Do U.S. Family Planning Clinics Encourage Parent-Child Communication? Findings from an Exploratory Survey

CONTEXT: *Clinics that receive Title X funding have a mandate to encourage parent-child communication for minors seeking family planning services. Little is known about the programs and practices that clinics have adopted to achieve this goal, or whether clinics not receiving Title X funds encourage family participation.*

METHODS: *As part of a larger project examining parental engagement among adolescents using family planning clinics, 81 clinics that served 200 or more adolescent contraceptive clients in 2001 completed a questionnaire containing closed- and open-ended items. Topic areas included clinic counseling and policies regarding clients younger than 18, activities to improve parent-child communication and community relations. Frequency distributions were calculated for the prevalence of activities, and cross-tabulations were used to compare prevalence by clinic characteristics.*

RESULTS: *Every clinic engaged in at least one activity to promote parent-child communication, and nine in 10 offered multiple activities. Most of the clinics used counseling sessions to talk to adolescent clients about the importance of discussing sexual health issues with parents (73–94%, depending on the reason for the visit). More than eight in 10 clinics (84%) distributed pamphlets on how to talk about these issues. A substantial minority (43%) offered or referred interested individuals to educational programs designed to improve communication. Some of these exploratory findings reflect the prevalence of activities among all U.S. family planning clinics that serve adolescent clients.*

CONCLUSIONS: *Evaluation and expansion of clinic efforts to promote voluntary communication about sexual health issues between parents and children could help encourage family participation.*

Perspectives on Sexual and Reproductive Health, 2006, 38(3):155–161

By Rachel K. Jones

Rachel K. Jones is senior research associate at the Guttmacher Institute, New York.

Generally speaking, adolescents have the legal right to consent to contraceptive and STD services. All states allow minors (adolescents younger than 18) to consent to STD services, and these state laws implicitly guarantee confidentiality. Twenty-one states and the District of Columbia explicitly allow all minors to consent to contraceptive services, and another 25 states have confirmed the right for certain categories of minors, such as those who are parents.[1] In addition, some types of federal funding stipulate that services must be confidential. Most prominent is Title X of the Public Health Service Act, enacted in 1970 with the stated goal of making comprehensive, confidential family planning services readily available to all persons who desire them, including minors. Title X is the only federal program dedicated solely to family planning, and the 4,568 clinics that it supported in 2004 served 628,000 minors.[2]

In 1981, Congress amended Title X to require that "to the extent practical," grantees "encourage family participation in the decision of minors to seek family planning services."[3] Notably, there is evidence that even without this mandate, family planning clinics have found it useful to involve parents. Research based on interviews with administrators in 375 Title X–funded facilities in 1981 (before the federal mandate could have been fully implemented) found that 85% of facilities had adopted activities that directly involved parents in clinic services, including family counseling, parental advisory and discussion groups, and training workshops.[4] Clinics that serve adolescents, including clinics that do not receive Title X funds, have also implemented programs and policies intended to encourage adolescents to involve parents when making decisions about sexual health. In recent, nationally representative surveys, substantial minorities of publicly funded family planning clinics (42–43%) have reported offering educational programs intended to improve communication between parents and children.[5] The overwhelming majority of clinics (89%) routinely counsel clients younger than 18 about the importance of discussing sexuality issues with parents, and a significantly higher proportion of Title X–funded clinics than of other facilities do so (95% vs. 79%).[6]

However, little is known about how parent-child communication is addressed in these educational programs, or at which types of service visits adolescent clients receive such counseling. This exploratory study presents new information obtained from 81 U.S. family planning clinics serving adolescents, and focuses on programs and policies intended to improve and promote parent-child communication.

METHODS

Surveys were mailed to a random sample of clinics selected from a database of all publicly funded family planning clinics in the United States, maintained by the Guttmacher

TABLE 1. Percentage distribution of U.S. family planning clinics participating in a survey on adolescent reproductive health services, by selected characteristics, 2003–2004

Characteristic	% (N=81)
Type of facility	
Planned Parenthood	40
Health department	36
Other	25
Primary function	
Reproductive health care	81
Primary care	15
Other	4
Title X funding	
Yes	79
No	21
No. of adolescent clients per year	
200–399	22
400–749	26
750–1,199	26
≥1,200	26
Region	
Northeast	22
Midwest	27
South	22
West	28
Total	100

Note: Percentages may not total 100 because of rounding.

Institute. The clinic survey was one component of a multiyear project examining positive parental engagement and parent-child communication among adolescents attending U.S. clinics, and the facilities were originally recruited to distribute surveys to reproductive health clients younger than 18.[7] To complement the information gathered from adolescents, facilities were surveyed about the programs and activities that encourage such communication, and sample materials were collected (e.g., pamphlets and newsletters).

The universe from which the sample was drawn was restricted to clinics that served 200 or more adolescent contraceptive clients in 2001; it excluded Utah and Texas, because some clinics in these states were required by law to obtain parental consent to provide family planning services to minors. Overall, 2,442 clinics were eligible for this study, and they represented 37% of all U.S. family planning facilities; these clinics served 82% of all adolescent contraceptive clients in 2001. Prior to sample selection, clinics were stratified according to the number of adolescent clients served (200−399, 400−749, 750−1,199 and 1,200 or more), receipt of Title X funds, type of facility (Planned Parenthood, health department or other) and whether state law explicitly permitted minors to consent to contraceptive services. Clinic recruitment began in May 2003, and fielding ended in February 2004. The study was designed to obtain a representative sample of minors, not clinics. Of the 79 clinics that successfully participated in the adolescent survey, 11 did not fill out the clinic survey. However, an additional 13 facilities that were eligible for the adolescent survey, but that either declined or did not successfully participate, completed the clinic survey, and so the total sample consists of 81 facilities.*

The 12-page questionnaire included closed- and open-ended items. Four main topics were covered: clinic characteristics, counseling practices and other policies regarding minors, activities to improve parent-child communication (divided into information distribution, educational programs and training) and community relations. Because the questionnaire assessed a range of issues, some clinics had multiple staff members fill it out.

Questions about clinic characteristics, counseling, policies and community relations requested information about activities at the clinic site. Questions about information distribution, educational programs and training asked clinic staff to answer them in reference to "activities and programs that are provided by your clinic or *your parent organization or agency* and that are available within the area you serve," to ascertain whether clients might have access to a wider range of activities provided by sister sites of the same agency. For example, state health departments typically have several family planning clinics in large cities, and staff at small facilities, or at facilities that serve relatively few adolescents, may refer clients to programs run by other health department clinics. In three instances, information was obtained from clinics that shared educational resources. For example, two Planned Parenthood facilities within geographic proximity of one another and belonging to the same affiliate (made up of approximately 40 clinics) referred clients to the same two educational programs and shared a sex education trainer. In summary statistics, each program is counted separately; thus, these two Planned Parenthood clinics were considered to provide four educational programs.†

From survey descriptions, it was determined that three educational programs cited by clinics probably did not address communication. Additionally, seven clinics mischaracterized nine activities as educational that were considered to be information distribution or training. These 12 activities were excluded from the analysis of educational programs.

Because this study is exploratory and its main purpose is to describe clinic activities, analysis is limited primarily to frequency distributions. Given the small sample size, cross-tabulations examine only those activities in which a majority of clinics participated. Weights were not constructed for the data, nor was the statistical significance of differences determined.

RESULTS

Clinic Characteristics

Forty percent of the 81 clinics were Planned Parenthood facilities, 36% were health department clinics, 7% were hospital clinics, 4% were community health centers and the remaining 14% were other types of facilities (Table 1). The

*For a discussion of the criteria used for determining successful completion of the adolescent survey and clinic replacement, see reference 7.

†In five situations, two clinics belonged to the same agency but were unable to share resources in this way, presumably because they were not in geographic proximity to one another.

primary function of most of these clinics was to provide reproductive health services (81%), but 15% focused on primary care services. Almost eight in 10 clinics received Title X funds, and about one-quarter fell into each stratum regarding the number of adolescent contraceptive clients served. Participating clinics were fairly equally distributed across the four major geographic regions, and were located in 35 states (not shown).

The study sample was considerably different from the larger population of U.S. clinics serving 200 or more adolescent contraceptive clients. Planned Parenthood facilities made up 27% of all clinics in the study universe, clinics with adolescent caseloads of 1,200 or more made up 9% and those in the West made up 19%; thus, these three categories of clinics were overrepresented in the study.[8] The sample underrepresented "other" types of clinics (which accounted for 33% of all clinics), those serving 200–399 adolescent clients (48%) and those in the South (41%).

TABLE 2. Percentage of family planning clinics that report routinely counseling minors about talking to parents, by selected characteristics, according to type of visit

Characteristic	First visit for prescription contraceptive (N=79)	First visit for any contraceptive (N=80)	Any sexual health visit (N=78)	Continuing contraceptive visit (N=78)	Any visit (N=75)
Total	**94**	**93**	**79**	**78**	**73**
Type of facility					
Planned Parenthood	97	94	76	66	75
Health department	97	97	83	86	74
Other	85	85	80	85	70
Title X funding					
Yes	95	95	82	79	78
No	88	81	69	75	56
No. of adolescent clients per year					
200–399	94	89	82	88	59
400–749	85	95	80	75	80
750–1,199	100	95	76	75	68
≥1,200	95	90	80	76	84
Region					
Northeast	94	100	88	81	75
Midwest	91	86	77	73	76
South	100	94	72	83	61
West	91	91	82	77	80

Counseling

The large majority of clinics routinely counseled adolescents on the importance of talking to their parents about sexual health issues (Table 2); only 5% did not routinely counsel minors on this topic during at least one type of visit (not shown). Nearly all clinics included counseling about parental communication during sessions with minors who were making an initial visit for a prescription contraceptive (94%) or a first visit for any type of contraceptive (93%), and three-quarters did so with minors seeking any sexual health service (79%), continuing contraceptive service (78%) or any clinical service (73%). Counseling on parental communication at the initial prescription contraceptive visit was more common among Planned Parenthood and health department clinics (97% of each) than among other types of facilities (85%).

Compared with facilities that did not receive Title X funding, those that received such funding had higher rates of counseling adolescents about talking to parents at the initial prescription contraceptive visit (95% vs. 88%) and at the first visit for any contraceptive (95% vs. 81%). More than three-quarters of Title X–funded clinics encouraged parental communication with clients who were there for any sexual health service or any type of service (78–82%); proportions were lower in facilities without such funding (56–69%). The proportion that routinely offered counseling during any clinic visit was lower among clinics that served the fewest adolescent contraceptive clients than among clinics that served larger numbers of adolescents (59% vs. 68–84%); this was probably because clinics with smaller adolescent caseloads placed less emphasis on, or had less experience with, adolescent reproductive health clients and had more clients seeking services unrelated to sexual health. Only 61% of clinics in the South provided counseling to minors who were there for any clinical visit, whereas 75–80% of clinics in other regions did so.

In response to an open-ended question, 36% of clinics reported other circumstances in which clients younger than 18 were routinely counseled about the importance of talking to parents (not shown); the most frequently cited reasons were abnormal Pap test results (11%) and positive pregnancy tests or the need for options counseling (10%). Parental involvement was also explicitly encouraged for adolescents considered at risk, such as clients with multiple sex partners and those who had mental health problems or were developmentally challenged. Furthermore, 54% of the clinics reported that the amount or content of counseling for first-time prescription contraceptive clients younger than 18 differed from that provided to those 20 or older: Twenty-seven percent devoted more time to counseling the younger clients, 11% emphasized abstinence and 11% emphasized talking with parents.

Information Distribution

All but eight of the study clinics or their parent organizations distributed information aimed at improving communication between adolescents and parents. The most common activity was the distribution of pamphlets (84% of all clinics—Table 3); a larger proportion of clinics directed these

TABLE 3. Percentage of family planning clinics that distribute information about parent-child communication, by type of distribution, according to target audience

Distribution	Any	Adolescent clients	Adult clients	Community
Pamphlets	84	76	55	40
Social events (e.g., health fair, open house)	70	41	33	54
Library of instructional materials	59	34	28	36
Posters	54	45	26	26
Web site	54	34	34	35
Media campaign	45	na	na	45
Hotline	31	24	18	19
Newsletter	31	11	10	25

Notes: Based on reports from 80 clinics, except for information on media campaigns, which was obtained for 75 clinics. na=not applicable.

materials toward adolescent clients (76%) than toward adult clients (55%) or the wider community (40%). Sample materials submitted with the survey included a pamphlet that an Oregon health department distributed to adolescents titled *Birth Control: Talking with Your Parents,* which offered strategies for initiating conversations about sex and birth control, and described potential parental reactions to be prepared for when discussing these topics. A reproductive health clinic in Wisconsin provided two pamphlets that it distributed to the community: *How to Talk with Your Child About Sexuality* (produced by Planned Parenthood, even though the clinic was not affiliated) and *Talking with Preteens About Sexuality.* These included tips on specific topics to cover and the timing of conversations, and acknowledged that discussions about sex could be awkward and uncomfortable.

Providing information at social events, such as health fairs and open houses, was the second most common way that clinics or their parent organizations distributed information about parent-child communication (70%). More than half of clinics reported having a library of instructional materials, posters or information on a Web site (54–59%). More than four in 10 were involved in media campaigns, consisting mostly of radio ads, and three in 10 had hotlines or distributed newsletters. In general, social events and newsletters appeared to emphasize providing information to the community, as opposed to youth or adult clients.

Few differences were found in how the types of facilities distributed information, though a majority of Planned Parenthood clinics used Web sites (88%), hotlines (53%) and newsletters (53%), while only a minority of health departments and other facilities did so (not shown).

Educational Programs

The questionnaire asked clinic staff to identify up to four programs or activities—other than counseling or information distribution—that their organization had provided or cosponsored in the past 12 months and that were intended to improve communication between adolescents and parents. Thirty-five clinics (43% of the sample) reported a total of 72 educational programs. The majority of Planned Parenthood clinics (or their affiliates) offered at least one such program (63%), and 38% offered two or more. Some 38% of health department clinics offered at least one program, as did 20% of other types of facilities. Parent-child communication was cited as a main goal for 40 of the programs, and as a secondary goal for 26. In six instances, clinic staff did not indicate whether improving communication was a primary or secondary goal.

Short profiles of each program provided by respondents suggested substantial variation in programs' content, number of participants, intended audiences and goals. Under a model developed by the Center for Applied Research and Technical Assistance (CARTA) for categorizing educational programs aimed at improving positive parental engagement,[9] programs could generally be classified according to whether information and activities were youth-centered, parent-centered or joint-centered (involving youth and adults). Youth-centered programs were the most common (42%, or 30 programs, including six offered in schools or in after-school programs). For example, Safe or Sorry was offered by two Planned Parenthood clinics belonging to the same affiliate in New York; it consisted of 20 hours of peer education training focused on HIV and pregnancy prevention. Though communication skills were not the focus, each session included a segment on "home fun," which involved communication activities with parents. The target audience was high school students, and the program reached an estimated 100 teenagers in 2002.

Parent-centered programs were the second most common type (31%, or 22 programs). For example, a health department clinic in Illinois provided an educational program for parents of fifth graders that focused on communication skills related to sexuality issues, including helping mothers become more comfortable in talking with sons and helping fathers in talking with daughters. A Planned Parenthood facility in New Jersey offered a two-part workshop for parents designed to identify their strengths, challenges and goals with regard to communicating effectively with children. The program's objective was to help parents create a safe environment for family discussion by using communication skills that are effective in other settings, by understanding youth culture and by identifying teachable moments. The workshop recruited parents from the local YMCA and other local youth-serving organizations, and provided training to 52 adults in 2002.

Twelve of the educational programs (17%) were joint-centered. Two Planned Parenthood clinics (in the same Pennsylvania affiliate) helped provide or referred clients and community members to affiliate-sponsored Becoming a Teen workshops. These workshops, which reached approximately 200 mother-daughter pairs, were designed to improve family communication on issues related to puberty. Similar workshops directed at mothers and daughters were offered by a health department clinic in Illinois. These focused on team-building exercises, one of which had mothers compete against daughters in a Jeopardy-style game that included questions about puberty and reproductive health; the content was adjusted to be appropriate for girls in sixth, seventh or eighth grade. Most participants were Latina or black, and some workshops were conducted in Spanish. A total of 75 mother-daughter pairs participated in 2002.

For the remaining eight programs, the intended audience was too broad to be categorized as parent-, child- or joint-centered. For example, Promotoras is an education and medical outreach program sponsored by a California Planned Parenthood affiliate in which *promotoras,* or Latina health outreach workers, share information about reproductive health, sexuality and clinic services with other Latinas in their communities. Promotoras are Spanish-speaking and conduct *platicas,* or small talks, with neighbors, friends and family in homes, churches and other familiar settings. Improving parent-child communication is a secondary goal of the program, but helping parents learn how to speak with their children about sexuality is an ex-

plicit aim of the platicas. An estimated 1,000 adolescents and 2,000 adults participated in the program in 2002 as either outreach workers or platica attendees. Another Planned Parenthood facility, belonging to a different California affiliate, conducted community workshops with a variety of organizations—some that worked only with youth and others only with adults. This program provided comprehensive information about sex and communication skills and was tailored to the audience; it served 1,500 adolescents and 1,000 adults in 2002.

The 46 clinics that did not offer programs on parent-child communication were given a list of potential obstacles and asked whether each had limited their organizations' ability to do so; 24 clinics responded to any of the items. Funding or staffing issues were indicated by 23 clinics, and the low numbers of participants and lack of community support were reported as limitations by 10 clinics.

Training

Half of the surveyed clinics trained staff or belonged to agencies that provided training for staff from other organizations that work with youth or parents on improving communication.* Two-thirds of Planned Parenthood clinics provided training, as did nearly half of the health departments and other types of clinics. Almost two-thirds of clinics that did not receive Title X funds trained staff from other organizations, compared with half of clinics that did receive such funds. Social workers and counselors were the most common recipients of training (43% of all clinics), followed by teachers (35%), medical personnel (28%), and religious instructors and leaders (19%).

Overall, every clinic engaged in at least one activity to promote parent-child communication. Eighty-nine percent offered multiple activities, most commonly counseling and information distribution. Twenty-eight percent engaged in all four activities.

Future Activities

Clinics were asked if their activities regarding parent-child communication would increase, decrease or stay the same in 2004. This question referred to all activities, but perhaps because this item directly followed the section on educational programs, 12 of the 46 clinics that did not offer such programs gave no response, suggesting that they believed it applied only to existing programs. Of the 63 clinics that responded, 54% indicated that their efforts would remain the same; 43% expected to increase their activities (e.g., hire more educators, implement a new program or evaluate existing programs). Three facilities said their counseling activities would be altered in an effort to improve parent-child communication. Only two said they expected to decrease activities, both because of funding cuts.

Community Relations

To assess the local context in which clinics operate, the survey asked about their relationships with four types of community organizations: public schools, health care providers, youth-serving organizations and religious groups. Most commonly, clinics reported formal or informal relationships with public schools: Eighty-three percent reported that nearby schools referred teenagers to their facility for reproductive health services, and 78% provided schools with requested information (Table 4). Relationships with schools were most common among health department clinics: Eighty-nine percent indicated that schools referred teenagers for services, and 83% provided information (not shown).

TABLE 4. Percentage of family planning clinics, by characteristics of their relationships with community organizations and health care providers

Characteristic	Public schools	Health care providers	Youth-serving organizations	Religious groups
Clinic sees teenagers referred by organization	83	83	74	33
Clinic provides information requested by organization	78	57	74	36
Clinic staff make presentations at organization	70	35	63	36
Clinic programs include teenagers referred by organization	46	40	47	21
Clinic trains staff at request of organization	27	30	22	7
Clinic cohosts programs with organization	23	22	38	19
Clinic refers clients to programs sponsored by organization	11	33	23	2

Note: Based on reports from 81 clinics.

Local health care providers and youth-serving organizations also relied on family planning clinics. A majority referred teenagers to clinics (83% and 74%, respectively) and requested information (57% and 74%, respectively). Sixty-three percent of youth organizations asked clinic staff to make presentations.

Nearly three out of four clinics reported having some kind of relationship with religious groups in their communities: One-third reported that religious groups referred adolescents for services, requested information or invited clinic staff to make presentations.

Even though clinics reported a variety of positive relationships with community organizations, a higher proportion perceived general community opposition to than support for providing confidential reproductive health care to minors (59% vs. 37%). Health care providers were the most commonly mentioned supporters (indicated by 13 of the 26 clinics that perceived support), whereas religious and antichoice groups were mentioned most frequently as opponents (indicated by 26 of the 44 that perceived opposition).

DISCUSSION

Family planning clinics that receive Title X funds are mandated to encourage adolescent clients to involve parents in their sexual health decisions. These findings suggest that clinics—both those that receive Title X funding and those that do not—have taken this mandate seriously. All clinics in this study engaged in at least one activity intended to

*Sixteen clinics indicated that their parent organization provided training even though they did not provide, or were not able to provide referrals for, educational programs. These clinics were typically part of a large agency (e.g., the Georgia Department of Public Health).

promote parent-child communication, and most clinics engaged in multiple activities. Many facilities appear committed to helping teenagers talk to parents about sexual health issues and to helping parents and other supportive adults initiate conversations with youth. Furthermore, clinics used a range of activities to achieve these goals.

Counseling was the most commonly reported approach to encourage communication; it may be particularly effective because it often occurs on a one-to-one basis and thus allows adolescents to ask questions and receive information that is specific to their family circumstances. Future research might evaluate how useful adolescent clients find counseling, and randomized, controlled studies could evaluate whether counseling does, in fact, increase parent-child communication and what types of counseling practices are most effective in achieving this goal.

Educational programs can be cost- and labor-intensive, but a substantial minority of clinics either offered them or referred interested adolescents, adults and community members to programs sponsored by their parent organization. These programs were usually directed at youth, but many involved parents—either as the target audience or in programs that brought parents and adolescents together.

Several barriers limit the extent to which family planning clinics are able to provide educational programs or refer clients to programs that address parent-child communication. Inadequate funding and staffing are common concerns. Many clinics without programs need more money and trained staff before they can offer such activities; several clinics reported that funding cuts may force them to reduce the availability of existing programs.

Though this study was exploratory and the sample was small, the programs and activities reported here likely reflect those of the larger population of U.S. family planning clinics. For example, the proportion of clinics that offered educational programs was the same as that from nationally representative surveys that collected information on this topic (43% vs. 42–43%).[10] A slightly higher proportion of clinics in the study sample than in a national survey reported that parent-child communication was addressed in counseling with minors during the initial prescription contraceptive visit (94% vs. 89%),[11] probably because this sample was restricted to clinics that served at least 200 adolescent contraceptive clients per year. Subsequent research should determine whether other patterns found in this study parallel those in larger surveys of family planning clinics. For example, to what extent do U.S. clinics provide youth-centered, parent-centered and joint-centered programs? And among clinics that do not offer educational programs, are inadequate funding and staffing the only or primary obstacles? Similarly, family planning clinics would benefit from research that provides in-depth information on the content and approaches that improve parent-child communication and on which audiences are most receptive to various types of information and activities.

This study has several possible limitations. Though estimates of counseling activities and educational programs are similar to national estimates, this sample may be biased if clinics that do relatively little to address this issue did not participate in the study. Also, a social desirability bias may have led clinic staff to exaggerate efforts in this area or to be overly generous in their definition of activities that promote parent-child communication. This may account for the need to correct for overreporting of educational programs.

In June 2005, the Parent's Right to Know Act was introduced in both houses of Congress. This legislation would require federally funded family planning clinics to notify the parents of any minor seeking prescription contraceptives at least five days before dispensing them. An assumption of such legislation is that clinics "usurp the legitimate rights of parents to guide their children" when they provide confidential sexual health services to minors.[12] However, this study demonstrates that most clinics are not trying to limit parental guidance, but rather are making concerted efforts to involve parents. Furthermore, a majority of adolescents who use family planning clinics say that a parent knows of their visit, and adolescent females who have made prior visits for contraceptives are more likely than those who are there for the first time to report that a parent knows about the visit.[13]

Many family planning clinics have adopted activities to promote communication between adolescents and parents, and these activities have likely helped some young women talk to parents about their clinic visits and sexual health issues. Thus, a more promising alternative to mandating parental notification would be to support clinics in their efforts to improve parent-child communication.

REFERENCES

1. Jones RK and Boonstra H, Confidential reproductive health services for minors: the potential impact of mandated parental involvement for contraception, *Perspectives on Sexual and Reproductive Health,* 2004, 36(5):182–191.

2. The Alan Guttmacher Institute (AGI), *Family Planning Annual Report: 2004 Summary,* Table 1-FP, <http://www.guttmacher.org/pubs/FPAR2004.pdf>, accessed Oct. 3, 2005.

3. Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, sec. 931(b)(1), 95 Stat. 570.

4. Furstenberg FF et al., Parental involvement: selling family planning clinics short, *Family Planning Perspectives,* 1982, 14(3):140–144.

5. Finer LB et al., U.S. agencies providing publicly funded contraceptive services, *Perspectives on Sexual and Reproductive Health,* 2002, 34(1):15–24; and Lindberg LD et al., Provision of contraceptive and related services by publicly funded family planning clinics, 2003, *Perspectives on Sexual and Reproductive Health,* 2006, 38(3):139–147.

6. Lindberg LD et al., 2006, op. cit. (see reference 5).

7. Jones RK et al., Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception, *Journal of the American Medical Association,* 2005, 293(3):340–348.

8. Unpublished tabulations from the 2001 Family Planning Clinic Census, New York: AGI, 2005.

9. Sugland BW, León J and Hudson R, *Engaging Parents and Families in Adolescent Reproductive Health: A Case Study Review,* Baltimore: Center for Applied Research and Technical Assistance (CARTA), 2003; and Innocent MA and Sugland BW, *Connecting the Dots: How Practitioners Engage Parents, Families and Youth Around Reproductive and Sexual Health,* Baltimore: CARTA, 2004.

10. Finer LB et al., 2002, op. cit. (see reference 5); and Lindberg LD et al., 2006, op. cit. (see reference 5).

11. Lindberg LD et al., 2006, op. cit. (see reference 5).

12. James JE, letter to the editor, *Journal of the American Medical Association,* 2002, 288(23):2970.

13. Jones RK et al., 2005, op. cit. (see reference 7); Furstenberg FF et al., Family communication and teenagers' contraceptive use, *Family Planning Perspectives,* 1984, 16(4):163–170; Kenney AM, Forrest JD and Torres A, Storm over Washington: the parental notification proposal, *Family Planning Perspectives,* 1982, 14(4):185, 187–190 & 192–197; and Torres A et al., Telling parents: clinic policies and adolescents' use of family planning services, *Family Planning Perspectives,* 1980, 12(6): 284–292.

Acknowledgments

The author thanks Alison Purcell for data entry and verification, and Susheela Singh, Cynthia Dailard and Jennifer Frost for reviewing drafts of this article. This research was funded in part by the Annie E. Casey Foundation. The findings and conclusions presented in this article are those of the author alone.

Author contact: *rjones@guttmacher.org*