness Act. The Adoption Institute is a nonprofit organization dedicated to improving the quality of information about adoption, enhancing the understanding and perception of adoption, and advancing adoption policy and practice.—CD

CD: First of all, what is your professional opinion of the best-practices guidelines that were developed under the IAAA?

AP: I think they were put together thoughtfully; if adhered to, they would be good for both women who choose adoption and women who choose another path. I think they are a positive step for putting adoption on a level playing field with the other options available to women who are not sure they want to—or are able to—parent their children. There appears to be a problem, however, with the implementation of these guidelines by the national grantee, the National Council for Adoption. NCFCA is an umbrella organization for adoption agencies that are mostly Christian and Mormon—many of which have certain moral, religious and philosophical views that do not comport with the notion of presenting women facing an unintended pregnancy with all of their options in a neutral, unbiased way.

CD: What do you believe are the major problems with NCFCA's national curriculum?

AP: First, let me stress that I am sure many if not most of the trainers—especially those with the more regional grantees—work hard to get it right, whatever guidelines are on paper. But the curriculum itself seems to violate the spirit and the letter of the law because it does not address the concept or techniques of nondirective counseling. For instance, good practice should start with a discussion of legal requirements, professional standards for options counseling and guidance for implementing the standards in practice. It also should follow the regulatory and ethical mandates to offer counseling and obtain consent before actually providing it. But all that is barely addressed in the national training curriculum.

Furthermore, the training curriculum presents only parenting or adoption as pregnancy resolution options, without recognizing—as the law dictates—that information about all options (including abortion) should be presented to pregnant women. And the information and the manner in which it is presented appear intended to convey the sense that adoption is the only right choice; that's not nondirective by any definition.

Here's an example of how the way in which adoption is presented is so important: The curriculum presents the best interests of the "child" as paramount; that sounds just right and, in the adoption world, it's accepted as a given. But it invariably refers to children

A fundamental complaint raised by a number of participants was the directive nature of the training. In January 2004, Charles Marquardt, the program coordinator and lead trainer for the Title X training program at the California Family Health Council (the largest Title X grantee in the nation), highlighted his concerns about the training experience in a seven-page letter to his federal regional health administrators. He wrote: "The trainer promoted tactics and techniques for attempting to persuade the client to choose adoption by (1) discouraging abortion as a viable option, (2) overly promoting adoption, (3) highlighting the difficulties [the] child will encounter if [a woman] should choose to raise it herself, and (4) encouraging counselor opinions in scenarios by having the counselor choose for the client the best option." Similarly, Kelly McBride of Planned Parenthood of Indiana noted the exclusive and "constant focus on 'child-centered' counseling" and "how to inform clients

that adoption is a 'good choice for the child.'" She said she was given "tips and techniques...about how to work against [women's] resistance, make them proud of their decision and convince them that adoption is a good choice." One family planning provider from Planned Parenthood of Collier County, Florida, said she was told to repeatedly bring up adoption as an option, even if a woman says she is not interested. These examples border on coercion and clearly violate both Title X guidelines and principles of medical ethics.

Another key criticism was the negative lens through which trainers viewed clients. Marquardt noted that counselors were encouraged "to identify clients as deluded, not living in the real world, not being practical, participating in self-betrayal, being ignorant, and generally being unable to make good choices, unless...it's the choice the counselor would make for the client." He

who need homes, not ones who are not yet born. No professional standards of practice advise physicians and counselors to recommend to pregnant women that they weigh the best interests of their fetuses and as yet unidentified adoptive parents on a par with their own. This perspective implicitly furthers an agenda aimed at minimizing the option of abortion and perhaps even the option of parenting by the biological mother.

Finally, the curriculum sometimes encourages the promotion of adoption actively, both implicitly and explicitly, by making value judgments and selectively presenting information and research. Additionally, it propagates basic misperceptions about pregnant women and birth mothers, and thus perpetuates the stigmas associated with unplanned pregnancy, single parenting and adoption.

CD: What *should* be taught as part of these trainings?

AP: Whether or not to choose adoption is an extremely difficult decision with profound lifelong implications, so it should be made thoughtfully and carefully. Pregnancy counselors need to recognize this and be as humanely respectful as possible. They need to be scrupulously conscientious not just in what information they impart, but also how they impart it. Their tone is very important, for example. They need to consider whether they make women feel empowered to make the decision that is right for them or whether they bring bias to the table or are directive and disrespectful. This means that adoption awareness training should emphasize that counselors must maintain a level playing field with respect to adoption, as well as the other options available to pregnant women. My experience working with

some of the more regional program grantees—who have chosen not to follow many aspects of the national curriculum because they do not share NCFA’s views—suggests they are doing a very good job on this front.

Ultimately, a counselor needs to be able to give a woman the best available information about adoption and let her make her decision. The government’s role should be to help ensure that this is how the process works.

CD: Do you have other concerns relating to these trainings?

AP: I do. A major one that is too seldom discussed is not just whether adoption is being presented in a nondirective way, but also *what kind* of adoption is being presented. The type of adoption that the NCFA curriculum promotes is the old-style, closed, secretive and still-stigmatized form that is no longer accepted by most adoption practitioners, who favor greater honesty and openness in the process. Often, NCFA promotes closed adoption in the guise of “protecting” women. It also frames this discussion in the context of the abortion debate: If a woman is not guaranteed secrecy in her adoption, NCFA says, then she will choose abortion instead. This view is shared by some of the congressional authors of the IAAA. It is an attitude, however, that is disrespectful of women and does not reflect reality. Research simply shows it is not true. In states where there is openness relating to adoption, abortion rates are lower. Openness in adoption has occurred because birth mothers have insisted on it. They want to know what happens to their baby. So, there is a direct link to abortion in all of this.

commented that such a negative view of the client is counterproductive, by preventing the counselor from establishing a constructive rapport with the client or aiding the client to make the choice that is best for her.

Finally, a number of participants noted a hostile training environment that left them feeling uncomfortable and even unsafe. For some, this discomfort stemmed from the religious overtones to the training, which one participant noted “actually included prayer.” Marsha Gelt, from the Center for Health Training in Oakland, California, a regional training center for the Title X family planning program, said that those conducting the training she attended represented either Christian or Mormon adoption agencies (NCFA’s key constituency). She was upset by the religious nature of the training, in part because government funding was being used to sponsor the training. Similarly, Marquardt noted that

“no effort was made to provide balance to the overtly Christian tenor of the discussion” or “to correct the comments of participants who discussed the importance of placing children in ‘good Christian homes.’” Related to this was the fact that many trainers and trainees were from crisis pregnancy centers or antichoice organizations, “creating an environment that seemed to barely tolerate those in the room who were pro-choice.”

A Solution in Search of a Problem?

In November 2002, one month *after* DHHS disbursed the first round of grants for adoption training, it submitted to Congress its “initial assessment” of existing practice in family planning clinics, as required by the IAAA. The report reviews the professional standard of care for counseling pregnant women, and summarizes conversations with experts from a variety of relevant fields and

clinicians working in community health centers and family planning clinics.

Released by the administration without fanfare, the report is extremely favorable to family planning providers. First and foremost, it acknowledges that nondirective options counseling that includes information about all of a woman's options is uniformly recognized as the standard of care both in federal programs and by professional organizations. Moreover, the experts consulted were consistent in their understanding of nondirective counseling, and explained that nondirective counseling is more prevalent in federally funded family planning clinics than in the private sector—in part because patient education is more likely to be emphasized by the public sector, and because public sector programs are held to high levels of public accountability.

Those experts and clinicians interviewed also emphasized that Title X providers are already extensively trained in this area, although some clinicians indicated that they would be interested in receiving further information on adoption “to help explain the complicated legal, confidentiality, and family issues related to the adoption process.” The report concludes, however, that “infant adoption as part of non-directive counseling to pregnant women is an accepted and adhered-to standard among clinicians in federally funded health clinics.”

Clearly, the report's findings raise fundamental questions about whether the IAAA was warranted in the first place and, if so, what kind of curriculum and training might have been appropriate to improve on an already positive situation. Certainly, they raise the key question

of whether the training, at least in its current form, represents a wise ongoing investment of federal funds. Nonetheless, Congress continues to fund the program on an annual basis, even though DHHS has not yet issued a second report, also required by the IAAA, evaluating both the effectiveness of the training and whether it comports with principles of nondirective options counseling. Although it would seem that such information should be a prerequisite for the release of any additional funding for IAAA trainings, DHHS in April announced the availability of \$9 million to support up to 10 grants “for the purpose of developing and implementing new, or adapting and implementing existing” infant awareness adoption training programs; each grantee must “adapt or develop” a training curriculum. Up to \$6 million of these funds will be awarded for a project that is national in scope (presumably to renew NCFAs grant).

DHHS is expected to announce the new list of grantees in early fall. Whether this round of grant awards will result in the development of curricula and training programs that are responsive to the criticisms of many family planning providers who have attended past training remains to be seen. Meanwhile, for many, the current situation, at best, represents a potentially lost opportunity for a positive, productive and mutually satisfying collaboration between adoption educators and pregnancy counselors. At worst, it appears to run afoul of the law's statutory requirement to train federally funded health care providers in how to impart adoption information in a *nondirective* manner, as well as best practices in the fields of both family planning and adoption. ☉



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