Decision-making support within the integrated care pathway for women considering or seeking abortion

Guidance for commissioners on improving access and outcomes for women
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The purpose of this guidance

One in three women in England and Wales will have an abortion in their lifetime¹ and abortion may be accessed by women in every town and every community. Those commissioning reproductive health services are responsible for pregnancy care pathways, including pathways for abortion care.

This guidance is intended to provide information about commissioning local services to ensure that women of all ages can access the support they need to make an informed decision about their pregnancy if they are seeking or considering abortion, or are undecided about their pregnancy options. It addresses: who is best placed to provide this support; what women typically want and need when making a pregnancy decision; and how provision can meet their needs both for good quality support and for robust and timely access to abortion if they choose it. There is an outline of what should be provided at each point in the pregnancy pathway, specifically with regard to the decision-making process; and the distinction between pregnancy decision-making and consent to treatment. It includes a rationale for ensuring early access to pregnancy services and addresses women’s needs post-abortion including follow up with contraception and unresolved emotional issues.

This guidance draws on existing guidance, law, practice, and research. It does not duplicate, but seeks to complement, a range of current evidence-based good practice guidance documents on the commissioning of clinical abortion services. These include: a national service specification² from the Department of Health; evidence-based information on abortion, and guidance for clinical services and commissioners from the Royal College of Obstetricians and Gynaecologists (RCOG),³ detailed guidance for commissioners and service providers including minimum standards and audit indicators from both the Faculty of Sexual and Reproductive Healthcare (FSRH),⁴ and Medical Foundation for Aids and Sexual Health (MedFash).⁵

Why is good commissioning important?

Good commissioning should ensure that women get the support they need with pregnancy decision-making. It ensures there are well-trained professionals within the care pathway who are able to identify women who are feeling ambivalent about their decision, or experiencing coercion – both of which are associated with poorer mental health outcomes⁶ and may be associated with a reduced ability to establish an effective contraceptive regime following abortion.⁷ A care pathway that provides this support can help women to make confident, informed decisions and can reduce the stigma that is sometimes associated with abortion and which can contribute to ‘negative psychological experiences.

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post-abortion'. It can also provide a ‘triage’ process – identifying and referring those who need or want counselling or additional support from specialist services. This is especially important for women who have experienced domestic violence and mental health problems which they might be reluctant or embarrassed to raise. A skilled practitioner can ‘put their feelers out’ and create the space in which women are encouraged to identify and disclose these issues.

Good commissioning can also ensure that decision-making support services facilitate early access to the appropriate pregnancy service. Early referral can maximise the length of time a woman feels she has available to her for informed, confident decision-making prior to proceeding with abortion, can increase her opportunities to access professional support with this process, and minimise any distress associated with waiting for the procedure.

**Early referral has other benefits:** the RCOG recommends that ‘the total time from seeing the abortion provider to the procedure should not exceed 10 working days.’ Its recommendations for commissioners state that ‘an increase in the proportion of abortions performed under 10 weeks of gestation would result in significant cost savings for the NHS as a result of greater use of non-surgical and local anaesthetic methods, as well as the reduced risks to women consequent to reduced gestation.’ (additional benefits of providing abortion as early as possible are detailed in [Appendix One](#)).

In the past 10 years there have been significant improvements in access to abortion for women in England and Wales. While the abortion rate has remained relatively stable (17 per 1,000 resident women aged 15–44 in 2002; 16.5 per 1,000 in 2012) the proportion of abortions taking place early in pregnancy has increased substantially (57% of abortions took place at 9 weeks or earlier in 2002; 77% of abortions took place at 9 weeks or earlier in 2012).

These service improvements have largely been brought about by removing obstacles and delays from the system through: commissioning that has got best value from NHS and independent providers (which provide 61% of NHS-funded services); redesigning care pathways to provide more access points for abortion; and streamlining the referral process in order to reduce the number of appointments women are required to attend.

### Recommendation 1
Commissioning of services to support pregnancy decision-making should specifically aim to ensure robust and timely access to abortion procedures and antenatal care

### What does good commissioning look like?
Good commissioning will provide: holistic pathways including good quality women-centred services at every point in the care pathway and good links between services; and monitoring of the quality of services through key performance indicators, including patient experience, demonstration of clinical competence and continuing professional development (CPD).

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Commissioning decision-making support in the care pathway

Women present with unintended pregnancies at very different points in their decision-making process. Any one-size-fits-all model of provision is likely to result in some women finding the level of intervention invasive or obstructive and others finding it inadequate to meet their needs. Local care pathways for abortion should provide flexible and responsive services that allow women to spend as little or as much time as they feel they want discussing their options with a professional at the point when they need it. Where support is provided in a range of settings, it is likely to maximise the number and range of women who will find it acceptable and accessible.

**Recommendation 2**

Commissioners should map existing provision of services that support women with pregnancy decision-making and referral into abortion and ante-natal services

The care pathway for women seeking or considering abortion can be broken down into specific stages. All of these stages should offer opportunities to provide a discussion of pregnancy options and support with pregnancy decision-making with a practitioner who has received training in providing objective, evidence-informed pregnancy decision-making support based on the core principles of good practice (page 14) (for more on training see Appendix Three).

1. Free, accessible pregnancy testing in a range of primary care, education and other settings – to include information about pregnancy options and an initial pregnancy decision-making discussion

2. Information about pregnancy options and support with decision-making in a range of primary care, social care and education settings (decision-making support and/or counselling)

3. Referral/signposting to the chosen pregnancy service (antenatal care, local adoption services if relevant, or abortion care).

Then, if abortion is chosen:

4. Assessment for the abortion including obtaining ‘valid consent’ for treatment and an additional opportunity to assess need for (or for woman to request) additional support/counselling.

In practice there is often overlap between the different services within the pathway. They are not always delivered in different places or at separate appointments. Depending on commissioning arrangements and provider models, women may be able to access some services in the same place and at the same time.

This guidance focuses primarily on the steps in the pathway that provide opportunities for decision-making support, but the abortion procedure itself and follow up care including contraceptive care, STI management, and post-abortion support (if required) are all essential parts of a comprehensive care pathway.
The pregnancy care pathway

1. Pregnancy testing

Commercial pregnancy tests are very accurate, easily available and are getting more affordable. However, there are benefits to providing free tests in a range of settings including GP clinics, sexual health clinics, community-based agencies supporting women of all ages, young people’s clinics, school nurse clinics etc. Those offering tests can provide important information and advice about negative results, recommend re-testing where appropriate, and initiate discussion of/provide contraception. Positive test results carried out by trained staff can lead to immediate initiation of discussion about pregnancy options, support with pregnancy decision-making and/or referral to appropriate pregnancy services and may ensure women are supported into ante-natal care or abortion care sooner. The Department of Health recommends that service objectives include ‘access to free pregnancy tests and appropriate onward referral to abortion services or maternity care’.10

Written information (in appropriate format/language – see Appendix Four) and the opportunity to discuss pregnancy options should be provided in all settings where women have pregnancy tests or present early in pregnancy.

Written information about pregnancy options, where to access support with decision-making, and how to access different pregnancy services should be provided wherever pregnancy tests are on sale including pharmacies and supermarkets.

Recommendation 3

Free pregnancy testing should be available in a wide range of primary care, youth, education and community settings

Recommendation 4

Services which offer pregnancy testing – e.g. GP clinics, sexual health clinics, and specially trained workers in youth, education, community and social care settings, should develop protocols for supporting pregnancy decisions and onward signposting/referral to appropriate pregnancy services

Recommendation 5

Written information in appropriate language/format about pregnancy options, where to access support with decision-making, and how to access different pregnancy services should be provided wherever pregnancy tests are on sale including pharmacies and supermarkets and in any setting where women present early in pregnancy

2. Pregnancy decision-making support and informed decision-making
(sometimes called ‘information and advice-giving or options and implications counselling’)

Informed pregnancy decision making
Informed decision-making entails a pregnant woman understanding all the different pregnancy options available – and assessing the relative disadvantages and benefits of those options in the context of her unique situation, feelings, aspirations and beliefs – in order to make a decision that she can feel confident is the right one for her.

Pregnancy decision-making support
Pregnancy decision-making support is the help that can be given by an appropriate professional to facilitate the decision-making process. At its most basic, it is a ‘protected space’ in which a woman feels she has time to consider and discuss her feelings and options confidentially with a non-judgmental professional. It entails providing whatever information and type of discussion a woman thinks is relevant to her.

Pregnancy decision-making support – who needs it?
This should be a universal service that all women seeking or considering abortion should have access to at some point in the abortion pathway. Nobody should have reached the abortion procedure without an opportunity to discuss her options, ask questions and establish confidence in her decision.

Checklist – what do women want and need?
The decision-making process ‘should be confidential, non-directive, non-judgmental, supportive and understood by the woman to be independent of any assessment for legal approval for abortion.’11

Women need:
- to be seen as quickly as possible
- to be reassured of the confidentiality of the service
- to be seen alone (without their partner, family member or friend) for at least some part of the consultation, and to have an opportunity to express their feelings honestly and confidentially, or to disclose coercion or pressure in the decision-making process
- to feel confident that the information they are given is impartial, evidence-based and accurate
- to be listened to by people who are respectful and non-judgmental
- to be offered sufficient information about all their options
- to be able to ask questions
- to be informed about ‘what next’ depending on the pathway they choose
- an opportunity to establish their confidence in their decision
- an experience of decision-making which is free from stigma or negativity associated with abortion, or for some groups with parenting (e.g. younger, older, gay, transgender, or single people)
- an opportunity to think about contraceptive options post-pregnancy.

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In addition they may need or want:
- an opportunity to discuss the pros and cons/risks and benefits of all the options in relation to their current circumstances, feelings, values, plans and aspirations
- an opportunity to think about which people (professional and personal) can offer them effective support in relation to their different options
- to be signposted/referred to specialist services to help with other issues in their lives
- to be offered counselling to address more complex feelings
- for those with English as a second language or learning disabilities – tailored care such as an interpreter or advocate.

Who can provide this support?

Women are already accessing support in a range of settings, and exercising choice as to who they think will best support them in their decision-making. Pregnancy decision-making support may be formally provided and promoted by a specific service. Sometimes these conversations arise in an ad-hoc or opportunistic way for practitioners already providing a woman with some kind of care or support, or because the woman has specifically identified them as someone they can confide in. It can be provided by:

- those who offer pregnancy testing in clinical and non-clinical settings
- health visitors, midwives, practice nurses, sexual health workers, GPs or other trusted health professionals to whom women might disclose pregnancy
- youth workers
- social workers
- workers in children’s and family centres
- school nurses and others providing on-site clinics in schools
- professionals working in maternity and abortion services.

Formalising and advertising this aspect of the service could ensure the needs of a wide range of women are met and may help to: reduce the number of appointments a woman needs to attend; maximise her choice of support options; minimise the possibility of women encountering judgmental advice; minimise delays, and reduce the costs that would arise from commissioning separate or discrete services.

Practitioners offering this support must be committed to the core principles of good practice (see page 14). They should have counselling skills (see definition of terms on page 18), and have participated in good practice training which: addresses values, professional boundaries and impartiality; provides up to date evidence-based information about pregnancy options and local pregnancy pathways for both abortion and antenatal care; ensures practitioners are confident about answering women’s basic questions regarding their pregnancy options, and can signpost them into the appropriate pregnancy service for antenatal care or abortion; includes basic information on contraception and local contraceptive services; and recommends evidence-based patient literature on contraception and abortion. (For more information on training, regulation and accreditation see Appendix Three.)
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Recommendation 6
Ensure that commissioning arrangements encourage existing primary care services pro-actively to offer pregnancy decision-making support and promote this aspect of their service as part of a comprehensive sexual and reproductive health service.

Recommendation 7
Commissioners should ensure workforce development and training to provide decision-making support is incorporated into service specifications and should be provided for all those working in frontline services with women (including young women) in clinical, non-clinical and counselling settings.

Recommendation 8
Ensure that core principles of good practice are highly publicised and promoted so that women and their partners understand the nature of good quality support and their entitlement to it.

Counselling – who needs it?
Independent abortion providers report that only a small proportion (as few as 6%) of women using their service opt for formal counselling. Many women, especially those who are sure of their decision, do not feel counselling is appropriate or necessary for them and may find it intrusive. While there should be a universal offer of counselling for those who want or need it, it should not be a mandatory element of the abortion pathway. The RCOG says, ‘Women who are certain of their decision to have an abortion should not be subjected to compulsory counselling’ however, ‘healthcare staff caring for women requesting abortion should identify those who require more support in the decision-making process’.3

While most women who have had an abortion feel a sense of relief following the procedure, evidence suggests women in some circumstances may be more at risk of regret or emotional difficulties. For these women counselling with a trained and qualified counsellor ‘may help pre-empt negative outcomes and reduce the need for support after abortion’.14

This may include women:
- with previous or current experience of mental health problems15
- experiencing abortions undertaken on medical grounds15
- experiencing abortions performed later in pregnancy
- with limited social support

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14 Personal correspondence with abortion counsellor, 09/07/2012.
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• with feelings of ambivalence towards the abortion\textsuperscript{15, 16, 17}
• experiencing pressure from their partner or family to have, or not to have, an abortion
• belonging to a religious, social or cultural group which is antagonistic towards abortion
• who have been adopted, are in care, or are care leavers
• adolescents.

Not all women meeting the above criteria will have difficulty with the decision to have an abortion and others outside of these groups may express a desire, or indicate a need, for counselling.

Who can provide counselling for women considering or seeking abortion?

Counsellors should be trained at least to diploma level. They should also participate in workforce training in pregnancy decision-making support, be committed to the core principles of best practice and to timely referral of women to their chosen pregnancy service. While many counselling processes take place over an extended period, for a woman seeking or considering abortion counselling is, by necessity, time-limited and counsellors must have the skills to work within a brief time frame.

See Appendix Three for more information on counselling training, regulation and accreditation.

Recommendation 9

Counselling, provided by suitably qualified and trained counsellors, working to core principles of good practice should be available locally for those women who need/ request it before or after abortion

3. Referral and signposting

Anyone providing decision-making support or counselling women should have accurate information about where and how they can access antenatal services, abortion services and specialist adoption counselling in their area.

They should also know how to refer women and their partners into appropriate support services to meet other specific needs including:

• Those with mental health problems
• Those who have received a diagnosis of fetal anomaly
• Survivors of rape
• Those at risk of domestic abuse or violence
• Those at risk of sexual exploitation or where there are safeguarding concerns.

(For more on these issues see Appendix Four.)


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Recommendation 10
Commissioners should ensure that care pathways into all pregnancy services and other specialist services to support women are advertised and understood by all potential referrers and services providing decision-making support

4. Assessment in abortion clinic

Informed decision-making

Most women attending an abortion clinic have already been through a decision-making process and chosen abortion. However, no assumptions should be made at this point about the certainty of a woman’s decision. The clinic provides a further opportunity for exploring thoughts and feelings about the decision before an abortion takes place.

While there is no legal requirement for a woman accessing abortion to be provided with or to participate in a pregnancy options discussion, offering this is a vital aspect of good practice. The RCOG guidelines on women requesting induced abortion, state that ‘all women attending an abortion service will require a discussion to determine the degree of certainty of their decision and their understanding of its implications. Clinic staff must be sensitive to the different stages of decision-making that individual women have reached and must be able to identify those who may require additional support and counselling.’ (see Appendix Four for more information on additional support needs.)

Abortion providers expect a proportion of women to leave their service without having an abortion, following further discussion. Women who attend the initial assessment may subsequently change their mind about proceeding with an abortion or may require additional time or an additional consultation. No woman should feel under pressure to go forward with an abortion if she isn’t confident of her decision, and commissioners should expect ‘did not attend’ (DNA) rates to be higher for abortion services compared to other services and should not include a reduction in DNA as a performance indicator.

Recommendation 11
Contracts with abortion providers should include provision of pregnancy decision-making support as an integral part of their service so that it is available for women who may not have accessed it up to that point

Recommendation 12
Commissioners should not include a reduction in DNA (did not attend) statistics as a performance indicator for abortion providers

Valid consent

Once a woman has confirmed that she wants to have an abortion she will have to give ‘valid consent’ to treatment. ‘It is a general legal and ethical principle that health professionals must obtain valid consent before starting treatment or physical investigation, or providing personal care’. Establishing valid consent entails ensuring that the woman is fully informed of all her treatment options, understands and has considered the risks and/
or possible side effects of the specific procedure she has chosen and has agreed to go ahead with it. As with any medical consent the clinician in an abortion service must provide sufficient and relevant information and assess the woman’s ability to comprehend the information she has been given, and her ‘competency’ to consent. The clinician must also be satisfied that the woman is free from duress.

This process usually takes place at a pre-abortion consultation with a clinician in the abortion clinic – alongside assessment of gestation, medical history taking and explanation of the chosen abortion procedure. As this process is an intrinsic aspect of clinical provision it is not addressed in this guidance in detail. Detailed guidance on establishing consent within sexual health services is set out in the FSRH service standards and the RCOG document ‘Presenting Information on Risk’.

**STI testing and contraception provision in abortion services**

Commissioning arrangements should follow RCOG recommendations on provision of STI prevention information, screening and treatment in abortion services.

‘Ovulation occurs within one month of a first trimester abortion in over 90% of women’. For all pregnant women, irrespective of whether they proceed to abortion, it is good commissioning practice to have a contraceptive consultation offered as part of the assessment for abortion. Provision of effective contraception including, but not limited to, long-acting reversible contraception (LARC methods), is an important part of a strategy to reduce unintended conceptions following abortion. Depending on the abortion method and contraception chosen, it may be possible to provide the chosen method at the time of the abortion. If this is not appropriate or wanted, clear referral or signposting processes must be in place for women to access their chosen method of contraception as soon as possible following abortion. (See Appendix Five for more information on contraception.)

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**Recommendation 13**

Commissioning arrangements should follow RCOG recommendations on provision of STI prevention information, screening and treatment in abortion services.

**Recommendation 14**

Contraceptive advice and information should be provided during the decision-making process and assessment for abortion. Provision of appropriate contraceptive methods should be included in commissioning of abortion services and a clear referral or signposting process and pathway should be in place for timely access to contraception after abortion.

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**5. Procedure – clinical care**

Separate commissioning guidance is available on provision of abortion procedures, this is not covered here.

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6. Follow up

Post-abortion counselling

Much of the need for support after abortion may be reduced through provision of appropriate support with pregnancy decision-making. While some women feel a mixture of positive and negative feelings following abortion, many women feel relief. Most women are able to cope with this mixture of emotions and when post-abortion counselling is offered as a default part of the abortion service, take up is very low. For those whose negative feelings persist, referral to a counsellor can be helpful, and the universal offer of post abortion counselling may enable women to ask for further counselling or support. Appropriate counsellors or counselling organisations to provide this support should be identified and publicised as part of a holistic, integrated care pathway.

See recommendations 8, 9 and 17.

Contraceptive follow up

Every woman should be signposted to local services for ongoing contraceptive support if she wasn’t able to have her chosen contraceptive method provided at the time of abortion, and in case she wants an opportunity to review her choice of contraception (this may be especially important in the event that she experiences unacceptable side effects from her chosen contraceptive method).

A woman may be happy to be contacted for a follow up appointment with her GP or with a contraceptive or sexual health service. However, it is up to her whether information about her abortion is shared with her GP and all types of post-abortion follow up (by post, phone, email or text, and by the abortion provider, local contraceptive service or specialist nurse) should be agreed with the woman in advance.

Evaluation

Services should ensure that service-users are consulted on their experience including with decision-making support within the abortion care pathway (examples of questions to ask service-users – in the MedFash ‘Recommended Standards for Sexual Health Services’).

Recommendation 15

Local providers should collect data on user-satisfaction with decision-making support using examples in Recommended Standards for Sexual Health Services, MedFash

Current routes into abortion and opportunities for decision-making support

Ad hoc support in clinical and non-clinical services

As described on page 6.

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**GP support**

Many women choose to see their GP to request an abortion referral or they may assume that it is the only way to obtain a referral. The amount of support a GP provides with the decision-making process depends largely on the individual preference and skills of the GP. Some are happy to provide medical information, but do not feel confident supporting a broader discussion. GPs in areas where there are effective central booking services into abortion services, or where they know there is a structured decision-making service within the NHS locally, may be happy simply to help arrange an appointment with or signpost to one of those services. Some GPs may wish to offer impartial support themselves to help a woman explore her options or may offer additional support with decision-making from other clinicians in their practice such as a family planning or practice nurse, or a counsellor.

GPs have the right to opt out of abortion referral because of a conscientious objection. General Medical Council guidelines say that they have a duty of care to refer the woman on to a qualified colleague who does not have an objection to supporting her choice as soon as possible, and without imposing their views upon her. General Medical Council. (2013). Good Medical Practice. Available: www.gmc-uk.org/static/documents/content/GMP_2013.pdf_51447599.pdf (Last accessed: 23/05/2013).

**Recommendation 16**

GPs, nurses, midwives or other practitioners who conscientiously object to abortion must ensure alternative referral routes for women and publicise these in practice/clinic information.

**Self-referral**

**Central Booking Service**

Central Booking Services are normally in place in areas where there are two or more abortion providers. Central Booking Services can help a woman access an abortion service in her area directly without going through a GP or sexual health clinic, can identify the earliest appointment for her, and sometimes offer a choice of clinic. Clinics are able to provide abortion free of charge to women if they have a contract with the commissioning body in her GP’s area.

**Direct access to an abortion provider**

Some abortion providers in the NHS and independent sector have helpline numbers which a woman can ring to book an appointment directly into an abortion service. Clinics are then able to provide abortion free of charge to women if they have a contract with the commissioning body in her GP’s area. Women should be provided with information on self-referral in order to ‘(promote) access and reduce waiting times to abortion services and maternity care’.10

A woman who accesses a commissioned abortion clinic via a Central Booking Service or directly, should be given an opportunity to talk about her pregnancy options and decide whether abortion is the right option for her, at the clinic and/or on the phone.
Open access and drop in provision

Providing decision-making support within health services that operate on an open access basis – which allow women to make appointments without a referral from another professional – may be beneficial for reaching women who do not want to visit a GP; and may also save time and money by reducing the number of visits a woman needs to make, in order to access the service she needs.

Well publicised ‘drop in’ provision – which service-users can attend without making an appointment – especially if it is out of office hours, is useful in providing flexibility for women who: work long or antisocial hours; find it hard to make appointments; have chaotic or unpredictable lifestyles; have difficulties communicating by phone; or who need urgent help.

Independent or ‘crisis pregnancy’ centres

There are over a hundred independent pregnancy advice centres in England offering pregnancy testing and advice on unintended or ‘crisis’ pregnancy, miscarriage and post-abortion counselling. These have historically been affiliated to organisations opposed to abortion. The quality of information and support provided by these centres is extremely variable and often down to the individual staff member providing the service. Even national networks may not have processes in place to ensure consistency or assure quality of service across different centres. Some centres will not provide impartial, non-judgmental services and won’t signpost a woman to abortion services or give her information that will help her access an abortion referral even if this is what she requests, and this may or may not be stated explicitly in their service materials.

Free-standing pregnancy advice centres that are independent of NHS sexual health services, and that will not provide signposting or referral into abortion services, may obstruct or delay access to abortion for women and entail additional costs for commissioners. Moreover, these services may not be able or willing to provide information and advice about contraception or other sexual health information, or otherwise meet the practical and ethical requirements of good care. A checklist of ways in which to assess these centres including mystery shopping is available.\(^{22}\) (More information on auditing of services is in Appendix Two.)

There is qualitative evidence about the nature of these centres and the variable quality of their practices, including practice that is deliberately obstructive.\(^ {23}\) However, there is currently no data available at national level about how many women attending these centres go on to access an abortion service or whether overall attendance at these clinics facilitates, delays or obstructs access to abortion.

**Recommendation 17**

Commissioners should only commission services that can provide evidence that they are working to the core best practice principles and to evidence-based guidelines such as those produced by the RCOG

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Core principles of best practice in commissioning pregnancy decision-making support

**Equalities**

Under the Equality Act 2010\(^{24}\) health services have a duty to ensure equal access to all users. They need to ensure that no user is at a disadvantage accessing a service as a result of their age, disability, gender reassignment, marriage or civil partnership status, race, religion or belief, sex or sexual orientation.

**Timely referral – reducing unnecessary delays**

It is essential that a woman can access ante-natal care or abortion care as quickly as possible. Any practice that, by design or default, unnecessarily delays access to the appropriate clinical service is unacceptable.

For a woman choosing to continue with pregnancy, receiving essential health and lifestyle advice and access to good antenatal care in early pregnancy is important. NICE recommends that women have their first antenatal booking appointment by 10 weeks.\(^{25}\)

If a woman chooses abortion, accessing it as quickly as possible has benefits for both clinical care and the woman’s experience. There is no evidence to support built-in delay, by creating additional steps, or ‘cooling off’ periods in care pathways.

**Evidence-based, accurate information**

All information provided to women should be of good quality, evidence-based and from a reputable source e.g. DH, RCOG, FRSH, FPA, Brook, local NHS or independent abortion provider. Patient information provided by the RCOG\(^{26}\) draws on large reviews of current research literature. Leaflets provided by local commissioning groups and service providers are particularly useful when they include local pathway and service information.

**Impartiality**

Research indicates that pressure or coercion in pregnancy decision-making has negative outcomes for the woman, increasing the risk of regret.\(^{8}\) Support with pregnancy decision-making should be provided by those who are genuinely prepared to facilitate access to whichever pregnancy option the woman chooses and have not undertaken this work with the intention of promoting a particular pregnancy option or obstructing access to one.

**Conscientious objection – refusal to refer**

The right of doctors (under the 1967 Abortion Act) to conscientiously object to participating in the process of abortion ‘does not entitle them to impede or deny access to lawful abortion’.\(^{27}\) Doctors who opt-out of referring women for abortion must ensure they are quickly referred to a doctor or other suitably qualified colleague who will help. They must not ‘express [their] personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or that are likely to cause them distress’.\(^{21}\)

Nurses and midwives also have the right to refuse participation in abortion, but are bound ‘to at all times adhere to the principles contained within the code: Standards of conduct, performance and ethics for nurses and midwives’.\(^{28}\)


Woman-centred practice
Professionals working with individual women should not let wider policy considerations (such as local targets to reduce the abortion or repeat abortion rate or to reduce the number of teenage maternities) compromise their ability to support each individual woman in making the choice and accessing the service that she believes is best for her at this time.

Transparency
Services should be transparent about what they can and cannot offer e.g. if they cannot or will not provide evidence-based information on abortion, impartial support, or facilitate help accessing abortion, or if they are opposed to abortion and will only offer support for continuing a pregnancy they should make this explicit in service information.

Inappropriate medical interventions
Services should be discouraged from the gratuitous use of interventions such as ultrasound – especially in a non-clinical setting – where there is no diagnostic purpose or medical benefit for the presenting woman, and where she will be offered this at a later point in a clinical setting if it is necessary in order to assess the gestational stage or health of the pregnancy.29

Stigma
Services must demonstrate a non-judgmental approach, respect for women and acceptance of their choices. Integrating abortion services into other sexual health services may help to mainstream abortion and decrease stigma.

Pressure
No pressure should be applied on women to ‘see-through’ an abortion referral. It should be made explicit that she can change her mind and opt to continue the pregnancy at any time. Women are often trying to ‘negotiate the tension between progressing gestation and ambivalence’.30 Professionals can help in this process by building flexibility into pathways, allowing women to book into services before they have completed their decision-making process, and to opt out of abortion referral at any point.

30 Verbal communication with abortion counsellor.
Summary core principles of best practice in decision-making support

Services, and those working within them, should be committed to the principle of reproductive control and the right of the women to choose whether or not to continue a pregnancy.

Services provided in primary care, community and abortion services should be:

1. Accessible and free
2. Timely
3. Evidence-based
4. Impartial
5. Confidential
6. Women-centred
7. Transparent
8. Respectful.

Services should also:

- Expedite access to appropriate services
- Provide an opportunity to discuss options for post-pregnancy contraception
- Meet the diverse needs of the population.

And should reflect the duty to:

- Provide services within an equalities framework
- Mitigate potential delays caused by conscientious objection
- Protect women from inappropriate medical interventions
- Create an environment free from pressure or coercion
- Reduce stigma.
### Commissioners’ checklist of recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Commissioning of services to support pregnancy decision-making should specifically aim to ensure robust and timely access to abortion procedures and antenatal care</td>
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<tr>
<td>2</td>
<td>Commissioners should map existing provision of services that support women with pregnancy decision-making and referral into abortion and antenatal services</td>
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<td>3</td>
<td>Free pregnancy testing should be available in a wide range of primary care, youth, education and community settings</td>
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<td>4</td>
<td>Services which offer pregnancy testing – e.g. GP clinics, sexual health clinics, and specially trained workers in youth, education, community and social care settings, should develop protocols for supporting pregnancy decisions and onward signposting/referral to appropriate pregnancy services</td>
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<tr>
<td>5</td>
<td>Written information in appropriate language/format about pregnancy options, where to access support with decision-making, and how to access different pregnancy services should be provided wherever pregnancy tests are on sale including pharmacies and supermarkets and in any setting where women present early in pregnancy</td>
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<tr>
<td>6</td>
<td>Ensure that commissioning arrangements encourage existing primary care services pro-actively to offer pregnancy decision-making support and promote this aspect of their service as part of a comprehensive sexual and reproductive health service</td>
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<tr>
<td>7</td>
<td>Commissioners should ensure that workforce development and training to provide decision-making support is incorporated into service specifications and should be provided for all those working in frontline services with women (including young women) in clinical, non-clinical and counselling settings</td>
</tr>
<tr>
<td>8</td>
<td>Ensure that core principles of good practice are highly publicised and promoted so that women and their partners understand the nature of good quality support and their entitlement to it</td>
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<tr>
<td>9</td>
<td>Counselling, provided by suitably qualified and trained counsellors, working to core principles of good practice should be available locally for those women who need/request it before or after abortion</td>
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<tr>
<td>10</td>
<td>Commissioners should ensure that care pathways into all pregnancy services and other specialist services to support women are advertised and understood by all potential referrers and services providing decision-making support</td>
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<tr>
<td>11</td>
<td>Contracts with abortion providers should include provision of pregnancy decision-making support as an integral part of their service so that it is available for women who may not have accessed it up to that point</td>
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<tr>
<td>12</td>
<td>Commissioners should not include a reduction in DNA (did not attend) statistics as a performance indicator for abortion providers</td>
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<tr>
<td>13</td>
<td>Commissioning arrangements should follow RCOG recommendations on provision of STI prevention information, screening and treatment in abortion services</td>
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<tr>
<td>14</td>
<td>Contraceptive advice and information should be provided during the decision-making process and assessment for abortion. Provision of appropriate contraceptive methods should be included in commissioning of abortion services and a clear referral process and pathway should be in place for women to have timely access contraception after abortion</td>
</tr>
<tr>
<td>15</td>
<td>Local providers should collect data on user-satisfaction with decision-making support using examples in Recommended Standards for Sexual Health Services, MedFlash</td>
</tr>
<tr>
<td>16</td>
<td>GPs, nurses, midwives or other practitioners who conscientiously object to abortion must ensure alternative referral routes for women and publicise these in practice/clinic information</td>
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<tr>
<td>17</td>
<td>Commissioners should only commission services that can provide evidence that they are working to the core best practice principles and to evidence-based guidelines such as those produced by the RCOG</td>
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</tbody>
</table>
Decision-making support within the integrated care pathway for women considering or seeking abortion

**Terms used in this guidance**

**Woman**
The word *woman* is used throughout this document in place of patient. This is a conscious decision to reflect the fact that most pregnancy is not an illness and most pregnant women are well.

We recognise that some people who are not women (e.g. transgender men) may also need access to pregnancy testing and the whole range of reproductive options and health services.

**Clinician**
The word clinician is used here to refer to all healthcare professionals involved in direct clinical patient care including doctors, nurses and midwives.

**Sexual health services**
This term is used in this document to include family planning clinics, contraceptive clinics, GUM clinics, and CASH (integrated contraceptive and sexual health) clinics.

**Counselling skills/counsellor/ counselling**
Many clinicians and non-clinicians have training in basic ‘counselling skills’, which can support them to facilitate a discussion of pregnancy options using appropriate professional boundaries to create a safe space, using active listening techniques, and verbal and non-verbal communication.

‘Counselling’ is used to describe a formal process provided by a trained ‘counsellor’ who can work with people to identify and reflect on present or past feelings of conflict, sadness or loss, which may be obstacles to decision-making, and can engender a sense of empowerment about the current choice using a range of therapeutic approaches and techniques.

The term counsellor in this document is used to describe a professional who is qualified to at least diploma level and has extensive experience of clinically supervised practice (more information on training in Appendix Three).

**Pregnancy decision-making support**
Is the term used in this document to describe the discussions that take place between a woman and a range of clinical and non-clinical practitioners aimed at helping her to make an informed decision about her pregnancy.

**Literature cited**
It was not within the scope of this project to carry out a comprehensive literature review of all research pertaining to the issue of abortion counselling and abortion outcomes. We have relied heavily on the work of the Royal College of Obstetricians and Gynaecologists, which carried out a comprehensive literature review as part the process of writing its abortion guidelines; and the National Collaborating Centre for Mental Health which carried out a review of literature on mental health outcomes of induced abortion. Both the RCOG and NCCMH use a rigorous process of grading literature against set eligibility criteria.

Additional literature includes guidance from professional bodies in the UK which is current in terms of health policy, and is in current use by health professionals; and abortion statistics published by the Department of Health.
Appendix One

Benefits of providing abortion as early as possible

- ‘abortion is a safe procedure for which major complications and mortality are rare at all gestations’ but the earlier it is performed the safer it is
- early referral allows abortion providers to offer more opportunities for women to attend and discuss their options and achieve a confident decision
- women who are sure of their decision can avoid any distress associated with waiting for the procedure
- women who access abortion early might be provided with a choice of clinic, a choice of pain relief/anaesthesia and a choice of procedure, including Early Medical Abortion
- most women in England can access abortion in their own area in the first 12 weeks of pregnancy, but as pregnancy progresses women are more likely to have the complication and cost of travel and accommodation for procedures that take place further from home
- earlier abortions are cheaper, placing less financial burden on the funder (normally the commissioner – 96% of abortions were NHS funded in 2011).

Appendix Two

Auditing services for ethical practice

For organisations with and without external accreditation or professional membership, evidence of commitment and adherence to the core principles of best practice, and participation in workforce training may be the best guarantees of ethical and high quality service. All sensible measures should be taken to assess local services’ commitment and adherence to the core principles of best practice in decision-making support. This may include:

- an audit of print and web-based materials provided by an organisation – checking for accuracy, impartiality or bias, appropriateness of images and language used
- an investigation of the ethos of those running, governing and funding the service in relation to all pregnancy options including abortion
- audit of training and training materials provided to staff
- observation of services provided, including education work in schools
- mystery shopping of services.

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Appendix Three
Who can provide pregnancy decision-making support?

What skills, experience, and knowledge is needed by people providing this?

- Someone with a commitment to providing impartial, non-judgmental support and to the core principles of best practice
- It is not necessary for this person to be a trained counsellor, but they should have been trained in information and support-giving and have good basic counselling skills
- A basic understanding of, and access to, some key evidence-based information and literature from reliable sources about abortion time limits, procedures and outcomes; and good knowledge of local referral pathways
- Someone with knowledge of care pathways for women continuing pregnancy and basic knowledge of the adoption process
- Someone with basic knowledge of contraceptive methods, and information about local services to support an initial discussion about contraception
- Someone who is clear about the scope and limitation of their remit, knowledge and skills
- Someone who understands appropriate terminology, as use of words can deliberately or inadvertently influence a woman’s decision in relation to pregnancy, abortion and contraception.

Workforce training specification

Training to provide support with pregnancy decision-making, to include:

- Exploration of personal values in relation to pregnancy options and maintaining professional boundaries
- How to provide accurate information
- How to facilitate a conversation about pregnancy options
- Techniques to maintain impartiality and use neutral language
- Ways to assess the confidence or ambivalence of the woman
- Ability to identify women who need additional support and ability to signpost to appropriate services where necessary.

An EFC toolkit provides more information on best practice in pregnancy decision-making support. Training programmes aimed at providing impartial, evidence-based support based on good practice principles are available from EFC and FPA.

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Decision-making support within the integrated care pathway for women considering or seeking abortion

Training for counsellors

Those offering formal counselling should be trained to diploma level and will have carried out many hours of supervised clinical practice. Counsellors should also participate in training to provide pregnancy decision-making support (see above).

Existing regulation

Apart from Department of Health regulated Pregnancy Advice Bureaux (PABx) – which are situated within sexual health and abortion services (a system under review at the time of publication) – there is no regulation of organisations that provide support with pregnancy decision-making. This lack of regulation may create opportunities for unethical practice by those who have a specific agenda around abortion or simply poor practice by those without the complete skills and knowledge to provide appropriate support.

Accreditation in counselling and information provision

Counselling

Some people providing pregnancy decision-making support are members of professional membership bodies (one example is the British Association for Counselling and Psychotherapy – BACP). However, these bodies do not provide specific training, accreditation or assessment for professionals working in pregnancy options support and there is evidence that not all practitioners who are members of such bodies comply with good practice standards in pregnancy options work.34

Kitemarking bodies e.g. the Information Standard may provide accreditation of an organisation’s recently published print resources. This does not provide any quality assurance for older publications, information on websites or other services (such as pregnancy options or post-abortion counselling) provided by the same organisation.

Information provision

Equally, lack of accreditation does not necessarily indicate lack of quality, but may reflect the fact that support work done by some practitioners is a small, often unfunded and unscheduled, element of their work. Many unaccredited, unaffiliated practitioners and organisations such as youth work or community organisations may provide good quality support on an informal, ad hoc basis.

Appendix Four

Women with additional support needs

Those offering counselling or support with pregnancy decision-making should also know how to refer women and their partners into appropriate support services to meet other specific needs such as:

- Mental health
- Youth
- Diagnosis of fetal anomaly
- Following rape
- Domestic abuse or violence (DV)
- Sexual exploitation/child protection
- Women with additional communication needs
- Support around female genital mutilation (FGM).

Mental health – it is important to identify those with existing mental health needs. Pre-existing mental health conditions can indicate increased risk of poorer pregnancy outcomes. Those with previous experience of mental health problems are more likely to have a negative emotional response to abortion, and are more vulnerable to post-natal depression and post-partum psychosis following childbirth. All those involved in pregnancy care pathways should have a good knowledge of local services to support those with mental health issues, and speedy referral routes into acute services and Child and Adolescent Mental Health Services.

Youth – young people may be less likely to have had an opportunity to formulate their own views and feelings on pregnancy and may have had less exposure to information about pregnancy options. They may also be more vulnerable to pressure or coercion from partners or families. In addition they may need specific support to disclose their pregnancy to parents/carers, or to proceed with abortion alone, without the support of family members. They are at risk of presenting later in pregnancy, and therefore may need to access abortion more quickly than is normal in their area. It may be necessary to provide additional practical or financial support with reaching services.

Teenage mothers are at higher risk of adverse pregnancy outcomes including low birth weight babies and post-natal depression. Early access to tailored ante-natal services is

essential for those continuing with pregnancy.\textsuperscript{40,41} Training in child protection/safeguarding processes for all those in frontline services with children and young people, is essential (see sexual exploitation/safeguarding below).

**Fetal anomaly** – a small proportion of pregnancies are ended because a woman has been given a diagnosis of fetal anomaly. This diagnosis will have come several weeks into (often a much wanted) pregnancy and can be devastating for the woman and her partner. In this situation they ‘may require expert help on the implications of the tests and nature of the diagnosed condition, and with the feelings of loss that may accompany the decision to end a wanted pregnancy.’\textsuperscript{42} ‘It should not be assumed that, even in the presence of an obviously fatal condition such as anencephaly, a woman will choose to have a termination. A decision to decline the offer of termination must be fully supported’.\textsuperscript{43} Specialist training and resources are available for frontline staff working in screening services who are required to provide support in this situation. Antenatal Results and Choices (ARC)\textsuperscript{44} provides a national helpline and information resources for women and their families making a decision following a diagnosis of fetal anomaly; and training for professionals supporting them.

**Following rape** – women who have been raped may need additional support with the decision-making process, but also with dealing with the emotional impact of the rape and legal proceedings, if the rape has been reported. It is vital that women in this situation can be given swift access to expert services (local to them) which can help with both.\textsuperscript{44}

**Domestic abuse or violence (DV)** – there is evidence that the incidence and intensity of intimate relationship violence often increases in pregnancy.\textsuperscript{45} Women requesting abortion may be at higher risk of having experienced violence.\textsuperscript{46} Women who continue with their pregnancy in this context are at increased risk of adverse birth outcomes such as pre-term birth.\textsuperscript{47} Therefore those talking to women about their pregnancy options in any setting need to have information in place to help women to access appropriate DV services that are local to their homes rather than the abortion service, which may be a long way from where they live. A protocol should be developed to address situations where it is not considered safe for the woman to return home.

**Sexual exploitation/safeguarding** – staff within abortion services should be trained in safeguarding, and to know who to contact to report concerns about child protection or sexual exploitation.\textsuperscript{48} A protocol should be developed to address situations where it is not considered safe for the woman to return home.

**Women with additional communication needs** – staff within referral and abortion services should have visual resources available to help explain pregnancy options to women with learning difficulties, those with English as a second language, or low literacy.

\textsuperscript{42} Antenatal Results and Choices. Available at: www.arc-uk.org (Accessed: 28/11/2013).
levels.\textsuperscript{49} Research by Deafax found that those with hearing impairment are at increased risk of having missed out on sexual health information. It emphasises the importance of providing appropriate resources and, where necessary, interpreters\textsuperscript{50}.

**Female genital mutilation (FGM)** – staff within referral and abortion services should be able to signpost women to resources and specialist clinical care and support for women who have experienced FGM.\textsuperscript{51}\textsuperscript{52} FGM is a form of child abuse and performing FGM is a criminal offence in the UK. FGM can be reported directly to the police via a dedicated service\textsuperscript{53} or to the NSPCC\textsuperscript{54} which can make a referral to statutory services.

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**Appendix Five**

**Information and advice about contraception before abortion**

Many women seek pregnancy options advice because they did not intend to get pregnant. At this point they may be strongly motivated to use contraception to prevent future unintended pregnancy. It is likely that a woman’s use or non-use of contraception will be part of the discussion about her current pregnancy, and this can be a good opportunity to provide information about different contraceptive methods. However, services should avoid making women feel guilty or inadequate for becoming pregnant unintentionally.

It should not be assumed that all women seeking abortion want to prevent future pregnancy. Women who have opted to end wanted pregnancies because of their own health or a diagnosis of fetal anomaly may want to conceive again soon and may be distressed by being expected to participate in a discussion about contraception.

All women seeking abortion should be informed that most women experience a rapid return to full fertility after abortion: ‘ovulation can return as early as 2 weeks after abortion putting her at risk of pregnancy unless an effective contraceptive method is used’.\textsuperscript{55}

In some services the process of contraceptive decision-making is recorded in order to provide follow-up and audit how well women were supported to choose and use an appropriate contraceptive method.

Resources on different contraceptive options are available here.\textsuperscript{56}


\textsuperscript{54} NSPCC 24-hour FGM helpline on 0800 028 3550 or email fgmhelp@nspcc.org.uk.


\textsuperscript{56} www.fpa.org.uk/professionals/publicationsandresources/contraceptionbooks (Accessed: 30/05/2013).
Appendix Six

Decision-making support flowchart

Woman attends GP, sexual health clinic, midwife, community service or young people’s sexual health clinic to discuss her pregnancy. She may have some discussion about her options at this stage. She can be referred from here to an abortion provider if she thinks she might/does want an abortion or may choose to go somewhere else for support and advice or access to counselling.

Woman chooses to go to alternative counselling*. From here she may be signposted to ante-natal or abortion services.

*not all independent advice centres give accurate information or impartial advice

Woman thinks she might want an abortion and phones the helpline at an abortion provider. Some providers will offer an abortion consultation at a clinic and some a telephone consultation and telephone counselling.

Whether a woman can book herself directly into a service or access telephone consultation and counselling is dependent on local commissioning arrangements.

Woman attends for an appointment with the abortion provider at which she will see a staff member who will establish whether she wants to proceed to abortion. The length of this discussion will vary widely from woman to woman depending on her needs. This stage can provide an additional assessment of confidence in her decision/need for additional information. If she opts for abortion she will also have a clinical consultation to provide information, discuss issues relevant to her health, give her information about her options and establish her ability to give valid consent.

Woman chooses not to have an abortion and is signposted to GP/midwifery services and adoption services if appropriate.

Woman attends abortion clinic for a surgical abortion or for the first part of her medical abortion. For medical abortion a woman attends an additional time to be given the medication that completes the procedure.

Woman seeks referral for support/counselling following the abortion from the abortion service/GP/other service.

Woman returns to clinic or gets follow-up with her own GP or sexual health clinic for ongoing contraceptive care.

Antenatal care (and local adoption services if appropriate).
Acknowledgements

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This guidance is endorsed by the Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists

The Faculty of Sexual and Reproductive Healthcare is a faculty of the Royal College of Obstetricians and Gynaecologists. The Faculty grants diplomas, certificates, fellowships and equivalent recognition of specialist knowledge and skills in sexual and reproductive health care. As a body it promotes conferences and lectures, provides a clinical advisory service and publishes the Journal of Family Planning and Reproductive Health Care.

www.fsrh.org

Brook is the UK’s leading provider of sexual health services, education and advice for young people under 25. The charity has 50 years of experience working with young people and has services across the UK. Brook’s clinical, helpline, counselling and education services reach more than 280,000 young people every year.

www.brook.org.uk
Registered charity number 703015

The sexual health charity FPA gives straightforward information, advice and support on sexual health, sex and relationships to everyone in the UK. FPA educates, informs and supports people through its specialist sexual health programmes, helpline and information service, counselling service, training and publications and public awareness campaigns.

www.fpa.org.uk
Registered charity number 250187