Teenagers' Access to Confidential Reproductive Health Services

Public policy has long protected the right of minors to receive contraceptive services confidentially. The same is not true for abortion, notwithstanding research suggesting that policies mandating parental involvement in either case present a significant threat to teenagers' health and well-being. Although the public remains ambivalent, professional organizations familiar with the scientific evidence uniformly support the provision of reproductive health care to minors on a confidential basis. Public policy developments at the state and federal level, however, suggest that teenagers' access to confidential services will remain under attack in the months and years to come.

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The public policy debate over whether teenagers should be allowed to obtain reproductive health services confidentially or required to involve their parents dates back to the 1970s, when teen sexual activity became increasingly visible and teen pregnancy was first deemed a national social problem. Although teenagers did not initiate sexual activity any earlier over the course of that decade (according to groundbreaking surveys measuring levels of teenage sexual activity), the age of marriage was rising. Therefore, pregnancies that would have occurred to teenagers within marriage in previous years increasingly occurred before marriage. At the same time, pregnant teenagers became less likely to marry to "legitimize" their pregnancies and births, and more teens began to terminate their pregnancies following the national legalization of abortion in 1973.

Meanwhile, a growing body of research demonstrated that teenagers who gave birth had worse maternal and child health outcomes than did those who postponed childbearing, and that these young women were more likely to be poor and have reduced educational and workforce achievement. Reproductive health providers and others concerned about adolescent health and well-being increasingly turned their attention to ensuring that teenagers had the information and services they needed to avoid early and unwanted pregnancy. New laws and policies at the state and federal levels began to allow teenagers to consent to reproductive health services and to ensure that services would be delivered confidentially when requested. And in the late 1970s, the Supreme Court in successive decisions extended the constitutional right to privacy to a minor's decision to both obtain contraceptives and choose an abortion.

These developments, however, produced a political backlash among social and religious conservatives, who contended that the very availability of confidential reproductive health services promoted sexual promiscuity among teens, undermined parental authority and interfered with parent-child relationships. They argued, then and now, that state and federal law should enshrine parents' rights to control their children's upbringing, and they have worked consistently over the course of three decades to legislate parental control over teenagers' reproductive health care decisions.

Public Policy

Parents generally have the legal authority to make medical decisions on behalf of their minor children, on the basis that young people typically lack the maturity and judgment to make fully informed decisions before they reach the age of majority (18 in most states). Exceptions to this rule have long existed, such as when medical emergencies leave no time to obtain parental consent and in cases where a minor is "emancipated" by marriage or other circumstances and thus can legally make decisions on his or her own behalf. Furthermore, some state courts have adopted the so-called mature minor rule, under which a minor who is deemed sufficiently intelligent and mature to understand the nature and consequences of a proposed treatment may consent to medical treatment without consulting his or her parents or obtaining their permission.

On the basis of scientific findings dating back to the late 1970s that identified the premium that young people place on confidentiality, public policy has long reflected the reality that many minors will not seek important, sensitive health services if required to inform their parents. Today, a significant body of federal and state law explicitly guarantees confidential access to services or does so by implication. Since its inception in 1970, Title X of the Public Health Service Act—the only federal program dedicated to providing family planning services to low-income women and teenagers—has

provided confidential services to people regardless of age (although minors must be encouraged to include their parents in their decision to seek services). The federal Medicaid statute also requires family planning services to be provided confidentially to sexually active minors who seek them.

Additionally, a host of state laws explicitly authorize minors to consent to a range of reproductive health services (including prenatal care and delivery), as well as to substance abuse treatment and mental health care. Currently, all states allow minors to consent to testing and treatment services for STDs. Twenty-one states and the District of Columbia explicitly allow all minors to consent to contraceptive services, and another 25 affirm the right for certain categories of minors, such as those who are married or who have had a previous pregnancy. Four states have no explicit policy in this area; in these states, and other states with very limited policies, the decision of whether to inform parents is typically left to a physician's discretion based on the best interests of the minor (see table, page 8).

In stark contrast to the protections generally afforded to minors seeking STD care and contraceptive services, laws addressing minors' access to abortion services are often quite restrictive.

Efforts by conservative lawmakers at both the federal and state levels to prevent teenagers from obtaining contraceptive care without a parent's knowledge have been largely unsuccessful. For example, federal courts struck down the Title X "squeal rule"—a 1982 regulation issued by the Reagan administration requiring that Title X–supported clinics notify parents before dispensing contraception to minors—on the grounds that it undermined one of the major purposes of Title X (preventing teenage pregnancies) and therefore subverted the intent of Congress. Similarly, Congress rejected a series of amendments in the late 1990s that would have attached a parental consent requirement to the annual legislation funding the program. Similar efforts have been unsuccessful at the state level as well, and today only two states—Utah and Texas—require parental consent in state-funded family planning programs.

In stark contrast to the protections generally afforded to minors seeking STD care and contraceptive services, laws addressing minors' access to abortion services are often quite restrictive. Currently, 34 states require that a minor either notify or receive consent from one or both parents prior to obtaining an abortion; 21 states require parental consent, and 13 states require parental notification. However, with the exception of Utah, whose law remains unchallenged, all of the 34 states provide for an alternative process that allows a minor to obtain an abortion without involving a parent, as is constitutionally required. These laws typically either allow a minor to obtain approval from a court (known as a "judicial bypass") or permit another adult relative to be notified of or consent to the procedure. Most laws also include provisions that allow the doctor to forego parental involvement in the case of a medical emergency or in cases of parental abuse, assault, incest or neglect.

Further complicating the legal landscape governing minors' ability to obtain confidential reproductive health services are state laws requiring the reporting of "statutory rape." Laws criminalizing sex with an underage minor vary considerably by state, on the basis of the age of the "victim," the age difference between the "victim" and "perpetrator," and the nature of the act. A separate body of laws that also varies widely by state requires those who have frequent contact with children, such as health care providers, to report to state authorities when they suspect that an underage minor has been a victim of sexual abuse—a term which sometimes but not always includes statutory rape. Interpreting these interlocking areas of laws, therefore, can be difficult and the laws themselves can be unclear. The obligation to report statutory rape, moreover, may directly conflict with the ethical—and legal, in the case of Title X and Medicaid—requirement that health care professionals maintain the confidentiality of health care services provided to their adolescent patients. And this is likely to have implications for teenagers' willingness to seek care ("Statutory Rape Reporting and Family Planning Programs: Moving Beyond Conflict," *TGR,* June 2004, page 10).

Similarly, a regulation issued in 2002 pursuant to requirements of the Health Insurance Portability and Accountability Act (HIPAA) technically vitiates the long-standing presumption that when minors legally consent to medical care, they can also expect their medical records to remain confidential. Under the regulation, minors will only control their medical records when states explicitly authorize them to do so. But when a state is silent on the specific subject of medical records (as most of them now are), the health care provider may decide whether to maintain the confidentiality of those medical records or disclose them to a parent. Thus, a state law granting minors the right to consent to reproductive health care no longer implicitly guarantees the confidentiality of their medical records. Still, it is worth noting that the regulation explicitly states that it "does not want to interfere with the pro-

PARENTAL INVOLVEMENT IN MINORS' ACCESS TO ABORTION AND CONTRACEPTIVE SERVICES

State	Abortion	Contraception
Alabama	PC	LMC
Alaska	PE	MC
Arizona	PC	MC
Arkansas	PC	MC
California	PE	MC
Colorado	PN	MC
Connecticut	LMC*	LMC
Delaware	PN†	LMC
Dist. of Columbia	MC	MC
Florida	PN	LMC
Georgia	PN	MC
Hawaii	NL	LMC
Idaho	PE	MC
Illinois	PE	LMC
Indiana	PC	LMC
Iowa	PN	MC
Kansas	PN	LMC
Kentucky	PC	MC
Louisiana	PC	LMC
Maine	LMC*	LMC
Maryland	PN†	MC
Massachusetts	PC	MC‡
Michigan	PC	LMC
Minnesota	PN‡	MC
Mississippi	PC‡	LMC
Missouri	PC	LMC
Montana	PE	MC
Nebraska	PN	LMC
Nevada	PE	LMC
New Hampshire	PE	LMC
New Jersey	PE	LMC
New Mexico	PE	MC
New York	NL	MC
North Carolina	PC	MC
North Dakota	PC‡	NL
Ohio	PC	NL
Oklahoma	PN	LMC
Oregon	NL	MC
Pennsylvania	PC	LMC
Rhode Island	PC	NL
South Carolina	PC	LMC
South Dakota	PN	LMC
Tennessee	PC	MC
Texas	PC	LMC§
Utah	PN	LMC§
Vermont	NL	LMC
Virginia	PC	MC
Washington	NL	MC
West Virginia	PN†	LMC
Wisconsin	PC†	NL
Wyoming	PC	MC

Notes: MC=Minor explicitly allowed to consent; LMC=Minor explicitly allowed to consent in limited circumstances (such as if married, a parent, pregnant or older than a specified age); PN=Parental notice required; PC=Parental consent required; NL=No explicit law or policy; PE=Law permanently enjoined.

fessional requirements…or other ethical codes of health care providers with respect to the confidentiality of health information or with the health care practices of such providers with respect to adolescent health care" ("New Medical Records Privacy Rule: The Interface with Teen Access to Confidential Care," *TGR,* March 2003, page 6).

What the Research Says

Proponents of laws and policies designed to require parents to be involved in their adolescent's decisions to seek reproductive health care argue that in addition to restoring "parental rights," such requirements will further parent-child communication while dissuading minors from engaging in sexual activity; however, research spanning almost three decades fails to confirm these claims. There is no research that supports the notion that mandatory parental involvement requirements for either contraceptive services or abortion improve parent-child communication or facilitate conversations about sex, birth control or related matters. To the contrary, the research suggests that these policies are potentially harmful to teenagers' health and well-being, and highlights the importance of confidentiality to teenagers' willingness to seek care.

Contraception. Surveys of teenagers in family planning clinics have found that approximately half of adolescents report that a parent knows that they were at the clinic, according to a literature review published in 2005 in *Current Opinions in Obstetrics and Gynecology.* Furthermore, a recent, national survey of teenagers at family planning clinics published in the *Journal of the American Medical Association (JAMA)* in 2005 found that one-quarter of those minors surveyed were there at a parent's suggestion. (Research has also found that younger teenagers are more likely than older adolescents to report that a parent knows about the visit, to make a family planning visit at a parent's recommendation or to be accompanied by a parent; black teenagers who use family planning clinics are more likely than whites to have parents involved in their reproductive health decisions.) Those who do not want to inform their parents that they are at a clinic, however, give many reasons, including a desire to be self-sufficient and not wanting to disappoint parents.

*Minor may obtain an abortion upon meeting specified counseling requirements. †Allows specified health professionals to waive parental involvement if judge is unavailable. ‡Requires the involvement of both parents. §State funds may not be used to provide minors with confidential contraceptive services. For more detail, see Guttmacher Institute, Parental involvement in minors' abortions, *State Policies in Brief,* October 2005, and Guttmacher Institute, Minors' access to contraceptive services, *State Policies in Brief,* October 2005, available at <http://www.guttmacher.org/statecenter/spibs/index.html>.

In addition, research suggests that laws that require teenagers to involve their parents in their decisions to obtain birth control are likely to have harmful consequences. According to the 2005 JAMA study, only 1% of minor adolescents visiting family planning clinics indicated that their reaction to mandated parental involvement would be to stop having sex, while as many as two in 10 said they would practice unsafe sex (by forgoing contraception entirely or relying on withdrawal). Significantly, seven in 10 of those whose parents did not know they were at the clinic said they would not use the clinic for prescription contraception.

Furthermore, there is evidence that parental consent requirements for birth control alone would deter teenagers from seeking care for other important reproductive health services at family planning clinics, such as testing and treatment for STDs. A 2004 study published in the *Archives of Pediatric Medicine* estimated that recent changes to Texas law requiring parental consent for state-funded prescription contraceptives and increased reporting of statutory rape would significantly increase the number of teenage pregnancies and untreated STDs, costing the state and federal governments approximately $44 million per year.

Because of the relative scarcity of these laws—only two states and one county require parental consent for contraception in state or locally funded family planning programs—only one U.S. study has measured the actual effect of such a policy. That study, published in 2004 in the *American Journal of Public Health (AJPH),* examined the effects of a 1998 parental consent requirement for contraceptive services provided at the McHenry County health clinic in Illinois. The study found that the proportion of all births to women under age 19 increased in McHenry County between 1998 and 2000, even as they decreased during the same period in nearby counties that had similar racial and economic profiles and no restrictions on minors' access to contraception.

Abortion. As with contraception, research shows that more than six in 10 teenagers in states without a parental consent requirement say one or both parents knew about the abortion, according to a study published in 1992 in *Family Planning Perspectives (FPP).* A similar study published in 1987 in *AJPH* found that the proportion of teens who inform their parents is approximately the same in states with and without such requirements. Moreover, there is no evidence to suggest that laws mandating parental involvement in a teenager's decision to obtain an abortion improve family communication or relationships.

In contrast, research suggests that parental consent requirements can have potentially serious adverse consequences associated with delayed access to timely medical care among those teenagers who do not wish to involve their parents in their abortion decisions. Teenagers typically detect their pregnancies later than do adults, and legal obstacles that create further impediments to timely care are likely to result in later abortions, which are significantly more dangerous to a woman's health and more expensive to obtain. Some teenagers seeking an abortion may obtain a judicial bypass; however, obtaining a judicial bypass can take time, inevitably delaying the abortion procedure. Other teenagers may travel to states with less restrictive abortion laws rather than involve a parent, and it can take time for an adolescent to muster the will and resources to undertake an out-of-state trip without a parent's knowledge. A delay also can result when a teenager who is reluctant to inform her parents puts off the dreaded discussion as long as possible. These factors help explain why three separate studies looking at Missouri, Minnesota and Mississippi—published between 1991 and 1996 in the *AJPH, FPP* and *Women and Health,* respectively—found that minors had later abortions following the enactment of a mandated parental involvement law than was previously the case, with a higher proportion performed in the second trimester (after 12 weeks' gestation).

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In addition, forcing teenagers to inform their parents that they are pregnant or seeking an abortion may place some at risk of physical violence or abuse. The 1992 *FPP* study found that approximately one-third of teenagers who did not tell their parents about their decision to seek an abortion had experienced violence in their family, or feared that violence would occur or that they would be forced to leave home. Among minors whose parents found out about their pregnancy from other sources, 6% reported physical violence, being forced to leave home or damage to their parents' health.

Proponents of parental involvement laws claim that such requirements reduce abortion and pregnancy rates among teenagers for two reasons. First, they argue that with their parents' guidance, more pregnant teenagers will choose childbirth (and perhaps adoption) over abortion. Second, they claim that teenagers who do not wish to inform their parents about a pregnancy to obtain an abortion will think twice before having sex in the first place. Studies with findings that appear to support these contentions typically suffer from methodological problems. For example, a 2004 analysis by the

Heritage Foundation concluded that parental involvement policies have resulted in modest declines in abortion rates. The analysis, however, ignores the possibility that some young people sought abortions in neighboring states where the laws are less restrictive. Similarly, a study published in *AJPH* in 1991 concluded that because abortion rates and birthrates declined among 15–17-year-olds in Minnesota following the enactment of a two-parent notification law, the law caused adolescent women to avoid pregnancy. This study appears to have neglected to take into account those instances where a parent accompanied a daughter to a neighboring state to receive an abortion rather than notifying the other parent. In contrast, studies published in *AJPH* in 1986 and *FPP* in 1995 demonstrate that while the number of abortions performed on minors falls dramatically in states following the implementation of parental involvement statutes, the number of abortions performed in neighboring states rises accordingly.

Public and Professional Opinion

Despite these findings, public opinion has consistently reflected a deep ambivalence toward the notion of providing confidential reproductive health services to minors. At the same time, surveys, polling data and voting patterns suggest that the public's attitudes are also complex and even unsettled. For example, an analysis published in the *Archives of Pediatrics and Adolescent Medicine* of a 2002 telephone survey of Wisconsin and Minnesota parents of adolescents found that slightly more than half (55%) of those surveyed supported the idea of a law requiring parental notification for contraception. Almost all parents, however, expected at least one negative consequence as the result of such a policy—with six in 10 citing increases in teen pregnancies and STDs—and approximately half expected at least five negative consequences. The more harms parents could associate with parental involvement laws, the less likely they were to support such policies. This led the authors to conclude that public education campaigns focusing on the potential outcomes of parental involvement laws are likely to broaden public support for minors' right to confidentiality.

With respect to abortion, a decade's worth of public polling on the issue suggests that the public favors mandated parental involvement by a margin of three to one. When the issue has been put directly to the voters, however, these margins are reduced. And although two statewide ballot initiatives requiring parental notification

STATEMENTS ON TEEN ACCESS TO CONFIDENTIAL CARE

American Academy of Family Physicians: "Concerns about confidentiality may discourage adolescents from seeking necessary medical care and counseling, and may create barriers to open communication between patient and physician. Protection of confidentiality is needed to appropriately address issues such as…unintended pregnancy." **(Adolescent Health Care, 2001)**

American Academy of Pediatrics: "Health care professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients…This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis….At the time providers establish an independent relationship with adolescents as patients, the provider should make…clear to parents and adolescents [that]…confidentiality will be preserved between the adolescent patient and the provider. **(Confidentiality in Adolescent Health Care, 2004)**

American College of Obstetricians and Gynecologists: "The potential health risks to adolescents if they are unable to obtain reproductive health services are so compelling that legal barriers and deference to parental involvement should not stand in the way of needed health care for patients who request confidentiality. Therefore, laws and regulations that are unduly restrictive of adolescents' confidential access to reproductive health care should be revised." **(Access to Reproductive Health Care for Adolescents, 2003)**

American College of Physicians: "In the care of the adolescent patient, family support is important. However, this support must be balanced with confidentiality and respect for the adolescent's autonomy in health care decisions and in relationships with health care providers. Physicians should be knowledgeable about state laws governing the right of adolescent patients to confidentiality and the adolescent's legal right to consent to treatment." **(Ethics Manual: Fourth Edition, 1998)**

American Medical Association: "Our AMA…reaffirms that confidential care for adolescents is critical to improving their health….When in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care." **(Confidential Health Services for Adolescents, 2004)**

Society for Adolescent Medicine: "Confidentiality protection is an essential component of health care for adolescents because it is consistent with their development of maturity and autonomy and without it, some adolescents will forgo care….Health care professionals should support effective communication between adolescents and their parents or other caretakers. Participation of parents in the health care of their adolescents should usually be encouraged, but should not be mandated….Laws that allow minors to give their own consent for all or some types of health care and that protect the confidentiality of adolescents' health care information are fundamentally necessary to allow health care professionals to provide appropriate health care to adolescents and should be maintained." **(Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine, 2004)**

for abortion have passed (Colorado in 1998 and Florida in 2004), an initiative in Oregon was defeated in 1990. Recent surveys of likely voters in California reveal that the public is closely divided on a parental notification ballot initiative to be voted upon in November.

Notwithstanding ambivalence among the general public, medical, public health and youth-serving organizations familiar with the research in this area have consistently come out against laws and policies requiring mandatory parental involvement for both contraceptive and abortion services. These organizations—made up of the professionals who study and work most closely with teens—include the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Medical Association and the Society for Adolescent Medicine, among others. The collective position statements of these respective organizations reflect the consensus that health care providers have an obligation to encourage adolescents to talk to their parents about matters pertaining to sexual activity and reproductive health care and, further, that they can play an important role in facilitating such conversations where appropriate. At the same time, however, they uniformly state that minors should not be compelled to involve their parents in their decision to obtain contraceptives or an abortion, reaffirming the right of minors to access and receive confidential care (see box).

What the Future Holds

To be sure, the notion of providing confidential reproductive health services to minors remains under attack at the state and federal levels. Legislators in seven states have introduced bills in 2005 requiring parental consent or notification for family planning services. Similarly, the Parents' Right to Know Act—legislation that would require Title X–supported family planning clinics to notify the parents of any minor seeking contraceptives at least five days before dispensing a method—is pending in Congress.

With respect to abortion, legislators in 29 states have introduced legislation in 2005 to either impose a new parental involvement requirement or tighten an existing law; bills were signed into law in seven states (Arkansas, Florida, Georgia, Idaho, Oklahoma, South Dakota and Texas). In California, a major ballot initiative will go before the voters in November that would amend the state constitution to require health care providers to notify parents or guardians 48 hours before they perform an abortion on an unmarried minor. (The measure includes an exception for medical emergencies and when a parent or guardian signs a waiver allowing the procedure to happen sooner.) And, at the federal level, the House of Representatives passed the Child Interstate Abortion Notification Act (CIANA)—a complicated and convoluted legislative proposal that would have the effect of imposing a strict federal parental notification requirement that would be applicable even in states that have rejected such a policy. The legislation is now pending before the Senate.

Even more ominous, perhaps, is that the Supreme Court is scheduled to hear the case of *Ayotte v. Planned Parenthood of Northern New England* in November. The case involves a New Hampshire statute that requires notification of one parent 48 hours before a minor's abortion, or a judicial bypass, with an exception only for situations where a physician can certify that the emergency abortion is necessary to prevent the minor's death. Lower federal courts have held the law unconstitutional because it does not contain an exception for emergency situations where an abortion is necessary to protect the minor's health. The New Hampshire attorney general is arguing that a parental notification law need not have a health exception on the theory that the judicial bypass can function quickly enough to allow for an emergency abortion when a minor's health is at stake. If a newly comprised Court accepts this reasoning, it would upset legal precedents that say that a physician must be able to proceed immediately to protect a minor's health.

Given the impending vote on the California ballot initiative, the upcoming Supreme Court case and anticipated congressional action on CIANA, it is clear that a great deal is at stake in the coming months that will determine whether many teenagers across the nation are able to obtain confidential contraceptive and abortion services or whether they will be forced to involve their parents. As the research indicates, this has significant implications for teenagers' health and well-being. How all of this plays out—and how teenagers fare as a result—remains to be seen.

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