F

TO: Hillary Rodham Clinton
FROM: Jennifer Klein j.k.
DATE: 3/25/96
RE: Teen Pregnancy

You had asked for a critique of the manuscript by Lainie Friedman Ross that Dr. Koop forwarded to you. Attached please find a short critique by Dr. Felicia Stewart, Deputy Assistant Secretary for Population Affairs at HHS.

I have also attached an article by the Council on Scientific Affairs of the American Medical Association on the same subject. Dr. Ross uses this article to support her claim that "most adolescents . . . do discuss these issues with their parents." The article actually concludes that confidential care is critical for adolescents and cites data showing that adolescents are more likely to seek care if they can do so confidentially. It also recommends that physicians involve parents in the medical care of an adolescent patient when it is in the best interest of the patient.

INFORMATION / COMMENTS requested

date: 12 March 1996
to: Peter Edelman, Asst Secty for Planning and Evaluation
Jennifer Klein
from: Felicia H. Stewart MD, Deputy Asst Secty for Population Affairs
re: Adolescent Sexuality and Public Policy: A *Liberal* Response
by Lainie Friedman Ross

Overview: This manuscript argues that "specialized consent statutes . . . are an inappropriate ***solution*** to adolescent sexuality." The analysis also notes that "such statutes ***endorse*** deception," and are ***"illiberal*** in that they circumvent parental decision-making authority," and that "recent legislation and court decisions in the United States ***usurp parental power*** on health care issues pertaining to adolescent sexuality and reproduction" [emphasis mine]. The analysis is centered on a hypothetical dilemma, which the author asserts is "***relatively common*** in pediatrics," involving a 14 year old who might seek confidential care from her pediatrician to obtain prescription contraception despite the fact that her family would, because of devout Catholic religious beliefs, prohibit use of contraception, and would not approve of premarital sexual activity.

Comment: Using "loaded" language (see emphases in the preceding paragraph) the analysis misconstrues the origins and reasons for existing statutes, as well as their effects–creating "straw men" to be dispatched. For example, by characterizing such statutes as a "solution" to adolescent sexuality, the author implies that someone believed them to be so. No one I know! Rather, availability of confidential services is but one part of an appropriate set of responses to serious and difficult, multifaceted, public health problems. The statutes and legal precedents involved are not "recent," and these are not new problems. The issues involved have been carefully weighed by many thoughtful, experienced, and deeply concerned people. Confidential health services for adolescents is such an important issue that the AMA Council on Scientific Affairs undertook a comprehensive review in 1992, and concluded that "confidential care for adolescents is critical to improving their health."[1] Similar deliberations have been undertaken, with similar policy recommendations reached, by more than 30 national professional organizations.

The hypothetical case upon which "moral arguments" and conclusions in this analysis are based, also seriously misrepresents the nature of the problems involved.

Contrary to the author's assertion, it is not at all common for a 14 year old to seek confidential contraception care. Half of all teens do not initiate sexual activity before age 17. Among 14 year-olds, although 23% have had intercourse, more than half (60%) have had ***involuntary*** intercourse.[2] So when a 14 year old seeks such health care, whether or not accompanied by a parent, the health issues are far more serious than contraception. In ***most*** cases, the issues of sexual assault or incest must be addressed, and appropriate resources and referrals arranged, and in ***most*** cases there will be, in addition, state reporting requirements related to abuse or neglect. The very fact of sexual

activity at age 14 is so defined in many jurisdictions. Statistics are slightly less severe for teens at age 15 (30% have had intercourse, 40% of those involuntarily),[2] but still a very serious health concern. The clinician's role in caring for very young teens, therefore, is first concerned with the teen's safety and health, and second with helping the teen acquire resources, knowledge and self-knowledge, and skills in negotiation and planning, that can help him or her avoid future exposure to unwanted sexual experiences. This role is not fairly described as "endorsing deception" or "approving or condoning responsible adolescent sexual activity;" it is a possible life-line for rescue in a situation where parental support has already proven to be insufficient.

The policy analysis in this manuscript, based on a highly atypical, hypothetical young teen situation, does not adequately represent the scope of the issues involved for young teens, nor the true dilemmas for mid-age teens, and ignores entirely the largest group involved– the nearly-adult minors.

Background: The author is a pediatrician, recently turned philosopher (with Ph.D. from Yale anticipated in 1996). She is a member of the Univ. of Chicago, Department of Medicine Faculty. Previous publications listed on the Univ. of Chicago world-wide-web home page include: "Spheres of Political Order" (written with David Schmidtz) forthcoming in *Nomos;* "Justice for Children: The Child as Organ Donor" in *Bioethics* (1994); and "Moral Grounding for the Participation of Children as Organ Donors" in *Journal of Law, Medicine, and Ethics* (1993).

The manuscript (apparently) will be published in *Politics and the Life Sciences,* a refereed but obscure journal. It is not included on the normal journal search lists, but was tracked down with the help of two extraordinary research librarians at the Parklawn reference library. It is published twice yearly for the Association of Politics and Life Sciences, by a British firm, Beechtree Publishing. Telephone information from the publisher indicates that the journal has a circulation of about 1,000, two-thirds of which is in the U.S. Its authors also are mostly from the U.S. We have requested a complimentary copy, and will forward it to you when it arrives.

References:

[1] Anon. Report of the Council on Scientific Affairs: Confidential Health Services for Adolescents, 1992. Reprint request to the Group on Science and Technology, American Medical Association, 515 North State Street, Chicago, Il 60610 (Janet E. Gans, PhD).

[2]Patricia Donovan *et al.* Sex and America's Teenagers. New York: The Alan Guttmacher Institute, 1994.

Confidential Health Services for Adolescents

Council on Scientific Affairs, American Medical Association

DURING the past 20 years rates of suicide,[1] illicit drug use,[2] sexually transmissible diseases (STDs),[3] and births to single mothers[4] have increased dramatically among adolescents. The changing nature of adolescent morbidity and mortality makes it critical that they receive medical care on a timely basis, and that barriers to care are removed.[5] One such barrier for many adolescents is their concern about whether sensitive information shared in private with their physician will remain confidential.

See also p 1404.

This report reviews adolescents' need for confidential health services and support by physicians and organized medicine for confidential care. Examined are two major barriers to confidential medical care: the prerogative to provide informed consent for medical treatment and payment for health services. The report describes how physicians can balance parental involvement and adolescents' needs for privacy in health care decisions and strategies to allay parental concerns and help them view the need for confidentiality as a normal part of human development. Policy recommendations for confidential care for adolescents are included at the end of the report.

ADOLESCENTS' NEED FOR CONFIDENTIAL HEALTH SERVICES

A major developmental task of adolescence is learning how to make appropriate decisions about education, employment, social relationships, and health behaviors. Physicians can help adolescents to incrementally assume greater responsibility for health behaviors and decisions by providing a context in which the adolescent may candidly discuss concerns, worries, and health-risk behaviors.

Privacy is essential to process. Confidentiality refers to the privileged and private nature of information provided during the health care transaction. It is generally acknowledged to be a cornerstone of the physician-patient relationship and "essential to a patient's trust in a health care provider and to a patient's willingness to supply information candidly for his or her benefit."[6] Exceptions to confidentiality include information required by third parties for billing purposes or when the law requires disclosure (eg, a threat to inflict bodily harm, cases of communicable diseases, gun shot and knife wounds, or child abuse).[7,8(p51)]

Uncertainty about whether health services will be confidential is perceived by both physicians and adolescents as a factor that may lead some adolescents to suppress relevant information or delay or avoid medical visits.[9] Lack of candor makes it harder for the physician to identify and provide appropriate treatment for the adolescent's medical problems. The delay or failure to seek nec care may result in more serious shor or long-term complications.

Adolescents are more likely to see necessary medical treatment, particu larly for problems of a sensitive natur if they can do so without their parent knowledge. A 1982 survey[10] of 180 sub urban New York City adolescents foun that if parental knowledge were man datory, only 45% of adolescents woul seek medical services for depressio 19% for birth control, 15% for STDs, an 17% for drug use. If assured that me ical treatment would be confidential, a additional 12% indicated that they wou seek care for depression, 50% mo would seek care for STDs, and 49% mo: would seek care for drug use. The desi for confidential medical care has led som adolescents to use community clinics school-based health centers rather tha seek health services from their primar

From the Council on Scientific Affairs, American Medical Association, Chicago, Ill.

This report was presented at the 1992 House of Delegates Annual Meeting as Report A of the Council on Scientific Affairs. The recommendations were adopted as amended, and the remainder of the report was filed.

This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. This report reflects the scientific literature as of June 1992.

Reprint requests to the Group on Science and Technology, American Medical Association, 515 N State St, Chicago, IL 60610 (Janet E. Gans, PhD).

Members of the Council on Scientific Affa include the following: Yank D. Coble, Jr, M (Vice-Chairman), Jacksonville, Fla; E. Ha vey Estes, Jr, MD (Chairman), Durham, N C. Alvin Head, MD (Resident Represent tive), Tucker, Ga; Mitchell S. Karlan, MD, Be erly Hills, Calif; William R. Kennedy, MD, M neapolis, Minn; Patricia Joy Numann, M Syracuse, NY; William C. Scott, MD, Tucso Ariz; W. Douglas Skelton, MD, Macon, G Richard M. Steinhilber, MD, Cleveland, Oh Jack P. Strong, MD, New Orleans, La; Chr tine C. Toevs (Medical Student Represen tive), Greenville, NC; Henry N. Wagner, MD, Baltimore, Md; Jerod M. Loeb, PhD (Se retary), Chicago, Ill; Robert C. Rinaldi, Pl (Assistant Secretary), Chicago, Ill; Janet Gans, PhD (staff author), Chicago, Ill.

care physician.[11,12] There is no evidence that adolescents receive inferior care in these settings, but continuity of care from a physician with greater understanding of the family unit and the individual adolescent's need and capabilities may be sacrificed in the process.

Many adolescents fear that physicians will report confidential information to their parents. In a 1982 survey of community clinics in 37 counties, one of four adolescents reported choosing a family planning clinic because they thought that their physicians would inform their parents about the visit. These fears appear to be somewhat exaggerated; 80% of physicians living in those counties reported that they would provide such services to unmarried minors younger than 18 years of age, and 63% would do so without parental consent.[11]

PHYSICIAN SUPPORT FOR CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS

Physician support for adolescent confidential health services depends on the age and maturity of the adolescent, the nature of the presenting problem, and the age and specialty of the physician. A 1983 national survey[13] of adolescent medicine specialists and board-certified pediatricians found that 83% of physicians favor confidential care for 17-year-olds, 66% for 14-year-olds. A 1987 national survey by the American Medical Association (AMA)[14] found that 63% of physicians support confidential health services for 15- to 17-year-olds, and 39% for 12- to 14-year-olds. Between 79% 94% of physicians favor confidential contraceptive services (depending on the age of the adolescent), and 48% to 60% favor confidential care for adolescents reporting illicit drug use.[13] Physicians than the age of 50 years are more likely than older physicians, and obstetrician-gynecologists are more than twice as likely as physicians in other specialties to support the use of confidential health services for adolescents.[15] State statutes regarding confidential services, concerns about liability, and the provision of preventive and diagnostic treatment also affect physician support.[16]

Organized medicine has supported confidential health services for adolescents, both for specific conditions and in terms of general guidelines for the development of public policies. In 1967, the AMA took the position that to stem the incidence and prevalence of STDs, minors needed to receive treatment for suspected STDs without parental notification.[8(p291)] The AMA[17] opposed regulations requiring parental notification for the provision of prescription contraceptives to minors through federally funded programs and urged that "obstacles to the distribution of birth control information, medication, and devices should be removed, and physicians should provide contraceptive services on a confidential basis where legally permissible."[18] The AMA policy states that while consultation with parents or other adults may be beneficial, "physicians should not feel or be compelled to require minors to obtain consent of their parents before deciding whether to undergo an abortion.... [M]inors should ultimately be allowed to decide whether parental involvement [in abortion decisions] is appropriate."[19]

In 1988, the American College of Obstetricians and Gynecologisis, the American Academy of Pediatrics, the American Academy of Family Physicians, and the National Medical Association jointly endorsed policy recommendations on confidentiality to guide the development of public policy.[20] The recommendations state that health professionals should provide the best possible care to adolescents and encourage parental participation in their care when appropriate. They encourage physicians to work with parents to facilitate payment, appointments, and other matters that reflect the confidential nature of arrangements made. They conclude that "ultimately, the health risks to adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed care."[20]

More recently, the AMA National Adolescent Health Coalition[21] prepared a compendium of recommendations on confidential health services for adolescents, which describes the policies of each organization on diverse topics related to confidentiality. Members of the Coalition include specialty societies in medicine, psychiatry, and the allied health professions, public health associations, private foundations, and federal agencies who are active in adolescent health. The compendium was designed to educate health professionals and policymakers about the need for confidential health services for adolescents, to prompt organizations to develop or clarify policy recommendations on this topic, and to enhance adolescent access to health services. Twelve of the 22 membership organizations had policy recommendations supporting confidential health services for adolescents. Half or more of the organizations supported the general need for confidential services, the need for physicians and providers to explain the limits of confidentiality to adolescents and parents, and the need to encourage adolescents to involve parents in medical matters, but not to make parental involvement a barrier to care.

INFORMED CONSENT AS A BARRIER TO CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS

Informed consent means that the individual can understand the diagnosis, the risk and benefits of a proposed procedure or treatment, alternative procedures and treatments and their associated risks, and the consequences of not undergoing the proposed procedure and treatment. The individual must also be able to decide voluntarily whether to proceed with the physician's recommendation.[9] Consent from a person legally entitled to authorize medical care must be obtained before medical care can be given, regardless of age. The traditional legal requirement of parental consent for the health care of minors reflects legal proscriptions against minors entering into binding contracts (which includes the physician-patient relationship) and the presumption that minors lack the developmental capabilities required to make decisions about their health care.[22]

During the second half of this century, the courts and state statutes created exceptions to parental consent requirements for certain categories of minors and certain types of medical services. Adolescents serving in the armed forces or living away from home and managing their own financial affairs are considered emancipated minors and are legally permitted to consent to treatment on the same basis as adults. States also allow mature minors to provide informed consent.[23,24] These are adolescents less than the age of 21 years who, although living at home as dependents, demonstrate the cognitive maturity to understand the risks and benefits of a proposed medical treatment and its alternatives and who can decide voluntarily whether to undergo the treatment.[25,26]

Since the 1960s, states have also developed medical emancipation statutes, which specify the types of medical services to which minors may consent without parental consent or notification. Most states allow minors to consent to pregnancy care (including prenatal and postnatal care, delivery services, and treatment for complications), contraceptive services, treatment for STDs,[27] and alcohol and other drug abuse treatment. Fewer states have statutes permitting minors to consent to inpatient or outpatient mental health counseling and treatment.[23,28] (There are no known cases in which a physician has been successfully sued for providing nonnegligent treatment to a minor aged 15 years or older without parental consent.[22,25,29,30])

The most publicly contested limitation on minors prerogative to consent to care centers on the early termination of pregnancy. At least 38 states require parental consent or notification before a minor may have an elective abortion.[31] These states, however, are required by law to establish a judicial bypass procedure to enable minors to obtain a court order authorizing the termination of pregnancy without first informing their parents.[31] Under precedents established by the Supreme Court, "the Constitution does not recognize any independent interest of the parents in the outcome of the abortion decision. The pregnant minor has a privacy interest which encompasses both independence in decision-making and non-disclosure of intimate information."[31]

The legal need for consent triangulates the adolescent patient–physician relationship by bringing parents or legal guardians into health care decision making. Few would deny that most adolescents would benefit from the advice and counsel of a parent or other adult on important decision affecting their health, and the AMA and several primary care specialty societies support parental involvement, as appropriate.[21] At issue is whether legal requirements that mandate parental involvement have the effect of enhancing parent-adolescent communication or family unity. Proponents of mandatory parental consent, particularly in decisions about adolescent pregnancy, maintain that parents have a right to know and participate in decisions affecting their child's health and well-being.[32] Opponents of these laws maintain that mandatory parental consent can delay or deter adolescents from seeking timely medical care and exacerbate the risks associated with an existing health problem.[32] These laws may endanger adolescents who live in dysfunctional families or who fear hostile or abusive responses from their parents.[22,33]

IMPACT OF MANDATORY PARENTAL CONSENT

Only a handful of studies have examined the impact of mandatory parental consent on adolescents' use of health services. Those studies have focused exclusively on reproductive health services, especially the decision to terminate a pregnancy. Overall, mandatory parental consent does not appear to significantly increase the proportion of adolescents who consult their parents about a pregnancy. For example, in a 1984 study,[34] 65% of adolescents in Minnesota and 62% of adolescents in Wisconsin reported consulting their parents. Minnesota had enacted a mandatory parental consent statute, Wisconsin had not.

Rather than promoting parental involvement, mandatory notification laws appear to have the unintended effect of increasing health risks to the adolescent by delaying the termination of pregnancy or forcing the adolescent into an unwanted birth. After Massachusetts enacted mandatory parental consent statutes in 1981, court proceedings delayed the abortion procedure by an average of 4 to 5 days, with some abortions delayed by nearly 6 weeks.[35] The law had little impact on the number of adolescents who conceived and elected to terminate the pregnancy.[32] However, the number of adolescents leaving the state to terminate a pregnancy climbed steadily in the months following enactment of the law.[36] Of the 477 adolescents in Massachusetts who chose a judicial bypass rather than informing parents, the judge assessed all but nine as mature and authorized them to consent to the procedure. In eight of the nine remaining cases, the judge determined that the abortion was in the minor's best interest. The ninth minor left the state to terminate her pregnancy rather than appeal the decision.[35]

Somewhat similar results were found after Minnesota adopted its parental notification requirement in 1981. The proportion of second-trimester abortions increased 12%; court proceedings delayed the procedure by 1 to 3 weeks.[37] For some adolescents, the length of these delays precluded the termination of the pregnancy.[38] However, the abortion rate and birth rate among 15- to 19-year-olds in Minnesota fell between 1981 and 1983.[39] It is possible that adolescent women took greater precautions to avoid pregnancy after enactment of this law. It is also possible that these trends reflect increased concern about STDs and human immunodeficiency virus infection among adolescents, and/or a greater awareness and availability of birth control following a 20% increase in funding for family planning services in Minnesota during 1980 and 1981.[40] There is little evidence that large numbers of adolescents left Minnesota to terminate a pregnancy in a state without parental notification laws.[34]

Most adolescents (55%)[41] inform parents about their use of reproductive health services, and 61% involve them in decisions about pregnancy.[33,42] Mandatory parental consent and notification laws are unlikely to convince adolescents who choose not to inform parents about these visits to do so. Forty-five percent of unmarried adolescent females attending Planned Parenthood clinics in 10 states reported that they had not informed their parents about the clinic visit. Of these, 80% reported that they would not seek clinic care if their parents had to be told, but fewer than one in 100 said that they would discontinue sexual relations.[41]

In sum, while the intent of mandatory parental consent laws is to enhance family unity, improve parent-child communication, protect adolescents from making deleterious decisions, and reduce abortions, there is limited evidence that the law has these effects. A majority of adolescents who want an abortion consult their parents regardless of statute mandating consent or notification. The vast majority who elect judicial bypass rather than consult parents are granted authorization to make the decision about the course of the pregnancy. These laws tend to increase the health risks to the adolescent by delaying medical care. It is unclear whether these findings also characterize the use of medical services for other problems, such as the treatment of drug abuse or mental disor

PAYMENT AS A BARRIER TO CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS

Confidential health care for adolescents may be compromised ultimately by the economic realities of medical treatment. Adolescents who rely on their parents' private insurance need to recognize that the insurance claim sent to parents will list the services provided, thereby compromising confidentiality. Adolescents living in families receiving Medicaid are also likely to have difficulty obtaining confidential care. Most adolescents cannot enroll in Medicaid without the family's involvement because applicants must provide financial information in order to determine eligibility. In many states the adolescent must show the family's Medicaid card or a Medicaid sticker in order to the coverage, and these must be obtained through the parent.[25] Some states parents who receive Medicaid a monthly itemized list of services provided to family members. Although this is meant to deter fraud, it may also prevent s adolescents from seeking needed medical care.[43]

State statutes allowing minors to consent to medical treatment typically hold the adolescent rather than the parent liable for payment.[25,29] Exceptions include emergency treatment or treatment given under court order. However, few adolescents can afford to pay for their own medical care,[44] and few physicians can provide subsidized care on a regular basis.

Health maintenance organizations and some prepaid health plans may be better able to offer confidential services to adolescents because care is provide

without disclosing the nature of the visit in a bill for services. Increased access to low-cost or free community clinics or to school-based clinics would also enhance confidentiality and would be especially helpful for adolescents living in poor and low-income families. However, because most adolescents are covered by private insurance or public insurance (74% and 9%, respectively), it is critical that third-party payers develop a system for listing services that preserves confidentiality for adolescents.

PHYSICIAN ROLE IN THE PROVISION OF CONFIDENTIAL HEALTH SERVICES TO ADOLESCENTS

Confidential health care is sometimes portrayed as a contest of rights between parents and adolescents.[9] In this scenario, the physician may be seen as either moderating or fueling conflict between parents and adolescents. However, confidentiality is better understood as a part of normal adolescent development in which the adolescent learns to assume greater responsibility for his or her own health and health care and pursues the growing need for privacy.

Both physicians and parents have a role to play in this process.[45] As the child gains maturity and experience, the degree of confidentiality may also increase. When the physician finds the adolescent capable of autonomous decision making, he or she becomes a full partner in the physician-patient relationship; at this time the physician must determine whether the adolescent is capable of giving informed consent.

At all times, the physician should inform parents and minors about the conditions under which confidential care will be provided and when it will be abrogated. This should include any arrangements for the adolescent to have independent access to health care, including financial arrangements. Many physicians meet separately with adolescents and parents, allowing each to express their concerns independently in a confidential context. Most parents and adolescents are comfortable with this arrangement, particularly those who have an ongoing relationship with a physician.[45]

At times the physician and adolescent may disagree about whether informing parents is in the adolescent's best interest or critical to effective treatment.[26,46] In such cases, the physician can offer to inform the parents (with the adolescent's permission), to be present when parents are informed, or to discuss with the adolescent ways to inform parents on his or her own.[45] The rare occasions for overriding adolescents' objections and informing parents (or others) include suicidal ideation or for immature minors or minors with limited competence.[25]

Primary care physicians and adolescent medicine specialists usually encourage parental involvement believing that most adolescents benefit from the counsel and support of concerned and caring parents. Some problems—hospitalizations or treatment for drug abuse or mental health problems—are difficult or impossible to manage without parental participation. When the parent is part of the problem, or when informing the parent would not be in the patient's best interest, physicians have the authority to provide medical treatment on a confidential basis under a fairly broad set of rules determined by case and statutory law.[25]

Physicians are under no legal obligation to provide a specific service or treatment requested by a minor if it conflicts with their moral principles.[8(p1)] One alternative in such cases is to advise the adolescent about where to go for help and when appropriate, to make a referral.

RECOMMENDATIONS

The AMA remains concerned about the serious health problems facing adolescents and the corresponding imperative that adolescents receive needed medical care. It is important to ensure that confidentiality is consistent with adolescents' developmental and physical needs. Therefore, the Council on Scientific Affairs recommends that the AMA:

1. Reaffirm that confidential care for adolescents is critical to improving their health.

2. Encourage physicians to allow emancipated or mature minors to give informed consent for medical and psychiatric care without parental consent and notification, in conformity with state and federal law.

3. Encourage physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care.

4. Urge physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements).

5. Encourage physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician.

6. Encourage state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis.

7. Urge undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law, and implementation into practice.

8. Encourage health care payers to develop a method of listing of services that preserves confidentiality for adolescents.

9. Encourage state medical societies to evaluate laws on consent and confidential care for adolescents and help eliminate laws that restrict the availability of confidential care.

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TO: Hillary Rodham Clinton
FROM: Jennifer Klein
DATE: 3/4/96
RE: Dr. Koop's Letter on Lainie Friedman Ross

You had asked me to look into the four questions on the attached post it:

1. You did not receive the manuscript from Lainie Friedman Ross.

2. I agree that Dr. Ross overstates when she cites your articles as part of a "movement that claims that competent children should not be treated differently from their competent adult counterparts." Your 1979 article, "Children's Rights: A Legal Perspective," does argue that "[t]he first thing to be done is to reverse the presumption of incompetency [that has been applied to children] and instead assume all individuals are competent until proven otherwise." However, you do not imply that children determined to be competent should be treated the *same* as adults, but only that they should be given certain given rights and responsibilities. You state that "[t]here are certain children at certain ages in certain circumstances who can and should exercise responsibilities," and that the law should recognize that reality.

   Dr. Ross' article concludes that children should not be able to get prescription contraceptives without parental consent. Your article does say that "[d]ecisions about motherhood and abortion . . . and others where the decision or lack of one will significantly affect the child's future should not be made unilaterally by parents."

3. Janet Abrams is the staff contact for the "National Campaign to Reduce Teenage Pregnancy" which is a private, nonpartisan organization chaired by Dr. Henry Foster. The organization has not included Dr. Ross (in fact, they have never heard of her) but would be happy to consider her.

4. I have asked Felicia Stewart, the head of the Office on Population Affairs, to critique the article for you.

C. EVERETT KOOP, M.D.

To Jen —
(1) Did I ever receive a copy of this?
(2) Please see P. 8 where she mentions my articles & I believe overstates. Could you review for me?
(3) Who is liaison for Teen Pregnancy taskforce? Find out if this person has been included +/or considered.
(4) Could someone critique for me? HRC

February 2, 1996

The Honorable Hillary Rodham Clinton
Office of the First Lady
2nd Floor, West Wing
THE WHITE HOUSE
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Hillary:

I recently was sent a manuscript by the journal, *Polit*
to write a critique. When I read it, I thought that it was sc
permission from the editor to forward it to you. He told n
but I am not sure whether your staff put it in your hands.

In any event, here is Lainie Friedman Ross' piec
Policy." I would like you to be familiar with her point of
was sent to you also asked that you write a critique.

Would Dr. Ross make a good addition to your ad

Sincerely yours,

Chick /am

C. Everett Koop, M.D.

enclosure

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Adolescent Sexuality and Public Policy: A *Liberal* Response

Lainie Friedman Ross University of Chicago, USA

Abstract. Conflicting U.S. statutes exist governing adolescent sexuality. While parents are allowed to remove their children from sex education, they cannot prevent their children from procuring medical care and contraception without parental awareness or consent. I argue that specialized consent statutes–statutes which empower adolescents to seek confidential reproductive and sexual health care–are an inappropriate solution to adolescent sexuality because (1) they empower individuals whom we otherwise believe are not ready for autonomous decision-making; (2) they endorse deception, which is the wrong message to be sending to our children; and (3) they are illiberal in that they circumvent parental decision-making authority to promote a particular conception of the good life. I argue that we should rescind these statutes and return these decisions to the family.

[Author Profile]

Lainie Ross is Assistant Professor in the Department of Pediatrics and the MacLean Center for Clinical Medical Ethics at the University of Chicago. She is a practicing pediatrician. In November 1995, she successfully defended a dissertation entitled "Health Care Decision Making for Children," and will receive a Ph.D. in Philosophy from Yale University in May 1996. Her main interests are pediatric ethics and ethical issues in genetics. Correspondence should be addressed to Lainie Friedman Ross, M.D., University of Chicago School of Medicine, MacLean Center for Clinical Medical Ethics MC 1057, 5841 S. Maryland Ave., Chicago, IL 60637, USA (E-mail: LROSS@MEDICINE.BSD.UCHICAGO.EDU).

Acknowledgments. I thank Walter Glannon, Ann Dudley Goldblatt, Robert E. Merrill, Jeffrey Oak, Mary Mahowald, Leslie Moore, Jacqueline Peterson, Julie Rothstein, John Ross, David Schmidtz, Sara Swenson, and Joanna Zolkowski-Wynne for reading earlier drafts of this paper. I also thank three referees for *Politics and the Life Sciences* for their thoughtful comments. *Editor's note*: Commentaries and a response by the author will appear in the August 1996 issue of *PLS*.

There is a contradiction between the purported acceptance of diverse lifestyles by our *liberal community*[1] and present-day U.S. policy regarding contraceptives for *minors*.[2] In a liberal community, it is presupposed that adults have a special insight into their own conception of the good life that they can pass on to their children. Yet, recent legislation and court decisions in the United States usurp parental power on health care issues pertaining to adolescent sexuality and reproduction.

Consider the following scenario: The Joneses are devout Catholics. Their third daughter, Jane, is 14 years old. Jane, who has become sexually active with her 18-year-old boyfriend Eric, asks her pediatrician for prescription-requiring oral contraceptives. Jane knows that her parents disapprove of premarital sexual activity, and that birth control is strictly prohibited by their religion. Genuine respect for different values would require that we respect the Jones's decision to raise their daughters according to strict Catholic doctrine. They have simplified this for us by enrolling Jane in a Catholic parochial school that does not teach the students about human sexuality, birth control, and abortion.

We cannot argue that the parents' strict prohibition against premarital sexual activity and sex education is a form of neglect. On the contrary, the Joneses are offering their children a coherent, viable lifestyle--a lifestyle that they believe would be threatened by such education outside the context of marriage. And yet, the Joneses cannot fully shelter their daughters because sexuality is pervasive in the mass media and literature. The Joneses recognize this risk, and expend much energy in monitoring their children's exposure to television programs and movies that address sexuality. Nevertheless, if Jane is truly bent on obtaining the facts about human sexuality, she can go to the public library!

A liberal community is and must be tolerant of various lifestyles. As such, our laws allow parents to remove their children from sex education in the public schools, as well as to send their children to private schools in which sexuality is either intentionally omitted from the curriculum or, if addressed, taught as a moral and not a biological issue. And yet most states also have specific statutes (specialized consent statutes) that allow Jane and her pediatrician to discuss contraceptives and allow for Jane to be given a prescription for birth control pills--all without parental consent, even without parental notification. That the laws are inconsistent in the way that they respect various lifestyles is not surprising: different policies were set by different people with different agenda.

Although Jane Jones is a hypothetical person, realize that patients like Jane are relatively common in pediatrics. And realize that Jane may come to my office alone, or she may come with a parent under some pretense (e.g., back pain) and then announce her real intention (her desire for oral

contraceptives) when her parent leaves the room. In this article, I consider--both from the private doctor-patient relationship and from the public context of the larger liberal community--whether specialized consent statutes are a moral response to Jane and her parents.[3]

Specialized Consent Statutes

In a liberal community, parents have the legal right to raise their children according to their own values, and to make major educational, religious, and social decisions for them. Within the context of health care, parents in a liberal community are presumed to be the child's proxy voice for minor as well as serious conditions.[4] In general, physicians can neither examine nor treat a child without parental consent; if they do, they can be charged with battery and assault. There are two important exceptions. First, physicians can treat a child when a life-threatening emergency exists even if parents are unable or unwilling to give their consent. Second, the state does not require parental permission if it has a substantial compelling interest, such as with universal vaccinations (which it can actually require for all citizens, both children and adults--*Jacobson v. Massachusetts*, 1905).

Nevertheless, all fifty states have specialized consent statutes that--although varying in scope--give adolescents some autonomy to seek and consent independently to the diagnosis and treatment of drug and alcohol abuse, contraceptive counseling, and/or the procurement of contraceptives (Holder, 1985). Some states even allow minors to consent to abortions without disclosure or consent from their parents. The statutes were designed to encourage adolescents to seek health care for problems that they might deny, ignore, or delay if they had to get parental permission.

The purported purpose of the specialized consent statutes is laudable: to encourage early, responsible sexual health care for adolescents. But the empirical data do not support the claim that adolescents will seek medical care for sexual and reproductive issues if they are assured complete confidentiality. Despite the inception of the specialized consent statutes in the 1960s, adolescent pregnancy and sexually transmitted diseases (STDs) are on the rise.[5] And the data suggest that most adolescents (especially those younger than 16 years) do discuss these issues with their parents.[6]

Is this a case in which a few "bad" cases have produced "bad" laws? That is, were the specialized consent statutes written to protect the rare adolescent whose parents might harm or threaten to harm her were they to learn that she had a sexually transmitted disease or that she went to a physician for birth control? Were the statutes written without concern for the vast majority of

parents who are both able and willing to guide their adolescents' medical care and who consider this role integral to their child-rearing rights and responsibilities?

I am deeply troubled by specialized consent statutes and believe they are an inappropriate response by a liberal government. A liberal community must accommodate families that hold a wide spectrum of attitudes toward sexuality, and it must realize that these families may seek to structure the experience of their children according to these values. A truly liberal community would allow the Joneses to prevent Jane from procuring all contraceptives and from aborting a fetus, if conceived. But we do not want adolescents having children. So we allow adolescents to get birth control because we agree with them that they are not ready to be parents, and we are willing to override their parents' role as medical decision-makers in order to prevent what we perceive to be a greater tragedy. That is, the specialized consent statutes support those particular conceptions of the good life that approve--or at least condone--responsible adolescent sexual activity. These statutes allow sexually active adolescents to circumvent parents who belong to subcommunities that discourage or forbid premarital sexual activity by their members. These statutes, then, circumvent parental decision-making authority without parental awareness of being excluded.

To minimize adolescent pregnancy, the specialized consent statutes, allow, if not require, Jane's physician to collude with Jane if she insists upon deceiving her parents.[7] This collusion leads to multiple moral difficulties. First, as Jane's pediatrician, I have developed relationships of trust with both Jane and her parents. What happens when Jane's parents discover the birth control pills? If they confront me and Jane, there is nothing to say but that I believed it was in Jane's best interest. But I have lost their trust, and rightly so. I have also made it clear that I do not respect their religious beliefs; and, since the law stands behind me, my action suggests that members of the larger community also do not respect their religious beliefs. Second, what happens if Jane has a medical complication? A sexually transmitted disease that leaves her infertile? Or an uncommon but serious medical complication from the pill, such as a stroke? How do I explain to Jane's parents that Jane understood and consented to these risks, and that she and I believed that their consent was unnecessary and undesirable, even though they are the parties who will remain responsible for the physical, emotional, and economic hardships that result? And third, what does this mean for Jane herself? She has learned that a physician, an authority figure, is willing to serve as an accomplice in deceiving her parents. What are we teaching our adolescents when they find persons in authority willing to help them deceive their parents? What does it teach these adolescents with regard to the respect owed to any adult, least of all a deceitful doctor or a duped parent?

There is more to our illiberal policy. As the health care system now stands, our classic suburban middle-class adolescent would find it difficult to go to a doctor without her parents' knowledge. The visit is expensive, and to maintain absolute secrecy, the insurance company cannot be billed. Even if the doctor agrees to see the adolescent free of charge, a month's supply of oral contraceptives costs $15-25. And then the nondriving suburban adolescent must get to the doctor's office, which is not accessible by public transportation. In effect, then, the law gives increased confidential access to oral contraceptives only to poor adolescents who live in inner cities, who can go to a hospital clinic, and who can get free care and medicine with their state Medicaid card. So the policy tends to disproportionately disempower welfare parents who are already politically impotent. I wonder whether the laws would be overturned if physicians were treating large numbers of children whose parents had more political clout?

The Failure of Arguments for Specialized Consent

Those who support the specialized consent statutes offer several pragmatic and moral justifications. The first pragmatic position is compelling: Given the fact that adolescents can be and frequently are sexually active even when birth control and other sexual health services are relatively inaccessible, they should be given the opportunity to be responsible for their sexual activity. The pragmatist does not need to concede or refute whether the availability of such services increases the number of sexually active adolescents. Rather, he or she must argue only that the number is sufficiently large, even when such services are unavailable, as to portend a public health crisis. I accept the pragmatist's position thus far. But the argument makes two assumptions that must be fleshed out: (1) that adolescents are competent to make health care decisions, and (2) that a policy that grants adolescents autonomy will achieve greater sexual responsibility than would a policy that requires parental involvement.

Consider if the two assumptions are false. If the first assumption is false--that is, if adolescents are not competent to make health care decisions--then the statutes are misdirected. If adolescents are incapable of giving informed consent in the area of sexual and reproductive health services, then the statutes unfairly hold them responsible for such measures. If the second assumption is false--that is, if granting autonomy to adolescents does not produce greater sexual responsibility--then the argument for extending autonomy fails. Since parents have presumptive responsibility for their minor children, even if the children are competent, legislation should override the parents' responsibility only if it can

be shown that the policies will promote adolescent well-being *significantly better* than a policy based on parental responsibility. The state should not override parental authority on any issue in which the state is only slightly more effective than parents *unless* the state is able and willing to take responsibility for the myriad of other concerns of its adolescent citizens; otherwise, state intervention inadvertently risks undermining parental authority in other realms--realms in which we both need and want enduring parental commitment. Thus, unless granting adolescent autonomy will promote significantly better sexual and reproductive health care for adolescents, the state must defer to parental authority.

Is the first assumption valid? Are adolescents competent to make health care decisions? The data support the claim that adolescents make decisions as competently as adults do in medical case scenarios designed by psychologists (see Grisso and Vierling, 1978; Weithorn and Campbell, 1982). But does this competency necessarily apply to actions in real life? Despite their knowledge regarding auto safety, adolescents account for a disproportionate number of fatal car accidents. And despite their ability to repeat the facts about the transmission of AIDS and other sexually transmitted diseases, adolescents tend to overlook long-term consequences. The result is that adolescents are quickly becoming a high-risk group for sexually transmitted diseases, including AIDS (DiClemente, 1993). Thus, if competency is understood as the ability both to choose *and* to act to promote one's own interests, then the claim that adolescents are competent is not persuasive.

The second assumption--that specialized consent statutes will promote significantly better health care for adolescents in the realm of sexual and reproductive services than if adolescents required parental involvement--is also unpersuasive. Despite the confidentiality assured by specialized consent statutes, adolescents typically delay seeking sexual and reproductive health care for almost one year after they become sexually active (American Academy of Pediatrics, 1990, citing Zabin and Clark, 1981). Of course, if parental involvement would cause adolescents to delay such services indefinitely, then the statutes achieve significantly better results. Proponents of these statutes need to present empirical evidence that adolescents will seek earlier and better care if they are assured complete confidentiality. Since such data do not exist, the presumption ought to be in favor of parental involvement.

A second pragmatic reason to favor adolescent autonomy in sexual and reproductive health care is the concern of domestic violence. The position is that some adolescents seek sexual and reproductive health care without parental knowledge because these adolescents fear potential parental abuse. They fear physical or emotional abuse if their parents were to find out that they are sexually

active. But many of these adolescents who claim to fear such parental actions have never been abused. That is, they believe that their parents would be so outraged that they would harm them even when their parents have never harmed them previously. There are no data to support their fears. Should the law be written to deal with the few potentially unfortunate cases? I would prefer legislation that included parents in procreative decisions for their sexually active children through the age of emancipation. In the rare event that a parent becomes abusive, I would dispose of this case to the system that deals with abused and neglected children.

A third pragmatic reason to support adolescent autonomy is that this position avoids conflict. Some adolescents want to act without their parents' consent because they know that their parents' religious convictions condemn premarital sexual activity and birth control. But why do we permit these adolescents to seek medical help when we do not allow them to get sex education against their parents' beliefs? That is, if parents can remove their children from sex education classes because we supposedly respect their traditional lifestyle, then why do we allow physicians to go behind their backs and prescribe birth control to their daughters? And would anyone suggest that, to avoid conflict, we should not tell parents when their adolescents are failing in school? Surely, poor grades are common and are a major cause of intrafamilial strife. The pragmatic arguments are weak at best. The empirical data that presently exist do not justify the policy.

The moral argument in support of the specialized consent statutes is based on the moral claim that competency should entail autonomy. This claim is the prevailing moral justification for denying physicians the right to act paternalistically towards competent adult patients. However, whether competency is necessary and sufficient to give children the right to make autonomous decisions is more ambiguous. The argument ignores the fact that parents are responsible, not only for responding to the child's *current* identity, needs, and interests, but also for shaping the child's *future* identity, needs, and interests. Granting autonomy to competent children should serve both their current selves and their future identities. Parents must be able to justify restricting a child's present-day autonomy in order to enhance his or her overall or long-term autonomy. I will return to this point below.

The moral argument that competency should entail autonomy depends on two assumptions: (1) that the competency of children is not morally different from the competency of adults, and therefore that competent children and competent adults should be treated similarly; and (2) that competency is necessary and sufficient to justify autonomy. Both of these claims can be refuted.

Let us consider the first assumption. There is a large and growing movement that claims that competent children should not be treated differently from their competent adult counterparts. These

advocates are known as child liberationists, and they are found in both academic circles (see, for example, Cohen, 1980; Harris, 1982) and the White House (see Rodham, 1973, 1979). Child liberationists differ on when children should be emancipated, depending on how they define competency. One group uses a minimum rationality test: as long as an individual has some minimal capacity to get what she wants, she should be deemed competent to make her own decisions. A second group uses a thicker notion of competency that includes the ability to make informed, intelligent, and voluntary decisions that can take into account both short-term and evolving long-term interests.

Laura Purdy offers a compelling argument on why competent children should not be treated the same as their competent adult counterparts. First, she rejects the minimal competency argument on the grounds that society should not use a least common denominator as its standard for competency:

> Even liberationists, after all, lament the mistakes and immorality of adults. It seems to me that instead of asserting children's right to be equally silly and weak, it would be at least as plausible to argue for the overriding importance of helping children develop the self-control and other enabling virtues necessary for living more satisfying and moral lives. (Purdy, 1992:78)[8]

Purdy is in favor of granting *all* competent adults, even minimally competent adults, the right to self-determination on the grounds that the right to make autonomous decisions has intrinsic value. Even if a minimally competent adult might benefit from guidance, the intrinsic value of acting autonomously often outweighs the benefits of guidance. Children, on the other hand, have a great potential for improving their capacity to make decisions that reflect their best interests, and therefore Purdy is willing to restrain present-day decision-making authority in order to enhance overall decision-making authority (Purdy, 1992:55-84).

When children are competent according to the thicker notion of competency, Purdy is still willing to restrict their autonomy. Purdy argues that the knowledge and skills that individuals need for genuine autonomous choice are accumulated only gradually and are developed, in part, by practicing these skills in areas of lesser import (e.g., young children should be free to choose between equally nutritious cereals). Purdy maintains that children, by contrast with their adult counterparts, have a great potential for *improving* their knowledge base and their skills of critical reflection and self-control. By adulthood, however, most individuals will have developed the skills and obtained the necessary background knowledge to use their autonomy to achieve their own goals, and those who have not are not likely to benefit from a longer training period. Thus, at some point an individual must be allowed to live her own life, provided that she has attained some minimal level of competency (Purdy, 1992).[9] For children, on the other hand, we can and should aspire to higher goals.

The second assumption holds that competency is necessary and sufficient to justify autonomy. I believe, for two reasons, that competency is necessary but not sufficient. First, granting autonomy to children may actually be autonomy-restricting over a lifetime, and so we can justify restricting a child's autonomy now to give her greater overall autonomy. An example helps to clarify this point. If Jane enjoys great sexual freedom now, she may suffer several cases of pelvic inflammatory disease, which may cause her to be infertile. This condition may prevent Jane from becoming a parent when she is psychologically prepared to do so. Or she may contract an incurable sexual disease (preferably herpes and not AIDS) that will limit her sexual expression as an adult. Both of these conditions, then, have long-term consequences to which Jane may not give adequate attention during her adolescent years. Thus, we can justify withholding autonomy from adolescents in the short run in order to promote their potential for greater lifetime autonomy in the long run.

Second, I favor continued proxy decision-making authority by the adolescent's parents on the ground that her parents have a valid third-party interest in her development and activities, even after she has achieved a significant level of competency. In general, parental decision-making authority serves both the children and the parents. It serves the needs and interests of the child to have autonomous parents who will help her to become an autonomous individual capable of devising and implementing her own unique life plan. It also serves the adults' interests in having and raising a family according to their own vision of the good life. This freedom does not automatically stop when the child becomes competent. If anything, parents then have the opportunity to try to inculcate their beliefs through rational discourse, instead of through example, bribery, or force. While children are still dependent upon their parents for emotional, economic, and material support, the parents' interest in their children must be balanced against the competent children's interest in acting autonomously. In contrast, the present-day specialized consent statutes give unilateral responsibility to adolescents who can still benefit from adult guidance, and thus deny the parents' enduring interest in educating and guiding their competent children according to their own values.

For Rescinding Specialized Consent Statutes

There are several reasons why we ought to rescind specialized consent statutes. First, these statutes send adolescents the wrong message. They teach adolescents that their decisions regarding sexuality are unrelated to other aspects of their lives. Consider that parents dictate what schools and church their children attend and the activities in which their children may participate, but these same

children have legal sanction to ignore parental discretion in the area of sexuality. Consider that these children cannot consent to a throat culture without parental permission,[10] but they can authorize their physicians to perform a pelvic examination.

Second, specialized consent statutes affirm the adolescents' attitude that their sexuality is solely a private matter. It is not. Adolescent sexual activity has numerous public consequences for which adolescents are ill-prepared to accept responsibility. Adolescents have a responsibility to themselves to delay sexual gratification until they are emotionally and psychologically prepared; they have a responsibility to their partners to practice safe sex; and, finally, they have a responsibility to their community to avoid parenthood until they are both emotionally and financially capable of caring for a child.

Third, our laws give parents decision-making authority for their children because parents are best situated to decide and to act upon what is in their children's best interest, and because parents are financially and socially responsible for them. This is, or ought to be, no less true of their medical care with regard to sexual health issues.

In arguing against specialized consent statutes, I do not deny the need for a public commitment to prevent and treat the unwanted consequences of adolescent sexual activity. In that vein, specialized consent statutes are on the mark: they affirm the community's belief that the cost of unwanted adolescent pregnancy and untreated sexually transmitted diseases is too high. But the implementation of these statutes entails moral hurdles for the ethical physician: collusion against parents, disrespect for parental conceptions of the good, and a disregard for the adolescent's need for further parental guidance.

I am committed to the prevention and treatment of the unwanted consequences of adolescent sexual activity, but I want parents involved in their adolescents' care. When parents are involved, I am able to call the house to discuss laboratory results instead of asking my nurse to pretend to be a classmate and see if the adolescent is available. Similarly, when the parents are not excluded I am able to call the house if an adolescent fails to follow up for her reevaluation after treatment for a sexually transmitted disease. Follow-up is improved when parents are involved because both the parents and the child are looking out for the adolescent's welfare. Parents have a responsibility for the well-being of their children, and they can fulfill that responsibility only if they are aware of their children's needs.[11]

A serious objection to rescinding the specialized consent statutes and requiring parental authorization for prescription-requiring contraceptives is that it is unrealistic: the result is a pregnant

adolescent (and we all know what we think of this option). But the fact is that over one million adolescents become pregnant yearly--and most of these adolescents are unmarried and their pregnancies are unplanned--which suggests to me that the present statutes are not working. A pediatric colleague suggested that I was missing the point.[12] She argued that adolescents get pregnant for many reasons, and not necessarily by mistake. Some hope that a child will strengthen relationships with their boyfriends; some seek legal emancipation from their parents; and others seek a child who will love them unconditionally. She argued that these "selfish" reasons were no less true of adult women. She asked why I condemned one and not the other.

My response is liberal in the classic sense of the term: I do not believe it is my prerogative, nor the prerogative of the liberal community, to decide what is or is not a good reason for having children. However, I do believe that the right to procreate entails responsibilities. Is an adolescent as capable as an adult woman of coping with the emotional, physical, social, and financial costs of a child? The data suggest she is not. For example, adolescent parents are less likely to graduate from high school, which involves significant social and financial costs. But even more worrisome is the impact on their children. Children of adolescent parents often have more behavior problems and are at greater risk for significant morbidity and mortality from accidents. In the long term, they are more likely to be high school dropouts, adolescent delinquents, as well as adolescent parents themselves (Juszczak, 1992).

Presently an adolescent mother is legally emancipated from parental authority and accountability. These adolescent mothers are legally allowed to leave home, get their own apartments, drop out of school, and receive welfare. And they will get additional state support by having a second child. What would the consequences be if adolescent motherhood did not emancipate Jane, but instead legislation held Jane's parents accountable for their grandchild until their own daughter was old enough for emancipation? Or should the Joneses be unwilling to care for their granddaughter, what if the child were to be placed in foster care until her mother was able to take care of her? Would this serve as a deterrent to adolescent pregnancy? My goal is not to penalize adolescents who unwittingly become parents, but to discourage adolescents from viewing parenthood as a means to early independence. I would like to help adolescent parents learn the skills that they will need to care for themselves and their children. They need parenting skills as well as vocational skills. And this requires more, not less, schooling; more, not less, adult guidance.[13]

I told my pediatric colleague that it is she who is missing the point. The liberal community must not be neutral with respect to adolescent pregnancy and parenthood. We must reemphasize the

emotional, physical, and yes, the financial obligations of parenthood. Adolescent sexual activity and pregnancy are not just private moral decisions, and neither physicians nor the community at large should act as if they were. As a pediatrician, I should not pretend that Jane's pregnancy has positive aspects in addition to the negative. Jane, her parents, and I should all anguish over how to deal with this most unfortunate consequence of her sexual activity.

Another objection to rescinding specialized consent statutes is the greater negative impact such action would have on adolescent females versus adolescent males. It was pointed out to me that this article claims to be about adolescents, but it is really only about female adolescents.[14] According to this objection, the specialized consent statutes are a part of the whole package that ensures *all* women the right to procreative freedom and control over their own bodies. To rescind specialized consent statutes would be to diminish women's autonomy in the sexual and reproductive arenas.

This argument fails because it is over-inclusive. Nothing in my proposal detracts from the sexual and reproductive rights that must be guaranteed to all adult women. I believe that adult women *must* have full control over their own bodies--and such empowerment entails public support for family planning clinics, pregnancy-related services including abortion services and prenatal care, rape-counseling programs, and public clinics that treat sexually transmitted diseases and counsel patients regarding HIV. But this commitment does not prevent me from distinguishing between adult women and female adolescents. The independent minor will still be protected under the emancipated minor statutes. My position is only that adolescents who live at home with their families must involve their families in their health care.

I mean no harm to either female or male adolescents by urging rescission of specialized consent statutes. In general, females need more sexual and reproductive health care than males, but that reality involves responsibility as well as privilege, for only females have the capacity to conceive and bear a child. That this biological fact gives female adolescents less sexual freedom as children (and as adults, at least in our contemporary culture) is surely outweighed by the fact that these same individuals have greater reproductive opportunities as adults.[15]

Public Policy Implications

Given my great respect for parental autonomy and family privacy, I favor existing policy that allows parents to remove their children from sex education courses, but I also favor rescinding specialized consent statutes. Sexuality and sexual expression are private matters to be decided upon

by individuals and their intimates, and not to be imposed by the state. This position does not mean that I would encourage parents to exclude their children from sex education classes: liberal institutions other than the family share responsibility for educating our youths. But parents have the right and responsibility to select the means and scope of those other institutions' teachings.

Since I accept the liberal position that adolescent pregnancy and adolescent parenthood are public crises, how can I justify my policy proposals? Morally, I believe that parents should be allowed to remove their children from sex education courses that conflict with their moral beliefs--it is the responsibility and prerogative of parents to teach their children their own values, including their values on sexuality. Parents play a leading role in the formation of their children's sexual identity, their sexual attitudes and mores, and the manner in which they give their sexuality expression. Pragmatically, I would also add, sex education has not worked. Sex education has not been shown to change risky behavior (see, for example, Cromer and Brown, 1992; Durbin et al., 1993; Ku, Sonenstein, and Pleck, 1992).

I am also against prescribing birth control to Jane without parental notification because I am morally uncomfortable with the deceit that it entails. I respect Jane's parents' right to lead a more traditional lifestyle and to inculcate this lifestyle into their children. This is not to deny that Jane's parents have a responsibility to fulfill Jane's basic needs and interests and to help Jane develop into a mature autonomous adult. It is only to deny that her parents are obligated to expose her to a wide range of possible ways of life, or that they must permit her to participate in activities at odds with their moral conception of the good. On the contrary, if parents want to inculcate certain traditional lifestyles--be they Amish, Hasidic, or Catholic--then they need to restrict their children's exposure to their own ways of life. A truly liberal community must tolerate non-liberal but legitimate (i.e., non-abusive, non-neglectful) lifestyles.

Unfortunately, some adolescents who are sexually active are unable or unwilling to discuss their decision with their parents. The public goal of preventing and treating the unwanted consequences of adolescent sexual activity applies to these adolescents as well. A liberal community can devise statutes that keep present-day over-the-counter birth control easily accessible to all individuals, even minors. And, in fact, the Supreme Court held in *Carey v. Population Service International* (1977) that state laws restricting the availability of over-the-counter contraceptives to minors were unconstitutional. I concur with the Court's decision.

How can I justify allowing adolescents to obtain non-prescription birth control without parental notification and yet advocate parental consent for prescription-requiring contraception?[16] To a great

extent my response is pragmatic: a policy that makes over-the-counter birth control easily accessible to all individuals, even minors, is neither an attempt to override parental moral values nor a statement condoning adolescent sexual activity. Rather, the decision to have barrier method birth control available to all adolescents is consequentialist: the costs of denying adolescent sexual activity are unwanted adolescent pregnancy and diseases, which are a larger community burden than we are willing to accept. But my response also has a deontological basis: the adolescent's procurement of over-the-counter contraceptives does not require deception by medical providers and does not entail that medical providers undermine parental authority.

Some have argued that adolescents have a constitutional right to procure prescription-requiring contraception from family planning clinics without parental notification. The proponents base their position on the repeal of the "squeal rule." In 1970, Congress enacted Title X of the Public Health Service Act, which provided for voluntary family planning projects. In 1978, Title X was amended "to encourage family participation." The Department of Health and Human Services promulgated the "squeal rule" in 1981, which sought to require family planning projects that received federal funds to notify a minor's parents within ten days that she had been given contraceptives.

I believe that this interpretation is misguided. In both court cases in which the "squeal rule" was struck down, it was overruled on the ground that the rule was inconsistent with congressional intent (*State of New York v. Heckler*, 1983; *Planned Parenthood Federation of America v. Heckler*, 1983). Neither decision discussed whether parental notification or parental consent requirements violated a minor's constitutional rights.[17] If family privacy and autonomy are the important ideals that the courts have claimed them to be,[18] then we must respect the different lifestyles that different families promote.

Conclusion

Specialized consent statutes were designed to empower adolescents with respect to their sexual identity. But to do this, the statutes permit or even encourage adolescents to circumvent their parents and the guidance they might offer. These statutes also permit physicians to collude with these adolescents. I have argued that the statutes are inconsistent with the respect owed to parents within a liberal community. The liberal response to the unwanted consequences of adolescent sexual activity requires a set of policies consistent with liberal goals and values. I favor laws that allow parents to decide upon the nature of their children's sexual education and laws that require parental involvement

in the procurement of medical care pertaining to adolescent sexual activity. I also favor laws that allow sexually active adolescents who refuse to involve their parents to have access to over-the-counter barrier methods of birth control. These latter laws enable adolescents to avoid the unwanted consequences of their decision without legitimizing disrespect for parental authority by other institutions. It is a liberal community's way of avoiding a lose-lose solution in a no-win situation.

Notes

1. By "liberal community" I refer to a political democracy in which there is limited government and institutional guarantees of basic rights and personal liberties. A liberal community can be either liberal or conservative, depending on where it places the boundaries between the public and private spheres. In general, we tend to think of family and domestic life as private and economic and political spheres as public. The distinction is not so clear-cut, as many feminists have shown (see, for example, Nicholson, 1986; Okin, 1989). Although the dichotomy is too rigid, the distinction is nevertheless important, as we tend to tolerate greater state supervision and intrusion in the public sphere. Whether a liberal community is liberal or conservative depends, in part, on the extent and type of state involvement it tolerates in the different spheres.

2. By "minors" I refer to all individuals under the age of 18, which is the current legal age of emancipation. The specific age at which emancipation should be granted is a political and not a moral question. I do not argue for any particular age. Rather, I believe that the age should be chosen by societal consensus, and may differ in different cultures and different epochs. My arguments are germane regardless of where the line is drawn. (I do favor line-drawing versus a case-by-case evaluation because I know of no value-free standards on which to judge individual cases.)

3. This article does not address the issue of abortion, nor should the reader extrapolate my position on the role of parental consent and/or notification from my arguments regarding contraception and the treatment of sexually transmitted diseases. Although I do not believe that a fetus is a moral person, the fetus does add further complexities to the public and private dimensions of adolescent sexual activity that require a separate analysis. I leave this project for another day.

4. By "parents" I refer to those adults who are intimately involved in their child's upbringing. That is, I use the term morally and not biologically. I would not respect the decision-making authority of uninvolved caretakers regardless of their genetic or gestational relationship to the child. In this hypothetical case, both of Jane's parents are responsible for her upbringing, and *either* parent can be the child's proxy voice. I thank Ann Dudley Goldblatt for asking me to clarify this point.

5. To be accurate, the increased number of pregnancies among adolescents today may be more a reflection of the larger number of adolescents who are sexually active than a rise in the rate of adolescent pregnancy (see DeAngelis et al., 1987). Regarding the data on STDs, see Washington, Sweet, and Shafer, 1987.

6. These data were culled from a variety of studies that were summarized and discussed by the Council on Scientific Affairs of the American Medical Association (1993). Of note, the council's emphasis was to show that other adolescents stated that they would avoid medical care if parental notification were required, but as the authors of a corollary article in the same issue of *JAMA* note: "what adolescents say they will do (i.e., regarding forgoing care) may be different from what they actually do" (Cheng et al., 1993:1406).

7. Technically, the statutes do not require physicians to deceive parents, because physicians are under no legal obligation to provide a specific service or treatment requested by a minor if it conflicts with their moral principles (Council on Long Range Planning and Development, 1990:1). Nevertheless, the point still stands that if the physician confidentially gives Jane the prescription that she requests, then the physician effectively has colluded with Jane in deceiving her parents.

8. Purdy defines "enabling virtues" as "a certain class of skills, habits and goals that . . . help us get what we want," which includes such traits as rationality, diligence, and the desire for excellence (Purdy, 1992:45).

9. Again, this is not to deny that adults can also improve their decision-making ability to better reflect their own interests, but only to acknowledge that at least part of the value of autonomy is in its use. That is, the capacity to make autonomous decisions is valued because it allows one to act according to one's own beliefs and judgments. It acknowledges that at some point an individual must stop preparing for an autonomous life and just live it.

10. I realize that this is also changing under the mature minor statutes which allow "mature" adolescents to consent to much of their own medical care (Sigman and O'Connor, 1991). Nevertheless, this freedom is not commonly sought when the issue is not sexual, reproductive, or psychiatric. Rather, in general, parents are an important influence in their children's decisions, and adolescents tend to seek their support and advice in most other matters (see Hendry et al., 1992). In addition, adolescents are often willing to conform to parental influence (see Scherer and Reppucci, 1988), particularly female adolescents (Gilligan, Lyons, and Hanmer, 1990).

11. In discussions with families regarding adolescent sexual activity, I have met a number of parents who have asked me to prescribe birth control for their children if their children request it, and then to respect their children's confidentiality. Although they hope that their children will be able to discuss these intimate issues with them, they are more concerned with their child's well-being and the avoidance of unwanted consequences. The policy that I propose to replace the specialized consent statutes would in no way prevent parents from giving physicians such pre-approved authorization.

12. I thank Joanna Zolkowski-Wynne for pressing me on this point.

13. In no way do I mean to deny Eric's and his family's responsibility for his and Jane's child. I would endorse a policy that required Eric's financial support and encouraged his social participation. Men as well as women must be responsible for their sexuality. I have focused on the Joneses because I am Jane's pediatrician and I frequently do not know the young man and his family.

14. I thank Sarah Swenson and Leslie Moore for pressing me on this point.

15. Consider, for example, that the single or lesbian woman can procreate by artificial insemination, whereas paid surrogate mothers for single or gay men are often illegal. At the other end of the spectrum, the pregnant woman has the final right to decide whether to carry a

child to term. If abortion were illegal, this part of my argument would be weaker.

16. I thank Robert E. Merrill for insisting that I address this issue directly.

17. This legal issue is discussed by Mnookin and Weisberg, 1989 and Wardle, 1989.

18. See, for example, *Meyer v. Nebraska*, 1923; *Pierce v. Society of Sisters*, 1925; *Wisconsin v. Yoder*, 1972.

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NOTE TO BETH BERMAN

FROM: Dan Porterfield

SUBJECT: Principles of Teen Pregnancy Prevention

DATE: October 9, 1996

The federal government's support of teen pregnancy prevention programs is guided by two principles: abstinence and flexibility for communities to determine strategies that fit their needs and values.

HHS believes that an essential element for preventing teen pregnancy is encouraging teens to be abstinent and delay sexual activity. In her testimony on August 2, 1994 before the House Committee on Education and Labor, Secretary Shalala emphasized, "We are absolutely committed to promoting abstinence-based programs in the schools as a key to preventing teen pregnancy." Similarly, in her letter to Ann Landers published on August 19, 1994, Secretary Shalala wrote, "The most important thing we can do to prevent teenage pregnancy is motivate young people to abstain from sex." In more recent remarks, Secretary Shalala stated, "We're sending a clear and consistent message to teenage boys and girls that they should abstain from sex" (Taped Remarks, Girls Inc. Conference, April 12, 1996). HHS is also encouraging communities to deliver this message. HHS' new publication, "Preventing Teen Pregnancy: Promoting Promising Strategies: A Guide for Communities," states that years of research and experience show that abstinence is one of the chief principles for promising strategies, therefore, "Abstinence and personal responsibility must be primary messages of prevention programs."

The federal government is also committed to enabling communities to design their own strategies to combat the problem of teen pregnancy. Communities must have the flexibility to develop strategies that are consistent with their own needs and values. As Secretary Shalala stated in her letter to Ann Landers, "Community members best understand the particular circumstances of young people's lives." Community involvement in the development of comprehensive strategies, including both public and private sector partners, is another of the principles outlined in HHS' community guide for teen pregnancy prevention. This emphasis on community flexibility is reflected in all of HHS' programs. For example, the grant announcement published last year in the Federal Register for the Center for Disease Control and Prevention's *Community Coalition Partnership Programs for the Prevention of Teen Pregnancy* required the lead organization submitting the proposal to, "seek to involve all relevant organizations in the community to work in partnership to prevent teen pregnancies."

While HHS encourages teen pregnancy prevention programs to promote abstinence, it is possible that some programs supported by HHS through block grant money, CDC grants, or other means also facilitate access to contraceptives, since condoms are the best means of preventing AIDS and sexually transmitted diseases for individuals who are not abstinent. If so, the decision to make contraceptives available was made at the local level, not the federal level.

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PRINCIPLES TO PRE

Teenage pregnancy remains a pro
national campaign to reduce it. R
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Since 1993, the Department of He
approaches to help communities d
experience, we believe that succes
principles:

Parental and Adult Involvement

Abstinence

Clear Strategies for the Future

Community Involvement

Sustained Commitment

These principles are reflected in tee
supports, including the demonstrati
Prevention and the Office of Popula
of the new $30 million teenage preg
in the 1997 budget.

DEPARTMENT OF HUMAN SERVICES

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Attachments:

1. Excerpts from Statement by Secretary Donna E. Shalala before the Committee on Education and Labor, U.S. House of Representatives, August 2, 1994.
2. Letter to Ann Landers, Washington Post, August 19, 1994
3. *Preventing Teen Pregnancy: Promoting Promising Strategies: A Guide for Communities*
4. Taped Remarks by Secretary Donna E. Shalala at Girls Inc., April 12, 1996
5. Excerpts from Announcement of CDC *Community Coalition Partnership Programs for the Prevention of Teen Pregnancy*
6. *Preventing Teen Pregnancy* Fact Sheet, October 4, 1996
7. Background: DES statement on AIDS prevention campaign for young adults, not teens.

P.S. If you need full copies of any document, please call Lisa Gilmore at 690-6035.

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1994/08/02; Secretarial Testimony; Welfare Reform
STATEMENT BY DONNA SHALALA
SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEFORE THE COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

First page -- only included relevant section -- for p. 12 (next page)

Thank you Mr. Chairman and members of the Committee for the invitation to appear before you today. I am very pleased that the Education and Labor Committee is holding a hearing on the Work and Responsibility Act of 1994 so soon after its introduction.

I am joined here today by two of the key architects of this legislation, Dr. Mary Jo Bane, HHS Assistant Secretary for Children and Families, and Dr. David Ellwood, HHS Assistant Secretary for Planning and Evaluation. Together with Bruce Reed, Deputy Assistant to the President for Domestic Policy, Drs. Bane and Ellwood have co-chaired a task force appointed by the President that sought the advice of several hundred experts, welfare recipients, and service providers in the design of this visionary plan.

Welfare as we know it has become a national tragedy. More than 14 million Americans depend on monthly AFDC checks that now cost taxpayers more than $22 billion dollars each year. In the last five years alone, well over 3 million recipients have been added to the AFDC rolls. Almost 30 percent of all births are to unmarried mothers. And nearly one in four children currently lives in poverty. Too many children grow up in households where none of the adults are working.

President Clinton, and many of us -- both inside and outside of his Administration -- have worked long and hard to put together this legislation. And we are proud of the result.

The Work and Responsibility Act of 1994 will fundamentally change this country's approach to helping parents move from dependence to independence. And, equally important, it will improve the quality of life for millions of young children. Americals children -- increasingly our poorest citizens -- deserve a chance to grow up to opportunity, not poverty and hopelessness.

If there is one thing that stands out the most from our nationwide hearings on this issue, it is that our current system doesn't work and that nobody likes it -- least of all the people who depend most on it for help -- welfare recipients themselves. So as Congress debates this issue, we know it won't be about whether or not we need welfare reform -- we all agree on that. The question is how best to go about it.

As the distinguished Chairman and members of the Committee know, there is no magic solution for the complex problem of chronic welfare dependency and poverty. But that should not deter us from meeting this challenge head-on.

This issue has become even more urgent in light of some disturbing trends: more and more children today are born to teenage mothers and outside of marriage. Almost half of all single mothers receiving AFDC -- about 42 percent -- are or have been teenage mothers.

The welfare system will continue to be part of the problem rather than part of the solution unless dramatic changes are

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roughly 1000 middle and high schools.

We are also proposing to fund larger, more comprehensive demonstrations to simultaneously address the broader health, education, safety and employment needs of young people. These grants are intended to galvanize local efforts and inspire communities to work together.

We are absolutely committed to promoting **abstinence**-based programs in the schools as a key to preventing teen pregnancy. And we are equally determined to build our strategy on the best available research.

Phasing-in Young People First.

We have chosen to phase in the plan by starting with young people: those born after 1971. We chose this strategy not because young single mothers are easiest to serve, but because they are so important to our future.

The younger generation of welfare recipients is our greatest concern. Younger recipients are likely to have the longest stays on welfare. They also are the group for which there is the greatest hope of making a profound difference. We strongly believe that the best way to end welfare as we know it is to reach the next generation; to devote energy and new resources to young people first, rather than spreading our efforts so thinly that little real help is provided to anyone.

This proposal represents a radical change in how we think about and administer welfare. But to get it right requires a solid and well-planned implementation strategy. Even if resources were plentiful, the lessons we learned from the Family Support Act, as well as from our site visits and discussions with state administrators, have convinced us that attempting to implement a time-limited transitional assistance program for the entire caseload at once would create enormous difficulties. We believe these difficulties could be avoided and the changes we envision successfully implemented by adopting this phase-in strategy.

Moreover, recent evidence from several programs serving teen mothers suggests that this population needs special attention and can be reached. By phasing in the plan with the youngest recipients first, we send a strong message of responsibility and opportunity to the next generation.

But let me be very clear about our proposal. Our legislation requires states to phase-in reform with recipients born after 1971. This implementation strategy limits the initial mandatory caseload to about one-third of the total in 1996, helping cash-strapped states enact meaningful WORK programs with time limits that can really be enforced. By the year 2000, this phase-in strategy means that half of all AFDC recipients, about 2.4 million people, will be in the new system. And by the year 2004, two-thirds will be subject to the new rules.

However, states will have the option to define the phased-in group more broadly, allowing them to apply time limits and other new rules to a larger percentage of the caseload if they wish. In addition, states will be required to serve volunteers from the non phase-in group to the extent that federal JOBS funds are available. At state option, these volunteers also may be subjected to the two-year time limit in exchange for access to services. And of course, the Family Support Act will continue to allow states to provide education and training for other AFDC recipients

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Wash. Post; 8-19-94

ANN LANDERS

DEAR ANN LANDERS: I am writing to ask your readers to become active in community efforts to prevent teenage pregnancy. The numbers are shocking. Every 104 seconds, a teenage girl gets pregnant. Four out of five children of teenage mothers who drop out of school live in poverty. This is a national tragedy.

The most important thing we can do to prevent teenage pregnancy is motivate young people to abstain from sex. This is not simply a matter of passing out information. It means taking bold steps to instill healthy attitudes, high self-esteem and credible expectations.

Both young men and women need to be held responsible for their behavior. We must provide healthful activities such as sports, art programs and jobs. We need to communicate high expectations about abstinence.

We need to address the reasons teenagers get pregnant. Some teens have insufficient education. Some have limited access to health care professionals. Teen pregnancy is often related to a dangerous pattern of abuse against girls.

Teenage pregnancy is a problem of gigantic proportions. To solve it, we need consistent and sensitive leadership from our families, our communities and our civic and religious leaders.

Young people respond to those who are closest to them—parents and teachers, siblings and friends, coaches and church members. Community members best understand the particular circumstances of young people's lives.

We want to challenge your readers to help safeguard our children's future. Befriend a young person. Organize an enrichment program for youths. Call a meeting of parents in the neighborhood.

Teens need to know that we care. Sincerely—Donna E. Shalala, secretary of Health and Human Services

Dear Madame Secretary:

Thank you for writing. Your message is extremely important. I hope it receives the attention it deserves. Today's teenagers need all the help they can get.

PREVENTING TEEN PREGNANCY

Promoting Promising Strategies

A Guide for Communities

PRINCIPLES OF PROMISING STRATEGIES TO PREVENT TEEN PREGNANCY

Teenage pregnancy remains a profound problem, and President Bill Clinton has called for a national campaign to reduce it. Real solutions lie at the grassroots level, with families, communities, and young people themselves. Communities must develop tailored approaches to meet their own needs, resources, and values.

Since 1993, the Department of Health and Human Services has supported a variety of approaches to help communities develop comprehensive strategies. Based on research and experience, we believe that successful community efforts incorporate the following five key principles:

Parental and Adult Involvement	Parents and other adult mentors must play key roles in encouraging young people to avoid early pregnancy and to stay in school.
Abstinence	Abstinence and personal responsibility must be primary messages of prevention programs.
Clear Strategies for the Future	Young people must be given clear connections and pathways to college or jobs that give them hope and a reason to stay in school and avoid pregnancy.
Community Involvement	Public and private sector partners throughout communities, including parents, schools, businesses, media, health and human services providers, and religious organizations, must work together to develop comprehensive strategies.
Sustained Commitment	Real success requires a sustained commitment to the young person over a long period of time.

These principles are reflected in teen pregnancy prevention programs the Department supports, including the demonstration programs of the Centers for Disease Control and Prevention and the Office of Population Affairs. They will be the basis for funding decisions of the new $30 million teenage pregnancy prevention initiative proposed by President Clinton in the 1997 budget.

Taped Remarks

Donna E. Shalala

Secretary of Health and Human Services

at

Girls, Inc.

April 12, 1996

I WANT TO THANK ALL OF YOU FOR GIVING ME THE OPPORTUNITY TO JOIN YOU VIA THE INFORMATION SUPERHIGHWAY.

WHETHER YOU'RE HELPING THE 10 YEAR-OLD IN DALLAS RIDE THE ECONOMIC WAVES OF TOMORROW BY PURSUING MATH AND SCIENCE TODAY ...

... EDUCATING THE 13 YEAR-OLD IN SAN DIEGO ABOUT THE DANGERS OF DRUGS, ...

... OR TEACHING THE 17 YEAR-OLD IN BALTIMORE TO SAY "NO" TO PREMARITAL SEX AND "YES" TO HER FUTURE, ...

... YOU ARE HELPING THE WOMEN OF TOMORROW TO REACH FOR THE STARS.

AND, THE CLINTON ADMINISTRATION APPLAUDS YOUR VISION.

WE BELIEVE AS MARIAN WRIGHT EDELMAN DOES THAT ...

... "OPPORTUNITY IS THE BEST CONTRACEPTIVE."

AND, WE BELIEVE THAT OUR SOCIETY AS A WHOLE MUST JOIN HANDS WITH PARENTS TO HELP YOUNG PEOPLE MAKE SAFE PASSAGES INTO YOUNG ADULTHOOD.

THAT'S WHY WE'RE TEAMING UP WITH THE U.S. WOMEN'S SOCCER TEAM TO TELL ALL GIRLS, THAT ...

... LIKE OIL AND WATER, TOBACCO AND FITNESS JUST DON'T MIX.

THAT'S WHY WE'RE CHALLENGING THE MEDIA TO DE-GLAMORIZE DRUGS AND RE-GLAMORIZE OPPORTUNITY.

THAT'S WHY WE'RE SUPPORTING THE V-CHIP TO GIVE PARENTS CONTROL OVER THE VIOLENCE THEIR CHILDREN ARE EXPOSED TO ON TV.

AND, THAT'S WHY WE'RE WORKING TO PREVENT THE TRAGEDY OF TEEN PREGNANCY IN AMERICA.

IN HIS STATE OF THE UNION ADDRESS LAST YEAR, PRESIDENT CLINTON CALLED TEEN PREGNANCY ONE OF THE GREATEST PROBLEMS FACING THIS COUNTRY.

CHILDREN BORN TO TEEN PARENTS ARE MORE LIKELY TO BE POOR,

... MORE LIKELY TO HAVE SERIOUS HEALTH PROBLEMS, ...

... AND MORE LIKELY TO DROP OUT OF SCHOOL.

THERE ARE NO EASY ANSWERS TO THIS NATIONAL TRAGEDY ...

... AND, WHILE MANY GROUPS HAVE RUN FROM THIS ISSUE, YOU HAVE SHOWN THE COURAGE TO TAKE ON A TOUGH BATTLE --

-- AND THE COMMITMENT TO DEMAND RESULTS.

AND, WE'RE PROUD TO STAND WITH YOU.

WE'RE SENDING A CLEAR AND CONSISTENT MESSAGE TO TEENAGE BOYS AND GIRLS THAT THEY SHOULD ABSTAIN FROM SEX.

WE'RE SUPPORTING CUTTING-EDGE RESEARCH TO HELP FIND WAYS TO REDUCE TEEN PREGNANCY.

WE'RE SUPPORTING LOCAL EFFORTS TO IMPLEMENT PREVENTION STRATEGIES THAT FIT LOCAL NEEDS AND LOCAL VALUES --

-- AND WE'RE REQUESTING MORE FUNDING TO HELP EVEN MORE COMMUNITIES.

AND, UNDER WELFARE REFORM WAIVERS WE'VE APPROVED, MORE STATES ARE REQUIRING TEEN MOTHERS TO STAY IN SCHOOL AND LIVE WITH A RESPONSIBLE ADULT --

-- AND MORE STATES ARE MAKING SURE THAT ABSENT FATHERS TAKE FINANCIAL RESPONSIBILITY FOR THE CHILDREN THEY BRING INTO THIS WORLD.

BUT, THE GOVERNMENT WILL NEVER MEET THIS CHALLENGE ALONE.

THAT'S WHY WE'RE GALVANIZING A NATIONAL PRIVATE SECTOR CAMPAIGN --

-- SO THAT COMMUNITIES, BUSINESSES, AND PARENTS FROM ALL OVER AMERICA CAN LOCK ARMS AND SOLVE THIS PROBLEM TOGETHER.

AND, THAT'S WHY YOUR LEADERSHIP -- AND THIS CONFERENCE -- ARE SO IMPORTANT.

AS WE APPROACH THE SUMMER OLYMPICS, ALL OF US MUST CONTINUE TO INSPIRE YOUNG GIRLS TO REACH FOR THE GOLD IN EVERYTHING THEY DO.

WE MUST HELP THEM BECOME HOOKED ON HOPE ...

... AND TOO STRONG FOR WRONG, ...

AND, WHETHER THEY WANT TO BE A WORLD CLASS ATHLETE ...

... OR AN ARTIST, ...

... A SCIENTIST ...

... OR EVEN A CABINET SECRETARY, ...

... WE MUST REACH THEM WITH A VERY CLEAR MESSAGE:

IN THE RACE FOR THE FUTURE --

-- EDUCATION, PHYSICAL ACTIVITY, AND HEALTHY LIVING ARE THE WINNING COMBINATION.

THANK YOU.

Federal Register Announcement

Billing Code: 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement 547]

Community Coalition Partnership Programs for the Prevention of Teen Pregnancy

This is not the complete announcement — include the relevant sections.

Introduction

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 1995 funds for cooperative agreements to support the efforts of "hub" organizations to strengthen and evaluate the effectiveness of their community program to prevent initial and repeat teen pregnancies and related problems. These cooperative agreements will support demonstration projects to plan for the implementation of appropriate and effective prevention intervention strategies for reaching the greatest proportion of teenagers in communities with high rates of teen pregnancy. "Hub" organizations are also encouraged, to the extent that it is feasible and desirable within their communities, to establish linkages with and participate in existing community-based efforts funded by the Federal government or others to prevent HIV/AIDS, sexually transmitted diseases, and first and repeat pregnancies among teenagers.

Purpose

These cooperative agreement awards are to support the efforts of "hub" organizations to enhance their capacity to strengthen and evaluate the effectiveness of coalition partnership programs; and, to develop "Community Action Plans" for the implementation of comprehensive community programs for the prevention of initial and repeat teen pregnancies and related problems.

Program Requirements

"Hub" organizations should seek to involve all relevant organizations in the community to work in partnership to prevent teen pregnancies. The community coalition partnership program should seek to reach the greatest proportion of teens within the community, giving emphasis to those teens who are in high risk situations. "Hub" organizations are encouraged, to the extent that it is feasible and desirable within their communities, to establish linkages, and to work in concert with existing community-based efforts funded by the Federal government or others to prevent HIV/AIDS, sexually transmitted diseases, and first and repeat pregnancies among teenagers, as a means to strengthen the program to prevent teen pregnancy.

⊗ Note this language

"Hub" organizations will work with current and/or new partner organizations to enhance the effectiveness of their teen pregnancy prevention efforts, and to increase the number of teens reached. Programs will involve teens in community service, job skills development, and other opportunities that build their self-esteem, self-sufficiency, and belief in themselves and their futures. In so doing, programs should strive to provide teens who are not yet sexually experienced with a strong incentive to remain abstinent, and teens who are sexually experienced with a strong incentive to delay pregnancies and childbearing until they are ready and able to assume the role and responsibilities of parents. For those teens who are sexually active, programs will promote the consistent and effective use of appropriate contraceptives, and will facilitate family planning counseling and services.

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under A.(Recipient Activities), and CDC will be responsible for the activities listed under B. (CDC Activities).

A. <u>Recipient Activities</u>

The "hub" organization will coordinate the efforts of coalition members and facilitate the development of

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

October 4, 1996

Contact: HHS Press Office
(202) 690-6343

PREVENTING TEENAGE PREGNANCY

Overview: Each year, approximately one million pregnancies occur among American teenagers. Last year, President Clinton challenged "parents and leaders all across this country to join together in a national campaign against teen pregnancy to make a difference." A group of prominent Americans responded to that challenge, forming the National Campaign to Reduce Teen Pregnancy. As the President's new Senior Advisor on Teen Pregnancy and Youth Issues, Dr. Henry Foster serves as liaison to the National Campaign.

The Administration's strategy to prevent teen pregnancy combines opportunity and responsibility -- and starts with a strong message from the top. It supports state, local government and community efforts and works in partnership with young people, parents, schools, civic leaders, businesses, nonprofit organizations, and state and local governments. It encourages abstinence and personal responsibility by young people. It provides financial support to enhance access to health and family planning services. And it invests in research and evaluation to determine what approaches work.

As part of this strategy, the welfare law signed by President Clinton on August 22, 1996 calls for additional efforts to prevent out-of-wedlock teenage pregnancies and to ensure that communities engage in local efforts to prevent teenage pregnancy.

The Administration's strategy is reflected in all of HHS' activities. Most recently, for example, HHS:

- *Awarded 17 grants totaling $5.0 million to innovative and comprehensive demonstration programs to prevent early teen sexual activity, reduce teen pregnancies and develop and implement innovative comprehensive programs for pregnant and parenting teens, their infants, male partners and family members. The prevention programs emphasize and encourage abstinence as the most effective way of preventing teen pregnancies, sexually-transmitted diseases, and HIV/AIDS.*

- *Launched the CDC Teen Pregnancy Prevention Program by awarding 13 grants to community-wide coalitions in communities with high rates of teen pregnancy. Increased funding in fiscal year 1997 totaling $13.7 million will allow for the expansion of local efforts to reduce teen pregnancy.*

- MORE -

RECENT TRENDS

After rising steadily from 1986 to 1991, the birth rate for teens aged 15-19 declined for the fourth straight year in 1995, according to preliminary figures. Recent declines in both birth and abortion rates indicate that teen pregnancy rates are also falling.

- The birth rate for teens aged 15-19 fell by an estimated 3 percent in 1995.
- From 1991 to 1995, the birth rate for teens aged 15-19 dropped by 8 percent.
- In addition, from 1991 to 1992, the pregnancy rate for 15-19-year-olds fell 3 percent.
- Pregnancy rates for teens aged 15-19 also declined in 30 of 41 reporting states in 1992.

A more complete listing of HHS teen pregnancy programs follows:

- **The Adolescent Family Life Program**, created in 1981, has awarded nearly $112 million to support demonstration projects that provide abstinence-focused educational services to prevent early unintended pregnancies, sexually-transmitted diseases, and HIV/AIDS and also to develop and implement new approaches in the delivery of medical, social, and educational services to pregnant and parenting adolescents, their infants, male partners, and their families.
- **Community Coalition Partnership Programs for the Prevention of Teen Pregnancy** is an ongoing demonstration program that will provide $13.7 million in fiscal year 1997 to enable communities to implement and evaluate community-wide interventions that are innovative, comprehensive, and sustainable.
- **Healthy Schools, Healthy Communities** established 27 school-based health centers in 20 states and the District of Columbia to serve the health and education needs of children and youth at high risk for poor health, teenage pregnancy, and other problems.
- **"Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood"** is a two-volume comprehensive review by HHS of the most recent literature on teen sexual behavior, pregnancy and parenthood and the effectiveness of teen pregnancy prevention programs.
- **Reproductive Health and Family Planning Services (under Title X of the Public Health Service Act)** are provided to nearly 5 million persons each year, nearly one third of whom are under 20 years of age. Abstinence counseling and education are an important part of the Title X service protocol for adolescent clients.
- **Health Care and Promotion** under Medicaid provides Medicaid-eligible adolescents under age 21 with access to a comprehensive range of preventive, primary, and specialty services within its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In conjunction with the Maternal and Child Health Bureau, guidelines are being disseminated to state Medicaid and Maternal and Child Health programs. These guidelines, from the Bright Futures project, stress the importance of family and community support for positive health and social behaviors, including adolescent pregnancy prevention.

- **Federal/State Partnerships**, including the Maternal and Child Health Services Block Grant and the Social Services Block Grant (authorized by Titles V and XX of the Social Security Act, respectively), include support for adolescent pregnancy prevention programs, state adolescent health coordinators, state prenatal care hotlines, family planning, school health, and other prevention services. The Community Services Block Grant enables local community agencies to provide low-income populations, including youth at risk, with job counseling, summer youth employment, GED instruction, crisis hotlines, information and referral to health care, and other services. The Preventive Health and Health Service Block Grant (under Title XIX of the Public Health Service Act) provides resources to 49 States for services to the general population, including health education, risk reduction and public health nursing.

- **Youth Programs** including Runaway and Homeless Youth Programs, the High Risk Youth Program, Community Schools, National Youth Sports, and Youth Violence Prevention Programs, address a wide range of risk factors.

- **Healthy Start** has demonstration projects in 22 communities nationwide to reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants, and their families. Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for adolescents that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem.

- **Empowerment Zones and Enterprise Communities** in 105 rural and urban areas across the country have been awarded grants to stimulate economic and human development and to coordinate and expand support services. As they implement their strategic plans, some sites are including a focus on teenage pregnancy prevention and youth development.

- **Health education in schools** supports the efforts of every state and territorial education agency to implement school health programs to prevent the spread of HIV and sexually transmitted diseases (STDs). Assistance is also provided to 13 states to build an infrastructure for school health programs. Efforts are targeted at preventing early sexual activity, STDs, HIV, drug and alcohol abuse, tobacco use, and injuries.

- **Community and migrant health centers**, including family and neighborhood health centers, operate in 1600 sites and provide primary and specialized health and related services to medically underserved adolescents. Some centers include special hours or clinics for adolescent patients.

- **Indian Health Service** provides a full range of medical services for American Indians and Alaska Natives. IHS has a special emphasis on youth substance abuse, child abuse and women's health care, and supports projects targeted at preventing teenage pregnancy.

- **Drug treatment and prevention programs** include services to prevent first-time and repeat births among teenagers. Sixty-five residential substance abuse treatment programs for pregnant and postpartum women, as well as women with dependent children, receive support to provide family planning, education, and counseling services. In addition, 13 grant demonstration projects offer interventions and outreach to female adolescents ages 12-20 who are at risk for alcohol, tobacco, and other drug use; physical and sexual abuse; and pregnancy. And, a two-year public information campaign is reaching out to adolescent girls ages 9-14, and to their families and social networks, to educate them about the risks and consequences of drug, alcohol, and tobacco use.

- **Resources centers and clearinghouses** at both the state and national level provide information and technical assistance to state and community-based health, social service, and youth-serving agencies. Toll-free hotlines also provide guidance on family and youth services, STDs, AIDS, and other issues.

- **Research, surveillance, demonstrations, and evaluations** are conducted on an ongoing basis to gather and provide information and technical assistance on the magnitude, causes, and prevention of teenage pregnancy and on programs and approaches that work.

WELFARE REFORM: REACHING THE NEXT GENERATION

Because estimates indicate that over half the mothers who receive Aid to Families with Dependent Children were teenagers when they had their first child, preventing teenage pregnancy has been a critical part of the Clinton Administration's approach to welfare reform. "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996," which the President signed into law on August 22, 1996, contains several measures to reduce teenage pregnancy and prevent welfare dependency. The new law will send teenagers the message that staying in school, postponing sexual activity, and preparing to work are the right things to do. As President Clinton has said, "Nobody should get pregnant or father a child who isn't prepared to raise the child, love the child, and take responsibility for the child's future."

- **Teen Pregnancy Prevention.** Under the new law, starting in FY 1998, $50 million a year in mandatory funds will be added to the appropriations of the Maternal and Child Health (MCH) Block Grant for abstinence education. In addition, the Secretary of HHS will establish and implement a strategy to (1) prevent non-marital teen births, and (2) assure that at least 25 percent of communities have teen pregnancy prevention programs. No later than January 1, 1997, the Attorney General will establish a program that studies the linkage between statutory rape and teen pregnancy, and that educates law enforcement officials on the prevention and prosecution of statutory rape.

- **Live at home and stay in school requirements.** Under the new welfare reform law, unmarried minor parents will be required to live with a responsible adult or in an adult-supervised setting and participate in educational and training activities in order to receive assistance. States will be responsible for locating or assisting in locating adult-supervised settings for teens.

- **Strengthened Child Support Enforcement.** The new welfare reform law includes the child support enforcement measures President Clinton proposed in 1994 -- the most sweeping crackdown on non-paying parents in history. The measures include: streamlined efforts to name the father in every case; employer reporting in new hires to catch non-paying parents who move from job to job; uniform interstate child support laws; computerized state-wide collections to speed up payments; and tough new penalties, like drivers' license revocation, for parents who fail to pay. These measures could increase child support collections by $24 billion and reduce federal welfare costs by $4 billion over 10 years.

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REMARKS BY: DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES
PLACE: "Respect Yourself, Protect Yourself" Press Conference
DATE: November 30, 1995

Background Info - CDC AIDS Prevention Campaign for young adults - it's not teens

Respect Yourself, Protect Yourself

GOOD MORNING:

Thank you for joining us.

Last week, our country reached another sad milestone in our fifteen year battle with AIDS. The Centers for Disease Control and Prevention reported that more than half a million men, women, and children have now been diagnosed with AIDS, and more than 300,000 Americans have lost their lives to this relentless killer.

This epidemic is taking a particularly heavy toll on young Americans. In 1993, AIDS became the leading cause of death among Americans between the ages of 25 and 44. And between 1993 and 1994, the number of AIDS-related deaths in that age group rose 8 percent.

We know that AIDS is only the final stage of a long-term illness that begins with an infection that can occur 10 or more years before diagnosis. That means that many of the Americans who are dying in their 20s, 30s, and 40s, were infected in their teenage years and their 20s.

The November 24 issue of "Science" includes a new study prepared by Dr. Philip Rosenberg of the National Cancer Institute giving us even greater cause for alarm about our young adult population. The study shows that cases of AIDS have increased much more rapidly among individuals born in 1960 or later.

As you can see by the chart behind me, new cases of AIDS are rising rapidly among young adults and peaking as they reach their late 20s and early 30s.

What we have is a generation in jeopardy, and it is up to us to take action now to reverse these tragic trends before a new generation of leadership for this country begins to be wiped out by the AIDS epidemic.

The new public service campaign we are launching today -- "Respect Yourself, Protect Yourself" -- offers young adults the information they need to stay healthy. The NIH study shows that as each generation of Americans reach their late teens and early 20s, they enter a danger period with very high levels of HIV infection.

These public service announcements are specifically designed to reach adults between the ages of 18 and 25 with a balanced message of abstinence, prevention, and responsibility. They use the words and experience of young adults themselves to urge this generation to exercise their personal responsibility to protect themselves from HIV.

We know that prevention efforts work to slow the rate of HIV infection in targeted population groups. We have seen some remarkable success, for example, among older gay white men, where infection rates were at their highest when this epidemic began and have come down considerably in recent years.

The key to successful prevention efforts is that they must be targeted. And they must be sustained over a period of years and even generations. We cannot start and stop because if we do that, this epidemic will just keep going and going.

Two years ago, our country took an important step forward when we launched the Prevention Marketing

Initiative, aimed at young adults 18 to 25. We offered young adults the accurate information they need to protect themselves from HIV. We told them that abstinence is the best way to avoid sexual transmission of HIV. And we told those who are sexually active that they must use latex condoms consistently and correctly to significantly reduce their risk of infection.

This campaign is beginning to work. We have seen signs of greater understanding of and use of condoms and we have seen promising signs of a greater degree of sexual abstinence in young people and a growing movement toward what is called "secondary virginity." For those who have begun to have sex early in their lives to choose to abstain is a sign of increasing personal responsibility.

But we cannot stop here. The latest trends show that we have a great deal of work to do, so we are rolling up our sleeves and getting to work. I'd like to ask Dr. David Satcher, the director of the Centers for Disease Control and Prevention, to join me and describe this exciting new campaign.

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