Confidential Reproductive Health Services for Minors: The Potential Impact of Mandated Parental Involvement for Contraception

By Rachel K. Jones and Heather Boonstra

Rachel K. Jones is senior research associate at The Alan Guttmacher Institute (AGI), New York. Heather Boonstra is senior policy associate at AGI, Washington, DC.

CONTEXT: *Recent legislative efforts to implement mandated parental involvement for minor adolescents seeking family planning services threaten the rights of adolescents younger than 18 to access reproductive health care.*

METHODS: *State and federal laws and policies pertaining to minor adolescents' rights to access services for contraception and sexually transmitted diseases are reviewed, and research examining issues of parental involvement among adolescents using clinic-based reproductive health services is synthesized.*

RESULTS: *Attempts to mandate parental involvement for reproductive health care often focus on contraceptive services and are typically linked to federal or state funding. Studies of teenagers using clinic-based family planning services suggest that slightly more than one-half would obtain contraceptives at family planning clinics even if parental notification were required. Mandated parental involvement for contraception would discourage few teenagers from having sex, but would likely result in more teenagers' using the least effective methods, such as withdrawal, or no method at all. Family planning clinics encourage teenagers to voluntarily talk to their parents, but relatively little information is available about the extent to which activities to promote parent-child communication have been adopted.*

CONCLUSIONS: *Mandated parental involvement for teenagers seeking contraceptive care would likely contribute to increases in rates of teenage pregnancy. Research that will help clinics implement and improve efforts to encourage voluntary parental involvement is urgently needed.*

Perspectives on Sexual and Reproductive Health, 2004, 36(5):182–191

The extent to which parents are, or should be, involved in their adolescent children's sexual and reproductive health decisions is a complicated issue. No federal law guarantees adolescents the universal right to confidential services for contraception or sexually transmitted diseases (STDs). Many states have enacted laws that explicitly allow adolescents younger than 18 to consent to contraceptive services, and all states allow minors to consent to STD services to some extent; minor consent laws implicitly guarantee confidentiality. Yet the terms of these guarantees vary considerably from state to state. Moreover, the types of funding that a provider receives can determine whether confidentiality is guaranteed and whether parental involvement is required.

Advocates of parental involvement laws, which include organizations such as the U.S. Conference of Catholic Bishops[1] and Concerned Women for America,[2] contend that government policies giving minors the right to consent to sexual health services without their parents' knowledge undermine parental authority and family values and are tantamount to condoning early sexual activity.

Youth-serving agencies and medical professionals recognize the important roles that parents play in the lives of adolescents. However, many also believe that confidential access to sexual health services is essential for adolescents who are, or are about to become, sexually active because some teenagers might avoid seeking contraceptive and STD services if they were forced to involve their parents. The American Medical Association,[3] the American College of Obstetricians and Gynecologists[4] and the Society for Adolescent Medicine[5] have issued statements asserting that confidential reproductive health services should be available to minors.

More than one-third of teenagers who visit reproductive health care providers obtain services at publicly funded family planning clinics, and adolescent clients in these facilities are disproportionately minority and low-income.[6] This means that adolescents most in need of government-funded reproductive health services would be disproportionately affected by mandatory parental involvement. However, few attempts have been made to synthesize what is known about how this population would react to such requirements or the extent to which parents are already involved in teenagers' reproductive health decisions.

To help inform public debate about the potential effects of mandatory parental involvement, we synthesized results of previous studies that have shed light on adolescents' disclosure to a parent regarding their use of clinic services, parents' involvement in their adolescent child's decision to use family planning services, minors' likely reactions to legally required parental involvement and parents' views on issues related to minors' having access to contraceptive and STD services. We also examined the types of activities that clinics are using to promote communication between adolescents and their parents.

CONFIDENTIALITY AND CONSENT FOR MINORS

Generally, parents have the legal authority to make medical decisions on behalf of their children, based on the principle that young people lack the maturity and judgment to make fully informed decisions before they reach the age of majority (18 in most states). Exceptions to this rule have long been made, however, such as medical emergencies when there is no time to obtain parental consent and in cases in which a minor is "emancipated" by marriage or other circumstances and, thus, can legally make decisions on his or her own behalf. More broadly, some states have adopted the so-called mature minor rule, which allows a minor to consent to services without consulting his or her parents if the minor is sufficiently intelligent and mature to understand the nature and consequences of a proposed treatment.[7]

No state law explicitly requires parental consent or notification for all minors seeking contraceptive services. Over the past 30 years, 21 states and the District of Columbia have explicitly allowed all minors to consent to contraceptives services, and another 14 have confirmed the right for certain categories of minors, such as those who are parents (Table 1). Where the law is silent, the decision of whether to inform parents is left to the provider, acting in the best interests of the minor.[8] All 50 states and the District of Columbia allow most minors to consent to STD testing and treatment, and many explicitly include HIV services.[9]

Clinics that receive federal funding from certain sources must provide confidential sexual health services for teenagers. Title X of the Public Health Service Act, the only federal program dedicated to providing family planning services to low-income women and teenagers, has provided confidential services to all clients, regardless of age, since its inception in 1970. Title X clinics also have a mandate to encourage adolescents to include their parents in their contraceptive decisions. In 2001, Title X clinics served 691,000 adolescents under the age of 18, who account for 14% of all clients in family planning clinics.[10] Courts have interpreted the federal Medicaid statute to require that family planning services paid for by Medicaid be provided on a confidential basis to sexually active minors who desire them. In 1995, 31% of women who obtained reproductive health care services in family planning clinics paid with Medicaid,[11] although the proportion of adolescents who did so may be lower.

The most visible efforts to limit minors' access to contraceptive services have been linked to federal or state funding, as opposed to state policies that would affect sexual and reproductive health services for all teenagers, regardless of funding source. For example, in June 2003, Rep. Todd Akin (R-MO) introduced federal legislation requiring parental involvement for teenagers seeking contraceptives at clinics funded by Title X.[12] If enacted, this bill would directly undermine the federal guarantee of confidentiality for services provided under the program. Since the Republican takeover of Congress in 1995, the House of Representatives has (unsuccessfully) voted three times to require parental consent for Title X services; the issue continues to emerge at the state and local levels as well. Two states—Texas and Utah—prohibit the use of state funds to provide contraceptive services to minors without parental consent. One county-level effort to mandate parental involvement for contraception is notable: In April 1998, McHenry County, Illinois, began requiring that minors seek-

TABLE 1. Conditions under which minors are authorized to consent to contraceptive and STD services, by state, 2004

State	Contraceptive services	STD services
Alabama	≥14 yrs., married, has a child, pregnant or H.S. graduate*	≥12 yrs. (HIV-explicit)†
Alaska	All	All
Arizona	All	All
Arkansas	All	All†
California	All	≥12 yrs. (HIV-explicit)
Colorado	All	All (HIV-explicit)*†
Connecticut	(No law)	All (HIV-explicit)
Delaware	≥12 yrs.†	≥12 yrs. (HIV-explicit)†
District of Columbia	All	All
Florida	Married, has a child, pregnant or risks health hazard if denied services‡	All (HIV-explicit)
Georgia	All	All†
Hawaii	≥14 yrs.†	≥14 yrs.†
Idaho	All	≥14 yrs. (HIV-explicit)
Illinois	Married, has a child, pregnant, received a referral or risks health hazard if denied services‡,§	≥12 yrs. (HIV-explicit)†
Indiana	(No law)	All
Iowa	All	All (HIV-explicit)*‡
Kansas	Mature minor	All†
Kentucky	All†	All (HIV-explicit)†
Louisiana	(No law)	All†
Maine	Married, has a child or risks health hazard if denied services‡	All†
Maryland	All†	All†
Massachusetts	All**	All (HIV-explicit)
Michigan	(No law)	All (HIV-explicit)†
Minnesota	All†	All†
Mississippi	Married, has a child or received a referral††	All (HIV-explicit)*§
Missouri	(No law)	All†
Montana	All†	All (HIV-explicit)†
Nebraska	(No law)	All
Nevada	Mature minor*	All (HIV-explicit)
New Hampshire	Mature minor*	≥14 yrs.
New Jersey	Married or pregnant*	All†
New Mexico	All	All*§
New York	All**	All*§
North Carolina	All	All (HIV-explicit)
North Dakota	(No law)	≥ 14 yrs. (HIV-explicit)
Ohio	(No law)	All*§
Oklahoma	Married or ever pregnant†	All (HIV-explicit)†
Oregon	All†	All (HIV-explicit)
Pennsylvania	Ever pregnant, H.S. graduate or married*	All (HIV-explicit)
Rhode Island	(No law)	All (HIV-explicit)
South Carolina	≥16 yrs.‡‡	≥16 yrs. (HIV-explicit)‡‡
South Dakota	(No law)	All
Tennessee	All	All (HIV-explicit)
Texas	(No law)§§	All†
Utah	(No law)§§	All
Vermont	(No law)	≥12 yrs. (HIV-explicit)*§
Virginia	All	All (HIV-explicit)
Washington	All	≥14 yrs. (HIV-explicit)
West Virginia	(No law)	All
Wisconsin	(No law)	All
Wyoming	All	All (HIV-explicit)

*Law applies to medical care in general. †Physicians may, but are not required to, inform minors' parents. ‡Applicable if a physician believes the minor would suffer a "probable" health hazard if denied services. §Referral by a physician, a member of the clergy or a Planned Parenthood clinic. **A statewide program gives minors access to confidential contraceptive services. ††Referral by a physician, a member of the clergy, a family planning clinic, a school of higher education or a state agency. ‡‡State policies permit physicians to provide services when necessary. §§State funds may not be used to provide minors with confidential contraceptive services. *†Physicians may inform parents of a minor's decision to consent to HIV or AIDS services if the minor is younger than 16. *‡A parent must be notified of a positive HIV test result. *§Excludes right to consent to HIV or AIDS treatment.
Sources: references 8 and 9.

TABLE 2. Selected characteristics of U.S. studies of parental involvement in adolescents' sexual and reproductive health care, 1978–2002

Study	Year conducted	Sample
Surveys of adolescents		
Chamie et al., 1982[23]	1981	3,523 female clients, aged <20, at family planning clinics in 37 U.S. counties
Furstenberg et al., 1984[17]	1980–1981	290 first-time female clients, aged <18, at nine federally funded family planning clinics in southeastern Pennsylvania (surveyed at baseline, 6 mos. and 15 mos.)*
Harper et al., 2004[19]	1994–1995	399 sexually active female clients, aged 13–19, at five San Francisco family planning clinics who were initiating use of the implant, the pill or condoms as their primary contraceptive method
Herceg-Baron et al., 1986[20]	1980–1981	469 first-time female clients, aged <18, at nine federally funded family planning clinics in southeastern Pennsylvania (surveyed at baseline, 6 mos. and 15 mos.)
Meehan, Hansen and Klein, 1997[47]	1991–1993	1,601 clients, aged 13–17, at HIV counseling/testing sites funded by the Connecticut Dept. of Public Health (Data came from report forms submitted for the 12-mo. periods before and after removal of a state law requiring parental consent for minors seeking HIV services.)
Mosher and Horn, 1988[23]	1982	Nationally representative sample of 1,540 sexually experienced females, aged 15–24, with at least one clinic/physician visit for reproductive health services other than pregnancy testing
Nathanson and Becker, 1986[16]	1980–1981	2,884 first-time female clients, aged <20, at all Maryland Health Dept. family planning clinics
Reddy, Fleming and Swain, 2002[38]	1999	950 sexually active females, aged <18, accessing reproductive health services at Wisconsin's 33 Planned Parenthood clinics
	2001	256 sexually active females, aged <18, accessing reproductive health services at three Milwaukee Planned Parenthood clinics
Torres, 1978[16]	1978	1,442 females, aged <18, accessing contraceptive services at 53 family planning clinics in 10 states
Torres, Forrest and Eisman, 1980[16]	1979–1980	1,241 unmarried females, aged <18, accessing contraceptive services at clinics participating in a nationwide survey
Zabin and Clark, 1981[30] and 1983[23]	1980	1,219 first-time, never-pregnant female clients, aged <20, at 31 family planning clinics in eight cities
Zabin et al., 1992[22]	1985–1986	334 black urban teenagers, aged <18, seeking pregnancy tests at two family planning clinics in Baltimore
Zavodny, 2004[13]	1997–2000	Women of reproductive age (15–44) in four suburban Illinois counties, including one that imposed parental consent for contraception in 1998
Surveys of parents		
Cutler et al., 1999[50]	nr	280 rural Minnesota parents with at least one adolescent child attending public school
Furstenberg et al., 1984[17]	1980–1981	95 mothers interviewed (with their adolescent daughters' permission) 15 mos. after their daughters attended one of nine federally funded family planning clinics in southeastern Pennsylvania
Resnick et al., 2003[50]	2002	1,069 parents in Minnesota/Wisconsin with a minor adolescent child
Santelli et al., 1992[49]	1990	262 Baltimore parents who registered their children at a school-based clinic

*This analysis involved a subsample of the cohort in Herceg-Baron et al., 1986. *Notes:* Superscript numbers refer to the reference list (page 189). nr=not reported.

ing prescription contraception at the county's only public health clinic obtain parental consent.[13] Of note, the law was not linked to a specific funding source, but the county purposely declined Title X support and instead relied on its own funds to cover the cost of contraceptive services.

Confidentiality for minors also faces more indirect threats. In August 2002, the Bush administration announced a new federal rule governing the privacy of medical records. Previous statements by the administration had suggested that the rule would grant parents a federal right to access their minor children's medical records, even when the minor lawfully consented to the services under federal or state law.[14] The rule, however, defers to state law on the subject or, in the absence of state law, provider judgment.[15] Whether the rule invites states to alter existing laws governing control of medical records remains to be seen.

RESEARCH ON PARENTAL INVOLVEMENT

We conducted a search for U.S. studies on parental involvement in the provision of clinic-based sexual and reproductive health services—other than abortion—to adolescents by using social science, medical and public health research databases (e.g., LookSmart, MEDLINE, POPLINE, ProQuest and PubMed). We also conducted a general Internet search and spoke with experts in the field to locate information addressing clinics' efforts to promote parent-child communication.

Adolescents' Reports of Parental Involvement

We identified 14 published reports that relied on data from adolescents.* Even with such a small number, the study populations were quite variable (Table 2). Some of the studies were restricted to minors, while others included 18- and 19-year-olds; one included young women up to age 24. Some studied sexually active teenagers only; others included sexually inexperienced teenagers. Many were limited to a specific geographic area or type of facility (e.g., Planned Parenthood clinics). About half of the studies were conducted more than 20 years ago, and none included males. Despite these variations and limitations, some consistent findings emerge.

Several studies found that the parents of a majority of adolescents using family planning clinics are aware of their children's visits. Five studies examined parental knowledge of teenage family planning visits: In three, slightly more than half of adolescents (52–55%) indicated that their parents knew they were at the clinic.[16] In another study, only 41% of first-time minor clients reported that their mothers knew they were accessing services; however, at follow-up interviews six and 15 months later, a majority indicated that their mothers were aware of their clinic visits (58% and 72%, respectively).[17] This pattern corresponds with cross-sectional research showing that young women who had made a previous clinic visit were more likely than first-time attendees to have informed parents;[18] findings from these studies suggest that many teenagers who use clinic-based family planning services inform their parents afterward.

In the most recent study to survey teenagers in clinics about parental knowledge, conducted in 1994–1995, 45% of contraceptive clients aged 13–19 reported that their mothers knew they were at the clinic.[19] Although the study was limited to a small sample in one city, this finding raises the possibility that contemporary teenagers are less likely than teenagers in previous decades to have informed their parents. However, the inclusion of 18- and 19-year-olds may partially account for the lower prevalence of parental knowledge, because older teenagers are less likely than younger minors to inform their parents.[20]

Some parents not only are aware that their daughters are accessing family planning services, but are involved in and supportive of these visits. Small but substantial proportions of adolescent contraceptive clients in two studies (12–13%) consulted with their mothers before visiting a family planning clinic.[21] The possibility of a pregnancy may result in higher levels of parental consultation: Of minors seeking pregnancy tests at Baltimore family planning clinics, 57% had discussed the potential pregnancy with a parent beforehand.[22] Elsewhere, 6% and 15%, respectively, of teenagers had learned of the clinic from a parent or had visited the clinic at a parent's suggestion;[23] 10–14% of adolescents visiting for contraceptive services were accompanied by a parent, typically their mother.[24]

Some teenagers may be more likely than others to have a parent involved in their reproductive decision-making. Younger adolescents are more likely than older ones to indicate that a parent knows about their visit,[25] to visit a family planning provider at a parent's recommendation,[26] or to have a mother who recommended the visit or accompanied them to the clinic.[27] For example, in large surveys of minors visiting family planning clinics, two-thirds of females younger than 15 had parents who knew about their visit, compared with 46–50% of 17-year-olds.[28] In another survey, one-third of minors younger than 15 indicated that they were attending the clinic at the suggestion of a parent, compared with 14% of 15–17-year-olds.[29] Similarly, a study conducted in eight U.S. cities found that young women who had never had sex—a group that tends to be younger—were more likely than sexually active teenage clients to indicate that a parent suggested the visit.[30] Barriers such as limited mobility, restricted financial independence and a lack of information about contraceptives, including where to obtain them, are more pronounced for adolescents younger than 16 than they are for 16- and 17-year-olds. It is possible, if not likely, that many younger teenagers who access family planning services do so specifically because parents are involved. Of note, most studies surveyed adolescents who were already at the clinic rather than adolescents in general; therefore, selection bias is a possibility. Notably, two studies found no age-based differences in parents' knowledge or support of a clinic visit.[31]

Black adolescents using family planning services are more likely than their white counterparts to indicate that their parents know about a clinic visit[32] and to receive parental encouragement and support for the visit.[33] Nathanson and Becker suggest that black parents' higher levels of involvement may be due to a combination of economic pressures and a strong sense of family obligations. In many lower-income and working-class black communities, much of the responsibility for children born out of wedlock falls to the adolescents' mothers. In turn, mothers of black adolescents at risk of unintended pregnancy may be particularly motivated to become involved in their daughters' reproductive health decisions.[34]

*A large body of research examines the role of parent-child communication about sex and contraception—whether it has occurred, which topics have been discussed and the potential effects of this communication on adolescent sexual behavior—in the context of parent-child connectedness. However, these studies do not distinguish teenagers who use clinic-based reproductive health services from teenagers who see private physicians or do not use any sexual health services; thus, we excluded them from this review.

Potential Impact of Parental Involvement

Advocates of mandatory parental involvement for family planning argue that such requirements would deter many teenagers from having sex.[35] Detractors express concern that teenagers would continue having sex but would reduce their use of the most effective contraceptive methods, which require a prescription, and this would result in more teenage pregnancies.[36] Research suggests that the latter outcome would be more common than the former.

During 1999–2000, the two years after McHenry County, Illinois, began requiring parental involvement for minors seeking contraceptive services, the proportion of births to women younger than 19 increased in the county while it decreased in nearby counties with racially and economically similar populations (and no restrictions on minors' access to contraception).[37] Three studies, spanning 1978–2001, provide insights into the behaviors that likely contributed to the increase in teenage births that occurred after parental consent was mandated. These studies asked female minors using clinic-based reproductive health services what they would do if parental notification were mandated for prescription contraception.[38] All three found that a majority (52–77%) would continue to visit the clinic. Among adolescents who would discontinue use of clinic services, the most common response—given by 15–20% of respondents in the late 1970s[39]and at least one-third in 2001[40]—was that they would use a nonmedical method, such as condoms or withdrawal. (That a higher proportion of contemporary minors would rely on nonmedical methods if they could not access prescription methods may be due to the increased acceptability of and reliance on condoms that have emerged in response to HIV and other STDs.) Small but substantial proportions of teenagers (4–12% in the late 1970s[41] and 14% in 2001[42]) reported that they would have unprotected sex. The least common response, given by fewer than 5% of teenagers in all three surveys, was that they would stop having sex. The findings from McHenry County probably reflect experiences of teenagers who were unwilling to use the clinic and, instead, used no method or switched from prescription contraceptives to withdrawal and condoms.

In studies conducted during the late 1970s, 9–18% of female minors indicated they would continue to use clinic services if notification were required for contraceptive services, although their parents did not yet know they were at the clinic.[43] Presumably, these young women would inform parents on their own or allow the clinic to do so, and mandated parental involvement could result in increased communication with parents about sexuality issues for at least some adolescents.

However, parental knowledge of adolescent contraceptive use does not mean that parents and adolescents discuss broader issues of sexuality and pregnancy prevention. In one study, mothers' awareness of daughters' clinic visits increased over time, but levels of communication remained stable; at baseline and at six- and 15-month follow-ups, 37–39% of teenagers indicated that they usually talked about sex and birth control with their mother.[44] The same study also tested, but found no support for, the hypothesis that parental involvement was associated with consistent contraceptive use over time. Several measures of involvement were examined (e.g., talking with mothers about sex and contraception, changes in the levels of communication with mothers about sex and contraception, parental knowledge of clinic visit and maternal approval of the teenagers' contraceptive use); none was associated with an increased likelihood of teenagers' consistently using an effective contraceptive method.

More recent research suggests that mandated parental notification for prescription contraceptives could negatively affect teenagers' willingness to use other services offered at family planning clinics. Eleven percent of minors indicated that they would not use or would delay accessing HIV or other STD services, and 4% responded that they would forgo pregnancy testing.[45]

That some teenagers would delay or forgo STD testing in the face of mandated parental involvement for prescription contraception may be due to the stigma attached to STDs. Moreover, some teenagers seem unaware that they can access certain sexual health care services without their parents' being informed; alternatively, some teenagers may be skeptical about conditional assurances of confidentiality, particularly in regard to STD services. A small study of high school students found that after participants were read a statement of conditional confidentiality,* a majority believed that physicians nonetheless would inform parents if their child received a diagnosis of an STD (62%) or received treatment for an STD (56%); 13% thought that parents would be informed about services for prescription contraceptives.[46] If mandatory parental notification for contraception were implemented, teenagers might worry that information about STD testing and treatment would also be reported to parents, either purposely or inadvertently, especially in the case of teenagers who access both STD and contraceptive services. Conditions threatening minors' confidentiality for contraceptive services might also deter some teenagers from accessing STD testing and treatment.

Finally, previously demonstrated changes in adolescents' use of services in response to policy changes support the argument that eliminating parental involvement requirements can increase adolescents' access to relevant services. Connecticut's HIV confidentiality law, which previously required parental consent for HIV testing, was amended in October 1992 to affirm minors' right to consent. In the year after this change, visits by minor adolescents to HIV testing sites (mostly STD or family planning clinics) increased by 44% compared with the previous year, and HIV testing of adolescents increased by 104%.[47] Among 18–22-year-olds, in contrast, testing decreased over the same pe-

*The statement of conditional confidentiality indicated that conversations between physicians and minor patients about sex and drugs were confidential and would not be shared with parents or other people. The statement also noted exceptions to confidentiality, including in instances of potential abuse or circumstances in which the teenager might be in danger—for example, if he or she expresses suicidal thoughts.

riod. Because HIV is life-threatening and is associated with stigmatized behaviors, such as homosexual sex and injection drug use, mandated parental consent for HIV services may have deterred more teenagers from seeking services than mandated parental involvement for contraception or testing for other STDs would have.

Parents' Perspectives

Most studies on parental involvement among minors in family planning clinics have gathered data from teenagers; we identified only four studies that relied on data from parents and addressed the issue of minor adolescents' having access to sexual health care services. In their panel study of minors who were first-time clients, Furstenberg and colleagues also gathered information from a subsample of 95 mothers (Table 2).[48] The mothers were contacted 15 months after their daughters first accessed family planning services, but only if their daughters permitted the researchers to do so. Hence, the information is not representative of all participants in that study, and the researchers acknowledge that the sample appears to have been biased toward more communicative mothers. Two-thirds of the mothers indicated that they knew their daughters had attended the clinic, but only half had found out because their daughters had told them directly; the remainder had inferred this from their daughters' behavior or through indirect communication, and most had learned of their daughters' use of clinic services after the first visit. One-third of mothers reported accompanying their daughter to the clinic at least once.

Three other studies examined involvement from the perspective of the parent, although they collected information regarding opinions and attitudes rather than behavior or knowledge, and their samples were not restricted to adults whose teenagers were using reproductive health services. In the absence of other studies, however, these provide some insights into parents' attitudes toward minors' right to access confidential contraceptive and STD services. In one of these studies, two-thirds of parents who registered their middle or high school children for services at a school-based health clinic in Baltimore supported the clinic's adding condom and birth control provision.[49] In the others—involving Minnesota and Wisconsin parents of at least one adolescent child—a majority had positive or neutral opinions of existing laws allowing minors to consent to confidential contraceptive services (66–74%) and STD testing (58–73%).[50] However, 71% of parents in one of the studies were neutral or supported a hypothetical law mandating parental notification for contraceptive services.[51]

These findings demonstrate the complexity of parents' opinions regarding adolescents'—including, presumably, their own children's—right to confidential reproductive health services. Many parents perceive value in having confidential reproductive health services available, but they also know that adult family members can be a source of information and guidance. Consequently, some parents may not be averse to mandated parental involvement, although they support teenagers' access to confidential contraceptive and STD services. These findings also attest to the difficulty in capturing this information through survey research.

Clinic Activities to Encourage Communication

Discussions of parental involvement for minors seeking sexual and reproductive health services—including some in support of minors' right to consent to these services—often fail to acknowledge that many clinics have adopted activities to encourage parent-child communication. Providers recognize that parents and other adult family members play a central role in the lives of most adolescents, and many offer activities to facilitate and improve parents' involvement in adolescents' lives. These activities range from educational programs to various ways of distributing information to counseling.

Formal educational programs are, perhaps, one of the most prominent ways that family planning clinics can encourage parent-child communication about sexual health issues. Limited information on these types of programs was obtained from a nationally representative sample of family planning agencies in 1999. Results indicate that 43% of agencies had one or more educational program to improve parent-child communication.*[52] Some agencies are more likely than others to adopt these programs. Most Planned Parenthood clinics (89%) had such programs, compared with a minority of other types of facilities (39–47%). Title X recipients differed little from nonrecipients (45% vs. 38%).[53]

Many providers adopt other types of activities to encourage parent-child communication. They provide information to clients, their families and the larger community by distributing pamphlets with tips on how to talk to parents or how to talk to teenagers, sponsoring media campaigns that encourage parents to talk to their teenagers about sex, providing communication tips on the clinic or agency Web site, and hosting open houses.[54]

Some clinics address parent-child communication in a more interpersonal manner—for example, by holding special clinic hours or drop-in centers for teenagers to ask questions[55] or, during regular counseling sessions, by asking teenagers whether they talk to a parent about sex and contraception and whether they would like to have such discussions (or more of them).[56] Counseling may be a particularly effective way of encouraging teenagers to talk to their parents because it often occurs on a one-to-one basis, and it provides young clients with the opportunity to ask questions and receive information specific to their family's circumstances. No national data document the extent to which clinics use counseling to address these issues with

Conditions threatening minors' confidentiality for contraceptive services might also deter some teenagers from accessing STD testing and treatment.

*The survey instrument asked about "programs that help parents communicate with their adolescent children," and respondents may have reported only on programs that directly involve parents. The survey did not contain a parallel item asking about programs that help adolescent children communicate with their parents. The prevalence of education programs aimed at both parents and youth may be higher than the estimated 43%.

teenage clients. However, 59% of clinics in a small-scale study in California reported discussing parental communication with every adolescent client during counseling, and an additional 33% reported doing so if the teenager brings up the subject.[57]

Research Shortcomings

The two decades that have elapsed since much of the research on teenagers in family planning clinics was conducted have witnessed many changes. Average age at first intercourse[58] has decreased; contraceptive use has increased, largely because of increased reliance on condoms;[59] new contraceptive methods (including highly effective prescription methods, such as the injectable and the contraceptive patch) have become available; and knowledge, availability and use of emergency contraception have grown.[60] Moreover, viral STDs, such as herpes and human papillomavirus, have become more prevalent,[61] and HIV has become a major health concern. These developments have changed the dynamics of sexual and reproductive health services, and are likely associated with changes in the characteristics and needs of youth who are accessing them. Future research needs to better explore the implications of mandated parental involvement and adolescents' reliance on nonprescription contraceptives. For example, would teenagers in family planning clinics who rely on condoms be more likely than those who use prescription contraceptives to forgo clinic-based services in the face of mandated parental notification? To what extent would mandatory parental involvement motivate pill users to switch to condoms?

We lack current, national information from adolescents about the extent to which a parent is aware of their use of clinic-based sexual and reproductive health services. The most recent study to examine this issue, which was conducted in the mid-1990s, was limited to a single city and included 18- and 19-year-olds.[62] Future research needs to determine what proportion of adolescents younger than 18 would now report their parent's knowing that they are at the clinic; which groups of young women would be most likely to indicate that a parent knows; and how parental knowledge, or lack thereof, would likely affect teenagers' willingness to use clinic-based contraceptive services if parental involvement were mandated.

Largely by default, surveys of teenagers using family planning clinics have excluded males, who constitute 4% of clientele at federally funded family planning clinics.[63] Some clinics that provide STD testing and treatment serve male clients, and some focus on serving this population; plus, an increasing number of providers are incorporating a range of reproductive health services for men, including contraceptive counseling.[64] How parental involvement laws for contraceptives might affect adolescent males' willingness to use clinic services remains to be seen.

Little is known about fathers' roles in adolescents' use of reproductive health services; this is mainly because of two factors. First, even when adolescents live with both parents, mothers are more likely than fathers to discuss sex and contraception with them.[65] Second, a substantial proportion of adolescents spend at least part of their childhood living apart from their father, and some have sporadic or no contact.[66] However, relationships with fathers influence the sexual activity and contraceptive use of some young women and men.[67] Gaining a better understanding of fathers' potential influence on adolescents' sexual and reproductive lives and attitudes, as well as of teenagers' interest in having their fathers' guidance on these issues, could help service providers to increase fathers' involvement.

Research is lacking on the reasons why some adolescents do not tell their parents about their clinic visits, but findings on parental involvement in abortion decision-making may offer some insights. Most minors who undergo abortions involve a parent in or inform a parent of the decision.[68] The most common reasons teenagers cite for not informing parents that they are terminating a pregnancy are the desire to preserve the relationship and to protect parents from stress and conflict. However, many are concerned about violence in the home or worried that they will be kicked out of the home.

Although research on teenagers' reports of parental involvement and responses to laws requiring this involvement is limited, even less is known of their parents' perspectives. Given that many clinics seek to encourage parents to become involved in the lives of their adolescent clients, and considering Title X clinics' mandate to encourage teenagers to talk to their parents, this information is crucial, as it could assist clinics in implementing and improving policies and programs. For example, clinics could benefit from knowing the extent of parents' support for their adolescents' use of sexual health services and their interest in getting information and enhancing communication skills. In addition, research examining the extent to which parents, in general, support teenagers' access to confidential sexual and reproductive health services and the reasons for their opinions would help clinics to understand and address parents' misperceptions and fears.

Many family planning clinics promote parent-child communication. Unfortunately, little is known about the extent to which clinics have adopted specific activities to do so or about which activities are most effective. Policymakers, youth advocates and family planning professionals would benefit from knowing, for example, whether clinic counselors typically encourage teenagers to talk to parents and which strategies are best at helping interested teenagers initiate discussions with parents about sexual health issues. More information is also needed on how family planning clinics can improve their efforts to promote parent-child communication and on the obstacles that keep them from launching programs in the first place.

DISCUSSION

The extent to which parents are involved in an adolescent child's sexual health decisions varies considerably, and there is a continuum of roles that parents, or even a single par-

ent, can occupy. Some parents may be completely removed from issues related to their child's sexual health—perhaps because both the adolescent and the parent opt not to discuss sex and contraception with each other or are uncomfortable dealing with these topics. At the other end of the continuum are parents with a high level of involvement, who provide information and advice about timing of sexual activity and specific contraceptive methods, and who encourage their child to visit a reproductive health care provider or accompany him or her on such visits. Additionally, parents' engagement in and knowledge of issues pertaining to their child's sexual health may vary over time; similarly, a parent may experience different levels of involvement with different offspring, depending on factors such as sibling order, the child's personality or behavior, and family circumstances.

Although many aspects of reproductive health services have changed over the past few decades, available studies from the 1970s to 2001 show that few adolescents would abstain from sex in response to mandated parental involvement. Another consistent finding over the years has been that about one-half of teenagers would be willing to access prescription contraceptives even if their parents were informed. Mandated parental involvement might motivate a small proportion of teenagers to inform parents of their contraceptive use, but whether this type of requirement would, by itself, broaden communication about sex and contraception, positively affect the quality of relationships or increase consistent contraceptive use is unclear. Furthermore, the availability of clinic services apparently does not encourage teenagers to become sexually active: The average young woman waits at least one year after her first sexual intercourse to make her first family planning visit.[69]

Research also suggests that mandated parental involvement for contraception would have some negative effects. Among adolescents who would not be willing to access prescription contraceptives, some would use the least effective methods or, possibly, no method. Clinic staff often encourage teenagers obtaining contraceptive services to undergo STD testing, and mandated parental involvement would mean that fewer teenagers would be provided with this opportunity. Moreover, lack of confidentiality for one type of sexual and reproductive health service may deter or prevent teenagers from seeking others, such as STD testing.

Given the variability of parents' involvement in their children's reproductive health decisions and the range of reactions teenagers would likely have to a parental involvement requirement, existing research suggests that a one-size-fits all approach, such as requiring parental involvement for all female minors who receive prescription contraceptives, would benefit only a small proportion of families and could have substantial negative consequences.

A promising alternative is to support and expand ongoing activities to improve parent-child communication in general and on issues related to sexuality. Several organizations and providers already have such programs, including religious groups, schools and universities, private physicians, parent-teacher organizations, and adolescent and sexual health advocacy groups. However, family planning clinics have a unique advantage for addressing these issues. These facilities generally have a reproductive health focus, trained staff and accurate, up-to-date information. Clinics come into contact with large numbers of adolescents and parents of adolescents, and they see many clients repeatedly. Sexual health visits allow for information exchange and provide clients (and staff members) with opportunities to ask questions. Research is urgently needed on clinics' efforts to promote parent-child communication, as such information would illuminate the actions clinics are taking to address the issue of positive parental engagement and would help clinics to determine whether, how and how much to expand their efforts in this area.

REFERENCES

1. United States Conference of Catholic Bishops, Parental notification needed in Title X program, 2003, <http://www.usccb.org/prolife/issues/abortion/factistook-2.htm>, accessed Sept. 9, 2004.

2. Green TL, Planned Parenthood–funded study says girls "impeded" from use of sexual health services, Concerned Women for America, 2002, <http://www.cwfa.org/articledisplay.asp?id=1556&department=CWA&categoryid=life>, accessed June 21, 2004.

3. American Medical Association, Confidential care for minors, 2002, <http://www.ama-assn.org/ama/pub/category/8355.html>, accessed July 12, 2004.

4. American College of Obstetricians and Gynecologists (ACOG), *Health Care for Adolescents*, Washington, DC: ACOG, 2003.

5. Ford C, English A and Sigman G, Confidential health care for adolescents: position paper for the Society for Adolescent Medicine, *Journal of Adolescent Health*, 2004, 35(2):160–167.

6. Frost JJ, Public or private providers? U.S. women's use of reproductive health services, *Family Planning Perspectives*, 2001, 33(1):4–12.

7. Boonstra H and Nash E, Minors and the right to consent to health care, *Guttmacher Report on Public Policy*, 2000, 3(4):4–8.

8. The Alan Guttmacher Institute (AGI), Minors' access to contraceptive services, *State Policies in Brief*, Sept. 10, 2004, <http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf>, accessed Sept. 10, 2004.

9. AGI, Minors' access to STD services, *State Policies in Brief*, Sept. 1, 2004, <http://www.guttmacher.org/statecenter/spibs/spib_MASS.pdf>, accessed Sept. 10, 2004.

10. AGI, Family planning annual report, 2001, Table 1FP, <http://www.agi-usa.org/pubs/FPAR2001.pdf>, accessed Jan. 7, 2004.

11. Frost JJ, 2001, op. cit. (see reference 6).

12. H.R. 2444, June 12, 2003 (Akin).

13. Zavodny M, Fertility and parental consent for minors to receive contraceptives, *American Journal of Public Health*, 2004, 94(8):1347–1351.

14. Dailard C, New medical records privacy rule: the interface with teen access to confidential care, *Guttmacher Report on Public Policy*, 2003, 6(1):6–7.

15. English A and Ford C, The HIPAA privacy rule and adolescents: legal questions and clinical challenges, *Perspectives on Sexual and Reproductive Health*, 2004, 36(2):80–86.

16. Nathanson CA and Becker MH, Family and peer influence on obtaining a method of contraception, *Journal of Marriage and the Family*, 1986, 48(3):513–25; Torres A, Does your mother know...? *Family Planning Perspectives*, 1978, 10(5):280–282; and Torres A, Forrest JD and Eisman S, Telling parents: clinic policies and adolescents' use of family planning services, *Family Planning Perspectives*, 1980, 12(6):284–292.

17. Furstenberg FF, Jr., et al., Family communication and teenagers' contraceptive use, *Family Planning Perspectives*, 1984, 16(4):163–170.

18. Kenney AM, Forrest JD and Torres A, Storm over Washington: the parental notification proposal, *Family Planning Perspectives*, 1982, 14(4): 185 & 187–190 & 192–197; and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 16).

19. Harper C et al., Adolescent clinic visits for contraception: support from mothers, male partners and friends, *Perspectives on Sexual and Reproductive Health*, 2004, 36(1):20–26.

20. Herceg-Baron R et al., Supporting teenagers' use of contraceptives: a comparison of clinic services, *Family Planning Perspectives*, 1986, 18(2): 61–66; and Nathanson CA and Becker MH, 1986, op. cit. (see reference 16).

21. Harper C et al., 2004, op. cit. (see reference 19); and Nathanson CA and Becker MH, 1986, op. cit. (see reference 16).

22. Zabin LS et al., To whom do inner-city minors talk about their pregnancies? adolescents' communication with parents and parent surrogates, *Family Planning Perspectives*, 1992, 24(4):148–154 & 173.

23. Chamie M et al., Factors affecting adolescents' use of family planning clinics, *Family Planning Perspectives*, 1982, 14(3):126–139; Mosher W and Horn M, First family planning visits by young women, *Family Planning Perspectives*, 1988, 20(1):33–40; and Zabin LS and Clark SD, Jr., Institutional factors affecting teenagers' choice and reasons for delay in attending a family planning clinic, *Family Planning Perspectives*, 1983, 15(1):25–29.

24. Herceg-Baron R et al., 1986, op. cit. (see reference 20); and Nathanson CA and Becker MH, 1986, op. cit. (see reference 16).

25. Torres A, 1978, op. cit. (see reference 16); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 16).

26. Chamie M et al., 1982, op. cit. (see reference 23); Mosher W and Horn M, 1988, op. cit. (see reference 23); and Zabin LS and Clark SD, Jr., 1983, op. cit. (see reference 23).

27. Nathanson CA and Becker MH, 1986, op. cit. (see reference 16).

28. Torres A, 1978, op. cit. (see reference 16); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 16).

29. Chamie M et al., 1982, op. cit. (see reference 23).

30. Zabin LS and Clark SD, Jr., Why they delay: a study of teenage family planning patients, *Family Planning Perspectives*, 1981, 13(5):205–207 & 211–217.

31. Furstenberg FF, Jr., et al., 1984, op. cit. (see reference 17); and Harper C et al., 2004, op. cit. (see reference 19).

32. Furstenberg FF, Jr., et al., 1984, op. cit. (see reference 17); and Harper C et al., 2004, op. cit. (see reference 19).

33. Harper C et al., 2004, op. cit. (see reference 19); Nathanson CA and Becker MH, 1986, op. cit. (see reference 16); Zabin LS and Clark SD, Jr., 1981, op. cit. (see reference 30); and Zabin LS and Clark SD, Jr., 1983, op. cit. (see reference 23).

34. Nathanson CA and Becker MH, 1986, op. cit. (see reference 16).

35. Green TL, 2002, op. cit. (see reference 2).

36. Ford CA and English A, Limiting confidentiality of adolescent health services: what are the risks? *Journal of the American Medical Association*, 2002, 288(6):752–753.

37. Zavodny M, 2004, op. cit. (see reference 13).

38. Reddy D, Fleming R and Swain C, Effect of mandatory parental notification on adolescent girls' use of sexual health care services, *Journal of the American Medical Association*, 2002, 288(6):710–714; Torres A, 1978, op. cit. (see reference 16); and Torres A, Forrest JD and Eisman S, 1980 op. cit. (see reference 16).

39. Torres A, 1978, op. cit. (see reference 16); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 16).

40. Reddy D, Fleming R and Swain C, 2002, op. cit. (see reference 38).

41. Torres A, 1978, op. cit. (see reference 16); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 16).

42. Reddy D, Fleming R and Swain C, 2002, op. cit. (see reference 38).

43. Torres A, 1978, op. cit. (see reference 16); and Torres A, Forrest JD and Eisman S, 1980, op. cit. (see reference 16).

44. Furstenberg FF, Jr., et al., 1984, op. cit. (see reference 17).

45. Reddy D, Fleming R and Swain C, 2002, op. cit. (see reference 38).

46. Ford CA, Thomsen SL and Compton B, Adolescents' interpretations of conditional confidentiality assurances, *Journal of Adolescent Health*, 2001, 29(3):156–159.

47. Meehan TM, Hansen H and Klein WC, The impact of parental consent on the HIV testing of minors, *American Journal of Public Health*, 1997, 87(8):1338–1341.

48. Furstenberg FF, Jr., et al., 1984, op. cit. (see reference 17).

49. Santelli J et al., Bringing parents into school clinics: parent attitudes toward school clinics and contraception, *Journal of Adolescent Health*, 1992, 13(4):269–274.

50. Cutler EM et al., Parental knowledge and attitudes of Minnesota laws concerning adolescent health care, *Pediatrics*, 1999, 103(3):582–587; and Resnick M et al., Parental perspectives on restricting adolescents' reproductive health options: a population-based survey of parents of teens, paper presented at the annual meeting of the Society for Adolescent Medicine, Seattle, Mar. 19–22, 2003.

51. Resnick M et al., 2003, op. cit. (see reference 50).

52. Finer LB et al., U.S. agencies providing publicly funded contraceptive services in 1999, *Perspectives on Sexual and Reproductive Health*, 2002, 34(1):15–24.

53. Unpublished tabulations from 1999 U.S. Family Planning Agency Survey, AGI: New York, 2004.

54. Sugland BW, León J and Hudson R, *Engaging Parents and Families in Adolescent Reproductive Health: A Case Study Review*, Baltimore: Center for Applied Research and Technical Assistance (CARTA), 2003.

55. Innocent MA and Sugland BW, Connecting the dots: how practitioners engage parents, families and youth around reproductive and sexual health, Baltimore: CARTA, 2004.

56. Sugland BW, León J and Hudson R, 2003, op. cit. (see reference 54).

57. Communication Sciences Group, Providing family planning services for adolescents: a report on 32 California clinics, San Francisco: Communication Sciences Group, 2000.

58. AGI, *Sex and America's Teenagers*, New York: AGI, 1994; Child Trends, Trends in sexual activity and contraceptive use among teens, 2000, <http://www.childtrends.org/files/teentrends.pdf>, accessed Sept. 8, 2004; and Singh S and Darroch JE, Trends in sexual activity among adolescent American women, 1982–1995, *Family Planning Perspectives*, 1999, 31(5):212–219.

59. AGI, 1994, op. cit. (see reference 58).

60. The Henry J. Kaiser Family Foundation, Emergency contraceptive pills, fact sheet, 2004, <http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=31598>, accessed July 12, 2004.

61. Centers for Disease Control and Prevention (CDC), *Tracking the Hidden Epidemics: Trends in STDs in the United States*, Washington, DC: CDC, 2000.

62. Harper C et al., 2004, op. cit (see reference 19).

63. AGI, Family planning annual report, 2002, New York: AGI, 2003.

64. Finer LB, Darroch JE and Frost JJ, Services for men at publicly funded family planning agencies, 1998–1999, *Perspective on Sexual and Reproductive Health*, 2003, 35(5):202–207.

65. Miller KS et al., Family communication about sex: what are parents saying and are their adolescents listening? *Family Planning Perspectives*, 1998, 30(5):218–222 & 235; Fisher TD, A comparison of various measures of family sexual communication: psychometric properties, validity and behavioral correlates, *Journal of Sex Research*, 1993, 30(3):229–239; and McNeely C et al., Mothers' influence on the tim-

ing of first sex among 14- and 15-year-olds, *Journal of Adolescent Health*, 2002, 31(3):256–265.

66. Fields J, Living arrangements of children: 1996, *Current Population Reports*, 2001, Series P-74, No. 74.

67. Nathanson CA and Becker MH, 1986, op. cit. (see reference 16); and Rodgers KB, Parenting processes related to sexual risk-taking behaviors of adolescent males and females, *Journal of Marriage and the Family*, 1999, 61(1):99–109.

68. Henshaw SH and Kost K, Parental involvement in minors' abortion decisions, *Family Planning Perspectives*, 1992, 24(5):196–207 & 213.

69. Finer LB and Zabin LS, Does the timing of the first family planning visit still matter? *Family Planning Perspectives*, 1998, 30(1):30–33 & 42.

Acknowledgments

The authors thank Kathleen Cardona, Cynthia Dailard, Jacqueline E. Darroch, Lawrence B. Finer, Elizabeth Nash, Alison Purcell, Susheela Singh and Barbara Sugland for reviewing earlier drafts of this article. Funding for this project was provided by a grant from the Annie E. Casey Foundation.

Author contact: *rjones@guttmacher.org*

CORRECTION

In "A Comparison of Hispanic and White Adolescent Females' Use of Family Planning Services in California," by M. Rosa Solorio et al. [2004, 36(2):157–161], the final panel of Table 2 should be labeled "Ever been pregnant, among those who used family planning services in the last year." The relevant text in the abstract and the Results section should likewise indicate that the denominator for this measure is adolescents who used services in the last year.