Appendices

Appendix A

Sample Disclaimers

Disclaimers

Medical

Our services are not intended to be a substitute for professional counseling, medical or pre-natal care.

Abortion Services

WE DO NOT PERFORM OR REFER FOR ABORTIONS

Confidentiality

All information shared by you during your relationship as a client with us will be kept in strictest confidence except as required by law or as required for the protection of you or others.

Appendix B

Facts on Abortion and Related Issues

Abortion in the U.S.

- In spite of easy contraceptive availability, nearly half (49%) of pregnancies among American women are unintended, an increase over the 2001 unintended pregnancy rate of 48%. 43% of unintended pregnancies end in abortion (down from 47% in 2001).[1]
- The abortion rate has increased slightly to 19.6 per 1000 women in 2008. The number of abortions remains steady at 1.21 million for 2008, down 25% since 1990 (1.6 million abortions).[2]
- From 1973 through 2008, about 50 million abortions occurred in the US.[3]
- Every year, 2% of women aged 15-44 have an abortion.[4] Half have had a previous abortion.[5]
- At current rates, 30% of women in the U.S. will have had an abortion by age 45.[6]
- 17% of all abortions per year (199,000) are medication abortions (RU-486).[7]
- 1066 abortion providers (59%) offer medication abortions (RU-486), an increase by 26% between 2001 and 2008.[8]
- The number abortion providers in the US increased slightly from 1,787 (2005) to 1,793 (2008).[9]

Abortion Demographics in the U.S.

- Women in their twenties account for more than half of all abortions; women aged 20-24 obtain 33% of all abortions, and women aged 25-29 obtain 24%.[10]
- Teenagers account for 18% of all abortions; those aged 15-17 obtain 6% of all abortions, teens aged 18-19 obtain 11%, and teens under age 15 obtain 0.4%.[11]

- About 61% of abortions are obtained by women who have one or more children. [12]
- Half of the women who have abortions have had at least one previous abortion.[13]
- 37% of women obtaining abortions identify as Protestant and 28% as Catholic.[14]
- Women who have never married and are not cohabiting account for 45% of all abortions.[15]
- Six in 10 women in the U.S. who experience abortion do so in the first eight weeks of pregnancy; 89% do so in the first 12 weeks.[16]
- 94% of abortion providers are located in metropolitan areas.[17]
- 36% of abortions occur to white women, 30% to black women, and 25% to Hispanic women. 9% of abortions are obtained by women identifying with another racial category.[18] 72.4% of women in the U.S. identify as white, 12.6% black, 16.3% Hispanic or Latina and 4.8% Asian.[19]
- Induced abortion is the second most frequent pregnancy outcome across races:
    - 12% of pregnancies among white women end in abortion,
    - 36% of pregnancies among black women end in abortion, and
    - 17% of pregnancies among Hispanic women end in abortion.[20]

Adolescents and Sexual/Reproductive Trends

- The teen pregnancy rate was 69.8 per 1,000 women aged 15-19 in 2005, down 60% from the 1990 high of 116.8.[21]
- 27% of teen pregnancies (ages 15-19) end in abortion.[22]
- Estimates suggest that while representing 25% of the sexually active population, 15-24 year-olds acquire nearly half of all new sexually transmitted infections (STIs).[23]
- Of the 18.9 million new cases of STDs each year, 9.1 million (48%) occur among 15–24-year-olds.[24]
- 1 in 4 sexually active youth under age 25 will acquire an STD each year.[25]
- From 1988 – 2002, the percentage of teens aged 15-19 who have ever had sex has decreased – from 51% - 43% among females, and from 60% – 42% among males. [26]

- Genital human papillomavirus (HPV) is the most common STI in the United States and, perhaps, the most common STI among sexually active youth. During 2003-2004, nearly a quarter of females aged 15 to 19 years and 45 percent of those aged 20 to 24 had a HPV infection.[27] Among females aged 14 to 24, the overall prevalence of HPV was 34 percent, representing approximately 7.5 million females with HPV in the U.S.[28]
- Young women and female adolescents are more susceptible to STIs, compared to their male counterparts, due to their anatomy. STIs are more likely to remain undetected in women than in men, resulting in delayed diagnosis and treatment, and untreated STIs are more likely to lead to complications in women, such as pelvic inflammatory disease and cervical cancer.[29]

Endnotes

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[8]Ibid

[9]Ibid

[10]Jones RK, Finer LB and Singh S, Characteristics of U.S. Abortion Patients, 2008, New York: Guttmacher Institute, 2010.

[11]Ibid

[12]Ibid

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[14]Jones RK, Finer LB and Singh S, Characteristics of U.S. Abortion Patients, 2008, New York: Guttmacher Institute, 2010.

[15]Ibid

[16]Henshaw SK, special tabulations of data from Strauss LT et al., Abortion Surveillance—United States, 2002,
Morbidity and Mortality Weekly Report Surveillance Summaries, 2005, 54(SS07):1–31.

[17]Finer LB and Henshaw SK, Abortion incidence and services in the United States in 2000, *Perspectives on Sexual and Reproductive Health*, Guttmacher Institute, 35(1):6-15.

[18]Jones RK, Finer LB and Singh S, Characteristics of U.S. Abortion Patients, 2008, New York: Guttmacher Institute, 2010.

[19]2010 U.S. Census brief: *Overview of Race and Hispanic Origin: 2010*, March 2011. Accessed at http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf on September 4, 2012.

[20]National Vital Statistics Reports, Volume 60, No. 7, *Estimated Pregnancy Rates and Rates of Pregnancy Outcomes for the United States,* June 20,2012. Accessed at http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf on September 4, 2012.

[21]Ibid

[22]Kost K and Henshaw S, *U.S. Teenage Pregnancies, Births and Abortions, 2008: National Trends by Race and Ethnicity*, 2012, <http://www.guttmacher.org/pubs/USTPtrends08.pdf>, accessed September 4, 2012.

[23]Weinstock H et al., Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000, *Perspectives on Sexual and Reproductive Health*, 2004, 36(1):6–10.

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[25] "Facts at a Glance," *Child Trends*, Publication # 2006-03, April 2006.

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Appendix C

Child Abuse and Statutory Rape Reporting Policy Checklist

1) What are the reporting requirements in my state?

2) Am I a "mandatory reporter?"

- Does the situation in question constitute statutory rape or some other form of criminal sexual misconduct under your state law?
- Does the definition of "child abuse" under your state law include this form of criminal misconduct?
- Are your center personnel deemed to be mandatory reporters under your state law?

3) What types of abuse must be reported in my state?

4) What is my state's definition of "child abuse?"

5) What is my state's definition of "statutory rape?"

- Does it fall under the category of "reportable child abuse?"
- Is there any "parental conduct" that may require reporting it as "child abuse?"

6) What is the "age of consent" in my state?

7) How do I report?

- Hotline number?
    - If your state does not have a specific # call 800-4-A-CHILD
- When?

- To whom?
- How?

8) If I am not a “mandatory reporter” do I still have a moral obligation to report?

9) If a center employee or volunteer suspects child abuse and/or statutory rape, what should he/she do?

*Source: Care Net (used with permission)

Appendix D

Sample Reporting Policy

Reporting Requirements and Concerns

While preserving client confidentiality is very important, there are certain situations that justify breaking client confidentiality for the protection of the client or others. This occurs in child abuse or neglect situations as well as in situations when a client is threatening harm to self or others.

All states now have laws that require the reporting of child abuse and neglect. These laws, however, vary significantly as to the persons and circumstances that are subject to them. Some states broadly impose reporting requirements upon all persons who become aware that child abuse or neglect has occurred. Other states only impose this duty upon certain designated professionals. The particular factual circumstances that are subject to reporting also vary. For instance, in some states "child abuse" is defined broadly enough to incorporate all instances of statutory rape. In other states statutory rape is only subject to mandatory reporting when the perpetrator is a parent, guardian, or caretaker of the victim. In adopting policies and procedures for reporting abuse, neglect, and statutory rape, a center should have access to and be familiar with these applicable laws.

When a client is suicidal or is threatening to harm third persons, the interest in preserving client confidentiality is outweighed by the need to protect the client or such third persons. In many states, mental health professionals have been held liable to victims for the negligent failure to intervene in these situations. Although such legal standards may not necessarily extend to lay counselors, your center should nevertheless adopt sound policies and procedures for addressing these situations.

Sample Policy and Procedure

[Center] recognizes that circumstances may arise in which otherwise confidential information must be reported to appropriate authorities for the protection of the client, for the protection of third persons, or to otherwise comply with legal reporting requirements. This may

occur when a client is a child who is the victim of neglect or abuse (including statutory rape); the client is engaging in child neglect or abuse; the client is a minor who is a runaway; or, the client is threatening to cause harm to self or others. It is expected that all employees and volunteers will be made aware of any reporting requirements that apply to these situations and will follow appropriate procedures when any such situations arise.

A.Situations involving minors:

If any center employee or volunteer reasonably believes that a minor client is or may have been the victim of child abuse, child neglect, sexual abuse, statutory rape, or is a runaway, such information shall be immediately reported to the Director. Similarly, if any employee or volunteer reasonably believes that a client has or is causing abuse or neglect to a child, that information shall also be immediately reported to the Director. The Director will determine whether the circumstances in question warrant reporting in accordance with applicable state law. If a determination is made that state law requires reporting, the Director will promptly proceed to report the situation in accordance with any applicable procedures outlined by state law. If a determination is made that no mandatory reporting duty exists, the Director may choose, at her discretion, to report the situation to appropriate authorities if she believes that the welfare and safety of the client or another person may be significantly threatened in the absence of such a report.

B. Threats of harm to self and others:

If an employee or volunteer receives a phone call from a prospective client who is threatening to cause harm to themselves, that person shall be promptly referred to a suicide hotline or other appropriate emergency service. If possible, the person's name and phone number should be obtained so that a hotline worker can call back. If any employee or volunteer otherwise encounters a client who is threatening to cause harm to self or others, prompt steps should be taken for the reasonable protection of the client or any third persons against whom threats are being made. The Director or such other appropriate supervisory employee will be contacted and involved in the situation as soon as reasonably possible.

If it is determined that the client is already under the care of a mental health professional, the client will be requested to contact that professional for assistance. If the client refuses, center personnel will attempt to contact the professional on behalf of the client. If no professional assistance is readily available, an assessment will be made to determine whether there is a serious or significant risk that any threats of harm being made by the client will be carried out. This assessment will be made with reference to the following criteria**:**

- **Specificity.** How specific are the details of the plan? Does the person have a plan? Has she thought through the process? If so, are the details of the plan vague or does she know how and when she will act? The greater the specificity of details in the plan, the higher the degree of risk.

- **Lethality.** What is the likelihood that the proposed method will result in death? How quickly will the person die if she does what she plans to do? For instance, guns are potentially more lethal and quicker than pills. The higher the level of lethality in the plan, the greater the degree of risk that should be assessed.

- **Availability.** What is the availability of the proposed method? Does she have means to carry out her plan immediately? Does she have a loaded gun? Does she have pills in her possession? The more readily available the implement to be used is, the higher the degree of risk.

- **Proximity.** What is the proximity to helping resources? How physically and geographically close is the person to others who could rescue her if necessary? Are there other people nearby who care about this person (family, loved ones, friends, and support people)? What are the chances the person will be found? Does that appear to be part of the plan? The greater the distance she is from those who could rescue her in an emergency, the greater the degree of risk,

If it is determined based upon such an assessment that there is any significant risk that the client will cause harm to self or others, immediate assistance will be sought by calling 911, If the client leaves the center before help can be obtained, 911 will be contacted and prompt steps will be taken to notify any specific persons against whom imminent threats of harm have been made, If it is determined based upon such an assessment that there is not a significant risk that the client will cause harm to self or others AND the client provides specific assurances that he or she will refrain from causing any such harm, no immediate reporting will be required, If, on the other hand, the client refuses to provide such assurances, the presence of a significant risk should be assumed and action should be taken accordingly.

C.Notification of Client

When the center is required to report otherwise confidential client information to authorities or third persons, reasonable steps will be taken, if feasible, to notify the client and to explain why the reporting is being undertaken.

*Source: Care Net (used with permission)

Appendix E

Child Abuse Reporting State Hotline Numbers

Alabama

334-242-9500

Arizona

888-SOS-CHILD

Arkansas

800-482-5964

California

Call 800-4-A-CHILD

Colorado

Call 800-4-A-CHILD

Connecticut

800-842-2288

Delaware

800-292-9582 or 302-577-6550

District of Columbia

877-671-SAFE 202-671-7233

Florida

800-96-ABUSE

Georgia

Call 800-4-A-CHILD

Hawaii

800-832-5300 (Oahu)

others call 800-4-A-CHILD

Idaho

800-926-2588

Illinois

800-252-2873 or 217-785-4020

217-782-6533 (after hours)

Indiana

800-800-5556 or 317-542-7002

Iowa

800-362-2178 or 515-281-3240

Kansas

800-922-5330 or 785-296-0044

Kentucky

800-752-6200 or 502-595-4550

Louisiana

225-342-6832

Maine

800-452-1999 or 207-287-2983

Maryland

800-332-6347

Massachusetts

800-792-5200 or 617-232-4882

Michigan

800-942-4357 or 517-373-3572

Minnesota

651-291-0211

Mississippi

800-222-8000 or 601-359-4991

Missouri

800-392-3738 or 573-751-3448

Montana

866-820-KIDS or 406-444-5900

Nebraska

800-652-1999 or 402-595-1324

Nevada

800-992-5757 or 775-684-4400

New Hampshire

800-894-5533 or 800-852-3388 (after hours)

603-271-6556

New Jersey

800-792-8610

New Mexico

800-797-3260 or 505-841-6100

New York

800-342-3720 or 518-474-8740

North Carolina

Call 800-4-A-CHILD for assistance

North Dakota

800-245-3736 or 701-328-2316

Ohio

Call 800-4-A-CHILD

Oklahoma

800-522-3511

Oregon

800-854-3508, ext. 2402

503-378-6704

Pennsylvania

800-932-0313 or 717-783-8744

Rhode Island

800-RI-CHILD

South Carolina

803-898-7318

South Dakota

605-773-3227

Tennessee

877-237-0004

Texas

800-252-5400

Utah

800-678-9399

Vermont

800-649-5285

802-863-7533 (after hours)

Virginia

800-552-7096 or 804-786-8536

Washington

866-END-HARM

West Virginia

800-352-6513

Wisconsin

608-266-3036

Wyoming

800-457-3659

Glossary and Abbreviations[1, 2, 3, 4, 5]

Abortifacient: a substance, drug or device causing the destruction of the embryo or fetus

Cervix: the narrow neck like passage forming the lower end of the uterus

Embryo: developing human from fertilization to the end of the eighth week during which time all the organs are formed. Means "growing within"

CDC: Centers for Disease Control

Client Advocate or Coach: a center staff member or volunteer who has completed requisite training to provide options counseling to clients in a crisis pregnancy

Conception (or fertilization): Joining of a male sperm and the female egg to create the smallest form of human life (zygote)

Conception dating: measures the developing human's age from the moment of conception; fetal age

Curette: A surgical instrument shaped like a loop or ring, used to remove tissue or growths from a body cavity

D&C: dilatation and curettage: surgical scraping of the uterine lining

D&E: dilatation and evacuation: surgical abortion done by stretching open the cervix and suctioning out the uterus through tubing connected to a vacuum

Ectopic pregnancy: any pregnancy located outside the uterus; typically found in the fallopian tube

EDC/EDD (estimated date of confinement or estimated delivery date): the date based upon a reliable LMP or an early ultrasound when the baby is considered due to deliver

Ejaculation: release of semen from penis

Embryo: the stage of prenatal development from the time of conception until the end of the eighth week. The period is characterized by rapid growth, differentiation of the major organ systems, and development of the main external features.

Fallopian tubes: slender ducts through which eggs pass from the ovaries to the uterus

Fertilized egg: zygote

Fetus: developing human from the end of the eighth week after conception to the moment of birth. Meaning "unborn offspring"

FDA: Food and Drug Administration: branch of the U.S. government responsible for evaluating and approving all medications and medical devices prior to their use among the public.

Full Term Pregnancy: The point at which the pregnancy has completed at least 37 weeks from the mother's last menstrual period.

Gestation: The period of time the baby is carried in the womb measured from conception until birth.

Gestational age: the age of a baby in utero at any given point in pregnancy

HPV (Human Papilloma Virus): a group of viruses passed by sexual contact; certain types cause genital warts and other types cause the vast majority of cervical cancer

Implantation: process where fertilized egg attaches to inner uterine wall

In utero: in the uterus

Laminaria: a type of seaweed made into small bundles that are placed in the cervical canal where they absorb water and swell, causing the cervix to open

Last Menstrual Period (LMP): the most recent episode of cyclic bleeding before conception. This is the point from which the pregnancy and the age of the unborn baby are measured.

Menstruation: the monthly flow of blood from the uterus in reproductive age females

Morula: a solid mass of cells resembling a blackberry, formed by the division of a fertilized egg

NIH: National Institutes of Health

Off-label use: Prescribing a medication to be used in a manner or for a condition that was not listed in the official U.S. Food & Drug Administration's labeling.

Ovaries: the pair of female reproductive organs that make eggs and female hormones; found on either side of the uterus

Ovulation: cyclic release of mature egg from ovary

Ovum: female egg found in the ovary

Placenta: A pancake-like structure that provides nourishment to the baby while in utero through the mother's bloodstream.

Pre-embryo: A fertilized egg up to 14 days old, before it becomes implanted in the uterus

Premenstrual syndrome: a group of symptoms that occur in women before the menses that include: bloating, breast tenderness, headache, fatigue, irritability, anxiety and depression

Scrotum: The external pouch containing the male reproductive glands (testes)

Semen: The thick whitish liquid released from the penis during sexual intercourse. It contains sperm and other secretions

Sepsis: the presence of disease causing organisms in the bloodstream and tissues resulting in an overwhelming total body infection

Sexually transmitted diseases (STDs): the presence of STI organisms in the body that have caused disease and damage, with or without associated symptoms

Sexually transmitted infections (STIs): the presence in the body and tissues of certain microorganisms that can be passed by sexual contact

Sperm: male reproductive cell produced by the testes

Testes: The pair of male reproductive glands located in the scrotum that produce testosterone and sperm.

Trimester: one of the three periods of approximately 3 months into which pregnancy is divided

Uterus: hollow muscular organ located in the pelvis of females where an unborn baby develops; womb

Vagina: muscular canal leading from cervix to vulva; birth canal

Viable: capable of living, developing and/or growing

Vulva: the external genital organs in the female

Yolk Sac: the earliest source of nutrients for the developing embryo

Zygote: a fertilized egg; a single cell that is formed when the sperm enters the egg at the time of conception; it contains the genetic material of both the mother and the father; from Greek zugōtos meaning yoked

Endnotes

[1]Gabbe: Obstetrics: Normal and Problem Pregnancies. Sec.2 Chap. 8 Drugs and environmental agents in pregnancy and lactation

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