Providence College
**DigitalCommons@Providence**

Social Work Theses | Social Work

Spring 2012

# Is Mental Illness an Access Barrier to Seeking and Receiving Abortion Services?

Miranda Cummings
*Providence College*

Follow this and additional works at: http://digitalcommons.providence.edu/socialwrk_students

Part of the Social Work Commons

Cummings, Miranda, "Is Mental Illness an Access Barrier to Seeking and Receiving Abortion Services?" (2012). *Social Work Theses*. 86.
http://digitalcommons.providence.edu/socialwrk_students/86

It is permitted to copy, distribute, display, and perform this work under the following conditions: (1) the original author(s) must be given proper attribution; (2) this work may not be used for commercial purposes; (3) users must make these conditions clearly known for any reuse or distribution of this work.

# Is Mental Illness an Access Barrier to Seeking and Receiving Abortion Services?

Miranda Cummings

Providence College

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Bachelor of Arts in Social Work.

2012

Abstract

This study examines the relationship between one's mental health status and access to abortion services. A review of the literature confirms that no prior research has been completed to determine whether or not mental health status is a barrier to seeking and/or receiving abortion services. A qualitative study using professionals from the mental health and abortion service fields was conducted to explore this relationship. Findings suggest that there are implications for some individuals experiencing mental illness. Another finding concludes that mental illness may be a secondary access barrier if one's health insurance is provided by governmental funds. An implication for future research pertains to examining the degree to which mental illness may be a primary barrier to accessing abortion services.

**Is Mental Illness an Access Barrier to Seeking and Receiving Abortion Services?**

It is well-known that abortion is a controversial moral, social, and political issue, especially in the United States. Because of its status in the United States, women who consider or have abortions, as well as providers and supporters of such services, face stigmatization from society. As a result of that stigma, policies have been created at all levels of government that restrict the right for women to have medically induced abortions.

When access to services of any type is restricted, marginalized populations within society are most likely to experience these restrictions. Common populations that have difficulty accessing reproductive services include minority, low-income, and adolescent women. One population whose relationship to access to these services that has yet to be considered is women who struggle with mental illness. It stands to reason that because mental health status is a variable that results in limited access to other resources and services because of the stigma associated with mental illness, then this population may also experience barriers to reproductive services.

The intent of this research is to review the stigma of mental illness and receiving mental health services, as well as examining marginalized populations that face barriers to accessing abortion services within the United States. Changing attitudes about each issue coincide with policy changes, which are also summarized in the literature review. After reviewing the literature, it is apparent that scholars have yet to explore whether such a relationship between mental health status and access to abortion services exists. In order to discover whether this relationship has been considered, reproductive service providers will be interviewed to determine whether mental health status is recorded in intake forms and whether that data is analyzed by the agency to better address this population, should it exist. It is important to also interview mental

health service organizations to discover if they provide any resources for clients who need help acquiring reproductive services.

Through these interviews with field employers and administrators, propositions can be made regarding what steps, if any, should be taken to empirically research the relationship between mental health status and access to reproductive services. This topic of study is relevant to the social work profession because social workers act as advocates of marginalized populations and as resources for their clients. This relationship is understudied; therefore, it is a responsibility that social workers must advocate on behalf of the mentally ill to ensure that this population has access to services, such as reproductive services, that are equal to the rest of society.

## Review of Literature

### A Summary of Federal Mental Health and Addiction Parity in the United States

Although progress has been made in recent decades, especially during the first decade of the new millennium, federal mental health and addiction parity in the United States has yet to be fully actualized. Parity intends to reduce the difference in access to and cost of services for behavioral healthcare under large group health insurance plans (Burns, 2009; Garcia, 2008). It is important to understand the role of parity as a sign of decreasing the stigma of mental illness and receiving mental health services. As the status of parity improves, one can logically assume that more individuals will have access to behavioral healthcare services. Through these services, individuals can become more aware of their behavioral health status. As the purpose of this paper is to explore whether one’s behavioral health status influences access to reproductive services, it is sensible to briefly review the status of mental health parity.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity (MHPAE) Act was passed as a provision of the Emergency Economic Stabilization Act of 2008. The intent of MHPAE is to "elminat[e] historical differences in group health insurance coverage for mental health and substance abuse (MH/SA) benefits and medical/surgical benefits" (Barry et al., 2010, p. 405). This Act is expected to affect coverage for 140 million Americans under both private and state and local government plans. Although such a high number of people are to be affected under this Act, a major form of resistance to parity regards its costs for providers and beneficiaries. It is estimated, however, that parity under this Act "will increase premiums by four-tenths of 1 percent, or $25.4 billion, over a ten-year period" (Barry et al., 2010, p. 405).

Prior to the passage of MHPAE, the costs MH/SA services covered under insurance packages were not equal to generalist healthcare services provided by insurance companies; this inequality derived from the belief that mental health services is not as important as physical health services. Under this Act, however, benefits for both types of coverage, if provided (because MH/SA coverage is not mandatory under the Act), must be equal. While the Act does not require that specific conditions be covered, it does mandate that the "[s]ervices are covered for those mental health conditions and substance use disorders [that are] defined under the terms of a [given] health plan" (Barry et al., 2010, p. 407).

The passing of MHPAE indicates that progress has been made with respect to viewing mental illness with the same level of importance as physical illness. Progress still needs to be made, though, for providing equal services within the United States healthcare system. Although progress towards complete parity has been accomplished, there continues to be stigma surrounding the seeking and the use of mental healthcare services.

**Stigma and Prejudice toward Individuals with Mental Illness**

As noted in the previous section, gains have been made in terms of parity; however, the stigma of seeking mental health services does continue to exist in society, which can have an effect on individuals seeking treatment and recovery services. In Conner et al., Diala et al. (2000) conducted a study which indicates "African Americans and White Americans with negative attitudes toward treatment were five times less likely to seek mental health services than individuals with more positive attitudes toward treatment" (2009, p. 696). According to Conner et al., "African Americans are also more likely to be stigmatized in relation to mental illness than their White counterparts" (p. 697). These conclusions indicate that stigma associated with mental health adversely affects the likelihood of people seeking services for mental illness and other forms of treatment.

In addition to attitudes about mental health status, terminology used to describe mental illness in itself is stigmatizing. The phrases "mental illness" and "mental disorders" were constructed under a medical model of understanding the conditions people were facing (Burns, 2009). This language frames mental health as a sickness of which an individual needs to be cured. By calling someone mentally ill, that individual is reduced to an illness and stripped of personhood. It is because of this framing language that stereotypes defining people with mental health conditions as crazy are created, which result in further stigmatization.

Although improvements in access to mental health care services have occurred in America over the past few decades, the public still has a negative stereotype for those who have mental health conditions. Knowledge within the public regarding mental health and substance abuse are both "minimal," resulting in the promulgation of this stigma for this population (Burns, 2009, p. 21). Individuals who are aware of these stereotypes, consequently, internalize that sentiment. As a result of the associated stigma, people are less likely to seek out mental health

services (Conner, Koeske, & Brown, 2009). The diagnosis itself can also create a barrier to access to receiving health care in that individual's future because of the negative association with seeking treatment options (Burns, 2009, p. 23).

**Stigma Regarding Abortion Services**

Induced abortion is one of the most common medical procedures in the United States (Kumar et al., 2009; Harper et al., 2005; Fried, 2000). Most abortions (90%) "occur [during] the first trimester (by 12 weeks gestation), and more than 98% are done by 20 weeks gestation" (Harper et al., 2005, p. 504). In 1973, *Roe v. Wade* established that the right to have a medically induced abortion was protected under the Fourth Amendment. Although *Roe v. Wade* protects a woman's right to have an abortion, "there has been a sustained effort by anti-choice forces to undermine these rights" (Fried, 2000, p. 178). Federal and state laws have been passed following the decision to restrict access to abortion services. In 1992, *Planned Parenthood v. Casey* upheld this right, but it also established that states have "the right to enact restrictions that do not create an 'undue burden' for women seeking abortion (Harper et al., 2005, p. 501). This decision has resulted in states imposing laws and regulations on abortion services and access to those services. Such restrictions include "zoning rules, state licensing, and inspection requirements," and they "explain the concentration of abortions in specialized abortion clinics" (Harper et al., 2005, p. 501). Other restrictions also include "state-mandated waiting periods and counseling topics, such as showing women sonographic or other images of fetal development, parental involvement for minors, and insurance restrictions" (Harper et al., 2005, p. 501). Barriers to access also include time limits imposed by individual clinics as well as the cost of abortions, which can adversely affect low-income women seeking abortion services (Jones & Kooistra, 2011).

The 1977 Hyde Amendment prevents the federal government from funding abortion services; Medicaid is only able to fund abortions in cases of rape, incest, or endangerment of the mother (Harper et al., 2005; Fried, 2000). Subsequent pieces of legislation have also been passed to prohibit federally funded abortion services for “Native Americans, federal employees and their dependents, Peace Corps volunteers, low-income residents of Washington, DC, federal prisoners, military personnel and their dependents, and disabled women who rely on Medicare” (American Civil Liberties Union, 2012, para. 4). Prior to the Hyde Amendment, the federal government paid for approximately two thirds of all abortions (Fried, 2000). Because of the restrictions enacted by this law, clinics currently provide 93% of abortions, whereas hospitals and physician offices provide 5% and 2%, respectively (Harper et al., 2005, p. 504). There are abortion clinics in only 87% of counties in the United States (Harper et al., 2005; Jones & Kooistra, 2011). Few physicians provide abortion services; in addition to laws that impose restrictions, abortion clinics, their workers, and their clients experience harassment from individuals protesting outside of clinics, which has affected the number of providers in the United States. Although the 1994 Freedom of Access to Clinic Entrances Act of 1994 “prohibit[s] property damage, use of force or threat of force, or obstruction of someone entering a clinic,” harassment from protesters continues to be a problem outside of abortion clinics (Harper et al., 2005, p. 503). According to Henshaw and Finer (2003), “56% of all nonhospital [abortion service] providers experience at least one of five types of harassment – picketing; picketing coupled with physical contact with or blocking clients; vandalism (such as jamming of locks or other physical damage); picketing of the homes of staff; and bomb threats” (p. 22). The number of abortion providers peaked in 1982 at 2,900 clinics; since that time, the number of providers has greatly decreased (Harper et al., 2005; Jones & Kooistra, 2011).

Women who seek reproductive services tend to belong to marginalized populations within society. Unmarried, adolescent, and Black and Hispanic women are some of the populations that experience higher incidences of unintended pregnancies and barriers to access to these services. Abortion rates have decreased for white women, although they have increased for Black and Hispanic women. Low-income (200% below the federal poverty line) women account for half of women receiving abortions, although they consist of 15% of the population (Harper et al., 2005, p. 509). Other demographics of women who have a higher likelihood of unintended pregnancy and abortion include women who have experienced physical, sexual, and/or intimate partner violence (Harper et al., 2005; Major et al., 2009). Through a closer examination of access barriers for adolescents, minorities, and low-income women, one better understands how these marginalized populations face challenges when seeking abortion services.

**Adolescent Access to Abortion Services**

While *Roe v. Wade* legalized abortion for all women in the United States, the Supreme Court decision did not guarantee the legal right for all adolescent females in the states (Guldi, 2008). As a result of this age distinction, a minor's access to abortion services has become a highly contentious topic of policy debate (Matthews, Ribar, & Wilhelm, 1997). Some states had laws restricting minors' access to abortion services prior to the decision that required parental notification and consent, and other states instated such laws following the decision. Furthermore, some states required parental consent because abortion is considered a surgical procedure (Guldi, 2008; Adler, Ozer, & Tschann, 2003). Not all states requiring parental consent had health exceptions for minors seeking abortions, but in July 1976 in *Planned Parenthood of Central Missouri v. Danforth,* the Supreme Court ruled that mandating consent to receive an abortion when the health or life of the minor was at risk was unconstitutional (Guldi,

2008). In 1979, the Supreme Court ruled that state laws requiring parental consent "with a health exception but without a judicial-bypass feature" were unconstitutional in *Bellotti v. Baird* (Guildi, 2008, p. 820). A judicial bypass allows minors to have a court hearing regarding their intentions to have an abortion as an alternative to notifying their parents (Adler, Ozer, & Tschann, 2003).

A major argument in support of requiring parental notification or consent asserts that adolescents are not as psychologically developed as adults; therefore, states are justified in establishing laws that prohibit minors from independently having abortions. In *Hodgson v. Minnesota* (1990), the American Psychological Association argued that minors should not have to seek parental consent from both parents to have an abortion because minors are prone to have the "skills and abilities necessary to make an informed decision about a medical procedure" by the time they are old enough to become pregnant (Steinberg, Cauffman, Woolard, Graham, & Banich, 2009, p. 593).

There are risks for minors as a result of limiting their access to abortion services that adult women do not endure. Minors "with serious concerns about the consequences of notifying their parents may pursue other avenues to obtain abortions. As a result, some adolescents subject themselves to risk of injury and death by seeking an illegal abortion" (Adler, Ozer, & Tschann, 2003, p. 216). Some members of this population fear notifying their parents about wanting an abortion to the extent that they would risk their lives to avoid disappointment or shame for wanting to have an otherwise legal procedure performed.

**Access to Abortion Services for Low-Income Women**

A vast majority of women (74%) personally finance abortions, and a majority of women receiving abortion services are low-income or poor (Jones & Kooistra, 2011; Henshaw & Finer,

2003). The median cost for an abortion in 2009 "at ten weeks' gestation was $470" (Jones & Kooistra, 2011, p. 47). As previously stated, poor and low-income women are more likely to have abortions than women of other socioeconomic statuses. This same population, however, faces serious access issues due to the cost of abortions and the lack of government funding to subsidize them (Fried, 2000).

## The Consequences of Abortion Stigma

The "stigmatization [of seeking and receiving abortion services] can create negative cognitions, emotions, and behavioral reactions that can adversely affect social, psychological, and biological functioning" (Major et al., 2009, p. 867). Stigma regarding abortion significantly derives from moral implications about the procedure that are perpetuated by society. These issues include "the beginning of life, foetal viability, foetal pain…, normative sexuality, policies related to abortion (its legal status, how it should be paid for, who is the ultimate decision-maker – woman, male partner or health professional), cultural and religious norms, demographic and political trends and family dynamics" (Kumar et al., 2009, p. 627).

Although studies have been performed to explore the effects having an abortion has on women's mental health, there have not been studies to explore whether one's mental health or status affects access to services (Major et al., 2009). This literature review demonstrates the need for scholarly research on a relationship between mental health status and access to reproductive services. Because other marginalized populations experience barriers to accessing reproductive services it is logical to assume that this population may also face similar access barriers.

# Methodology

The objective of this exploratory, qualitative study is to determine whether a relationship between mental health status and access to abortion services exists. The scope of this study is limited to Rhode Island due to concerns of feasibility.

**Participants**

The sample population for this study included reproductive service providers and mental health service providers in the state of Rhode Island. After identifying these providers, I contacted them via phone call and e-mail. Templates for these forms of correspondence can be found in Appendix A. Due to low a response rate and time constraints, the sample for this study was only comprised of one reproductive service provider and three mental health service providers.

**Data Gathering**

After making contact with providers in these two fields, I set up times to meet with them. A signed informed consent form was required before interviewing each individual (a copy of this form can be found in Appendix A). The signed form was not required by the interviews that occurred via telephone call; these respondents, however, provided oral consent for the interview. Once informed consent was given, I interviewed each provider to discover which resources are available for clients, as well as which restrictions they believe their clients may or do face when seeking abortion services. I also interviewed providers about any experiences clients have had with receiving these services. I asked providers about general and anonymous experiences to protect the confidentiality of their clients. I also asked the representative from the abortion service organization whether or not a question regarding mental health status appears on the agency's intake form. If yes, I intended to ask what the organization does with that information, and if no, I intended to ask why such a question was not included on the form. I also intended to

ask each provider whether any focus is given to this population because other marginalized populations have difficulty accessing these services due to legislation, court decisions, and regulations that impose barriers for women who seek abortion services.

### Data Analysis

After completing these interviews, I analyzed their content for themes and repeated words or phrases to further examine the relationship between mental health status and access to abortion services with this newly acquired data. Through this process, I have determined and proposed what steps will need to be accomplished in order to establish mental health status as a measurable variable with respect to matters of accessing abortion services within the state of Rhode Island.

## Findings

The purpose of this study was to examine whether or not one's mental health status affects one's access to seeking and/or receiving abortion services. Two sets of data were collected: one set pertained to mental health service provision, and the other set pertained to abortion service provision. Biased convenience samples were used to collect this data. Due to feasibility, the population is limited to service providers in the state of Rhode Island. For the former set, three professionals from the mental health service field were interviewed. Although contact was attempted with multiple people from the abortion service field, only one professional responded.

### Mental Health Service Provision

The three professionals from the mental health field came from different professional backgrounds, and all three interviewees were women. Interviewee #1 is a Licensed Clinical Mental Health Counselor and a Licensed Chemical Dependency Professional. Interviewee #2 is

a Licensed Independent Clinical Social Worker. Interviewee #3 is a Master of Arts. These professionals also work in different positions within the mental health field. Interviewee #1 is a Director of Residential and Intermediate Services. Interviewee #2 is a Director of Training and Communications. Interviewee #3 is a CEO/President. These three interviewees have the experience of working in the field from the administrative perspective, although Interviewee #2 disclosed that she previously provided direct services to mental health clients for many years.

**Mental health service providers with experience counseling clients seeking abortion services.** There are mental health service providers who do have or have had clients seeking abortion services. Interviewee #1 says she is "certain there have been" some clients at her organization who have sought such services. Interviewee #2 has had clients to whom she directly provided mental health services as an outpatient therapist that sought abortion services. Interviewee #3 does not work directly with clients, but she also acknowledges that the clients of direct service providers have and do seek these services.

For clients who do require such services, all three interviewees stated that referrals to abortion providers would be given to clients. Interviewee #1 said that the therapists and case managers at her organization would "provide [clients] with a referral source." They would also explain to their clients the "role of the abortion clinic to provide [an] overview of [the services] they offer," and they would explore all possible options for handling the unwanted pregnancy. This provider also stated that workers would "counsel [clients] or refer them out to another therapist or another clinic" if women obtaining abortions is significantly against their moral beliefs.

Interviewee #2, who has had clients who have sought abortion services, went over potential avenues of action with her clients:

> I gave them referrals for the abortion, to other counselors to make sure it's their right option. We spoke about organizations like Planned Parenthood that provide the services. The Code of Ethics really helped drive decisions because I'm personally against it [abortion] but believe the woman has the right to choose. It totally influenced my decisions because it is different from my personal beliefs.

This interviewee worked within the ethical guidelines of her profession and continued to help and work with her clients seeking abortion services.

**Relationship between health insurance funding mental health services and abortion services.** The final question asked of all the mental health service providers interviewed pertained to whether or not they knew if federal and/or state funding in any way impacts the ability of clients to access abortion services. Interviewee #1 had "no idea" whether or not government funding of insurance impacted clients' abilities to access these services. Interviewee #2 was also unaware of whether or not such funding was an issue. She added that "[funding issues] never came up – [it] was never part of the discussion" when exploring options with her clients. Interviewee #3 stated that she was aware that such funding can affect the ability of clients to access abortion services:

> Medicare and Medicaid cannot fund abortion services, so clients insured by those programs cannot pay for abortions through them. This can make it difficult for many of our clients who may want this procedure, because a lot of clients using our services are insured through Medicare and/or Medicaid.

Interviewee #3 was knowledgeable of this policy and understood that there can be barriers to services as a result of this policy.

At one moment during the interview, Interviewee #3 mentioned that in addition to economic difficulties, it must also be difficult for some members of this population to explore reproductive health options because a lot of people experiencing mental illness are "not seen as sexual beings." She cites this as a result of the stigma surrounding this population. Individuals experiencing severe mental illness may not be knowledgeable about sex and/or sexuality because

they were never taught about that aspect of life; therefore they may be unaware of how to respond to a pregnancy crisis or unwanted pregnancy.

**Abortion Service Provision and Implications for People Experiencing Mental Illness**

Unfortunately, the sole respondent for the abortion service provider questions was unable to answer questions about whether intake forms ask about mental health status or whether clients are asked about their mental health history. Her position at her organization does not involve providing clinical services to clients. This interviewee was, however, able to provide an answer to the question regarding whether she believed mental health status may be an access barrier to receiving abortion services. She stated that "in Rhode Island, [as a client], you have to be able to provide consent [in order to have an abortion]. If you are incapacitated [to do so], then a guardian ad litem must provide it for you."

This interviewee explained the concept of a guardian ad litem for a person by comparing it to the experience a minor in Rhode Island undergoes in order to have an abortion performed. The minor must either "receive parental consent or go through the courts to get a judicial bypass" before she can legally have an abortion because the minor is not allowed to make that decision for herself in Rhode Island. The interviewee stated that because some individuals cannot always make decisions for themselves if they are experiencing an episode that legally incapacitates them from doing so, then they would not legally be able to make a decision for themselves regarding abortion procedures.

## Summary and Implications

Due to the low response rate (3/6 of contacted mental health service providers responded to attempts to contact and schedule interviews, and 1/3 of contacted abortion service providers responded) and consequently a small sample size, the results of this study are inconclusive.

Though inconclusive, these results are informative for this study. From the results, implications regarding future research on the relationship between mental health status and access to abortion services can be made.

**Mental Health Provision Summary and Implications**

From the perspective of mental health service providers, the providers interviewed have confirmed that there are clients who have and do seek abortion services. Because obtaining an abortion is one of the most common medical procedures for women, this finding is not surprising (Kumar et al., 2009; Harper et al., 2005; Fried, 2000). When clients reveal to their workers that they want an abortion, the issue is discussed. Based on this population sample, all possible options that can be taken to address an unwanted pregnancy are explored with their clients. According to these providers, discussing other possible actions that can be taken helps to ensure that the client is sure of her decision to have an abortion before going forward with the procedure. After the choice to have an abortion is made, providers help clients find referrals to abortion clinics where they can undergo the procedure.

If having abortions is incongruous with the values system of a particular mental health service provider to the extent that it interferes with the ability to act in the best interest of the client, then that provider has the option of referring the client to another specialist to address the topic. This position was present for all three interviewees from within the mental health field. It is interesting to note that Interviewee #2, the Licensed Independent Clinical Social Worker, is "personally against" abortions, but she continued to provide counsel to her clients seeking abortion services. She stated that she owes the decision to continue working with her clients to her adherence to the National Association of Social Workers *Code of Ethics*, which instructs social workers to put the needs of clients before their own beliefs (2008). If this is impossible to

do so, then the *Code of Ethics* instructs social workers to refer clients to another social worker for services. While this interviewee does not personally believe in abortions, she believes that each woman “has the right to choose” to make her own decisions regarding unwanted pregnancies without external interference. This provider was able to focus on the needs of her client even though they did not align with her personal values system, and by doing so, the worker was able to help her clients access the desired abortion services.

It is also interesting to comment on the result pertaining to the knowledge of government funding in relation to funding mental health services and abortion services. The Hyde Amendment was passed in 1977, thus prohibiting the allocation of federal dollars for abortion services, with the exception of Medicaid being able to fund such services in the cases of rape, incest, or endangerment of the woman (Harper et al., 2005; Fried, 2000). As Interviewee #3 noted, many clients in the mental health system are receiving services funded by Medicaid and/or Medicare, both of which are federally funded programs. Two of the three providers were unaware that there may be potential barriers for clients seeking abortion services if their health insurance is provided by the government.

Knowledge of funding restrictions for such services is likely much more well-known for abortion service providers because it is logical to assume that they know the government regulations regarding their practice. Because this policy exists, it necessarily must affect some consumers of mental health services, primarily those who seek abortion services. An implication of this finding is that perhaps mental health service providers should be informed of the Hyde Amendment in order to have a working knowledge of the policy for if and/or when these professionals have clients who wish to discuss with them abortion as a possible avenue of action for themselves. Clients who receive government-sponsored healthcare do so as a result of their

low-income status. In this respect, one may conclude that mental health status is a secondary access barrier to seeking and receiving abortion services, and economic status is the primary barrier.

**Implications for Mental Illness as a Primary Access Barrier**

With respect to circumstances in which mental health status may, in fact, be a primary barrier to accessing abortion services, the sole interviewee from the abortion service provision field commented on legal competency. If a woman is legally incapable of making decisions for herself at a given time as a result of mental illness, then she will likely be unable to legally provide consent for an abortion, even if she wants to undergo the procedure. The implications of this legal competency can be explored in a thought experiment. Hypothetically, if a woman did not belong to any other population that experiences access barriers to seeking and receiving abortion services (e. g., income level, race, age, etc.), then her mental health status would be the primary access barrier. The guardian ad litem, the individual who becomes the legal decision-maker for the incapacitated individual according to this interviewee, would be responsible for making decisions regarding the termination of a woman's pregnancy.

There are two major courses of action that can be identified from this thought experiment. The first is that the guardian ad litem can prohibit a woman from obtaining an abortion. The second is that this individual may also compel a woman to have an abortion. This finding leads to serious ethical concerns regarding personal agency. The period in which a woman may be legally incapacitated as a result of mental illness may overlap with the timeframe in which she can legally have an abortion performed. It is recommended that future studies explore the implications of a guardian ad litem making reproductive decisions, specifically those

pertaining to abortion, for individuals experiencing an episode of mental illness which makes them legally incapable of making their own decisions.

**Future Study**

Although the results of this study are inconclusive, they help propel forward the conversation regarding the relationship between mental health status and access barriers to seeking and receiving abortion services. Prior to this study, there was no research on this relationship. Results from this study infer that in some cases, it appears that mental health status is a secondary access barrier, while in other scenarios it can be a primary barrier.

An individual who is receiving mental health services has government-sponsored health insurance may seek guidance from her counselor/therapist/clinician regarding steps to take in order to have an abortion. While the mental health service provider may be unaware that this insurance will not cover the procedure, the client will learn of this information when speaking with providers at an abortion clinic. It may benefit all parties involved in this process if mental health service providers are informed of the Hyde Amendment and its implications for some women seeking abortion services.

For individuals experiencing mental illness but no other societal stigma or oppression, mental health status has the possibility to be a primary barrier to accessing abortion services, as explained in the thought experiment in the previous chapter. A guardian ad litem for an adult regarding abortion decisions seems to pose some potentially serious ethical, and possibly legal, implications. It is understandable why a person experiencing a severe mental illness episode may need some decisions made on her behalf. With respect to abortion, though, the consequences of a choice regarding termination made by another individual can possibly be devastating for the woman who is unable to provide her own consent or legally make her own

decision. It is recommended that this area of concern be explored in future research to gain a better understanding of the effects of a guardian ad litem making reproductive decisions for adults.

An individual may not be associated with only one marginalized population within society. Different types of oppression can and do overlap or are somehow related. Another area of future study includes examining the role of mental health status as an access barrier in relation to other populations that experience barriers to accessing abortion services.

It is important to put these findings and implications within the context of the social work profession. As a profession, social workers are bound by their duty to serve at-risk and marginalized populations in society (National Association of Social Workers, 2008). Social workers must "pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people" (National Association of Social Workers, 2008, p. 5). Individuals experiencing mental illness comprise one of the populations with which social workers closely work. The findings from this study emphasize the importance of ethically working with clients who may be seeking abortion services. It is imperative that social workers adhere to the *Code of Ethics* when discussing this subject matter with clients. If abortion is not a procedure that an individual social worker supports and cannot put aside her/his beliefs when working with a client dealing with this issue, then the *Code of Ethics* instructs that the worker make a referral to a worker who can provide services without an ethical conflict.

In addition to direct service provision with this population, social workers can advocate on behalf of this population. Social workers can aim to further reduce the stigma surrounding this population. Reduction of stigma will result in society viewing and treating individuals experiencing mental illness as humans who are fully capable of establishing sexual relationships

with other individuals. Once this work is in effect, then perhaps this population will receive more comprehensive sex education which can help guide reproductive decisions. Another way in which social workers can help this population through macro service is by better ensuring that the voices of this population do not go unheard with respect to access issues around seeking and receiving abortion services.

This study, though limited in scope and sample size, provides some foundational work in an area of research which did not previously exist. This research will hopefully prompt future study in this area of abortion access that has not been thoroughly explored. With a larger population sample and a higher response rate, findings from similar studies examining the relationship between mental health status and access to abortion services may yield more fruitful, concrete findings.

Appendix A

Dear Potential Participant:

I am a social work major at Providence College, inviting you to participate in a study to explore whether a relationship exists between mental health status and access to abortion services. Data gathered in this study will be reported in a thesis paper in a social work capstone course at Providence College. It will also be added to the Providence College digital commons database.

At this time, mental health and abortion service providers are being recruited for this research. Participation for representatives of mental health service providers will involve answering questions about whether help is given if clients disclose they are in need of abortion services. Participation for representatives of abortion service providers will involve answering questions about whether people with mental illness is a population with which the service providers concern themselves. The interview time should not exceed 30-40 minutes. The interviews will be recorded using an audio recorder and the tapes will be destroyed once the data is transcribed.

Benefits of participating in this study include helping researchers to formulate a better understanding of whether the mentally ill are a marginalized group in society that experience barriers to accessing abortion service because of their mental health status.

Confidentiality will be protected by storing signed consent forms separately from data obtained in the study. Once the data are obtained, all identifying information linking the participant to his or her response will be destroyed so that responses can no longer be identified with individuals. Data will be reported by making generalizations of all of the data that has been gathered. Brief excerpts of individual responses may be quoted without any personal identifying information.

Participation in this study is voluntary. A decision to decline to participate will not have any negative effects for you. You may withdraw from the study at any time up until Sunday, April 1st, when the researchers will finalize the data.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Thank you for participating in this study.

Miranda Cummings, Social Work Student, (401) 323-4660

________________________________________ ____________________

(Name) (Date)

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

Appendix B

Abortion Service Provider Questions

Position: ______________________________

City: _________________________________

- On your intake forms, which demographic identifiers do you include (e.g., age, race, income)?
- Do you ask clients about their mental health status or mental health history?
  - Why or why not?
- Do you believe mental health status may be an access barrier to receiving abortion services?
  - If so, do you believe there is any way to help improve access to abortion services for this population?

Mental Health Service Questions

Position: ______________________________

City: _________________________________

- Have you had clients who require abortion services?
- What do you do for clients who require these services?
- Does federal and state funding in any way impact the ability for clients to access abortion services?

References

Adler, N. E., Ozer, E. J., & Tschann, J. (2003). Abortion among adolescents. *American Psychologist, 58*(3), 211-217.

American Civil Liberties Union (2012). Public funding for abortion. Retrieved from http://www.aclu.org/reproductive-freedom/public-funding-abortion

Barry, C. L., Huskamp, H. A., & Goldman, H. H. (2010). A political history of federal mental health and addiction insurance parity. *The Milbank Quarterly, 88*(3), 404-433.

Berer, M. (2002). Making abortions safe: A matter of good public health policy and practice. *Reproductive Health Matters, 10*(19), 31-44.

Burns, J. K. (2009). Mental health and inequity: A human rights approach to inequality, discrimination, and mental disability. *Health and Human Rights*, *11*(2), 19-31.

Conner, K. O., Koeske, G., & Brown, L. (2009). Radical differences in attitudes toward professional mental health treatment: The mediating effect of stigma. *Journal of Gerontological Social Work, 52*(7), 695-712.

Fried, M. G. (2000). Reproductive and sexual rights. *Health and Human Rights, 4*(2), 174-194.

Garcia, R. A. (2010). Equity for all?. *Journal of Legal Medicine*, *31*(1), 137-155.

Guldi, M. (2008). Fertility effects of abortion and birth control access for minors. *Demography, 45*(4), 817-827.

Harper, C. C., Henderson, J. T., & Darney, P. D. (2005). Abortion in the United States. *Annual Review of Public Health, 26*(1), 501-512.

Henshaw, S. K., & Finer, L. B. (2003). The accessibility of abortion services in the United States, 2001. *Perspectives on Sexual and Reproductive Health, 35*(1), 16-24.

Jones, R. K., & Kooistra, K. (2011). Abortion incidence and access to services in the United States, 2008. *Perspectives on Sexual and Reproductive Health, 43*(1), 41-50.

Kumar, A., Hessini, L., & Mitchell, E. H. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality, 11*(6), 625-639.

Major, B., Appelbaum, M., Beckman, L., Dutton, M., Russo, N., & West, C. (2009). Abortion and mental health: Evaluating the evidence. *American Psychologist, 64*(9), 863-890.

Matthews, S., Ribar, D., & Wilhelm, M. (1997). The effects of economic conditions and access to reproductive health services on state abortion rates and birthrates. *Family Planning Perspectives, 29*(2), 52-60.

National Association of Social Workers. (2008) NASW Code of Ethics. Washington, DC: Delegate Assembly.

Steinberg, L., Cauffman, E., Woolard, J., Graham, S., & Banich, M. (2009). Are adolescents less mature than adults?: minors' access to abortion, the juvenile death penalty, and the alleged APA "flip-flop". *American Psychologist, 64*(7), 583-594.