No. 112704 (consolidated with No. 112673)

IN THE SUPREME COURT OF ILLINOIS

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H.,	)	**On Appeal from the Appellate Court of Illinois, First Judicial District, No. 1-10-1576 (consolidated with No. 1-10-1463).**
Plaintiffs-Appellees,	)	
v.	)	**There heard on Appeal from Circuit Court of Cook County, County Department, Chancery Division, Circuit Number 09 CH 38661.**
BRENT ADAMS, et al.,	)	
Defendants-Appellants.	)	**The Honorable Daniel A. Riley, Judge Presiding**

BRIEF AND APPENDIX A OF CHICAGO ALLIANCE AGAINST SEXUAL EXPLOITATION, CHICAGO COALITION FOR THE HOMELESS, HEALTHY TEEN NETWORK, ILLINOIS CHAPTER OF NATIONAL ASSOCIATION OF SOCIAL WORKERS, ILLINOIS COALITION AGAINST SEXUAL ASSAULT, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL CENTER FOR YOUTH LAW, SARGENT SHRIVER NATIONAL CENTER ON POVERTY LAW, TEEN LIVING PROGRAMS, UCAN AND THE WOMEN'S CENTER, INC. AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES

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INTERESTS OF *AMICI CURIAE*

The following leading Illinois and national social service organizations submit this brief as *Amici Curiae* to assist the Court in understanding the lives of the young women who experience unintended pregnancies. The *Amici* have extensive knowledge of the strength and resilience exhibited by teens who face social and economic inequalities that are difficult for many to imagine. The Parental Notice of Abortion Act of 1995 (the "Act") (750 ILCS 70/1-99) will *fail* to "further and protect the best interests" of these teenagers, and social science data demonstrates that, in reality, these teenagers will be harmed by the Act. The Act is at odds with the *Amici*'s comprehensive approach to sexual health services and family planning -- one that includes both prevention of unwanted pregnancies and alternatives to abortion -- because it is likely that the Act will adversely affect teenagers' willingness to access sexual health services generally due to concerns over confidentiality. For these reasons and as demonstrated below, there is no justification for the Act or interest that outweighs the real and immediate harms teens will face if the Act is enforced.

The **Chicago Alliance Against Sexual Exploitation** ("CAASE") is a not-for-profit that opposes sexual abuse and exploitation by directly addressing the culture, institutions and individuals that perpetrate, profit from, or support such harms. CAASE engages in prevention and community engagement work and policy reform, and through its legal department—the Sexual Assault Justice Project—CAASE provides direct legal services to survivors of sexual abuse and exploitation. Through its various work, CAASE sees the following: girls under the age of eighteen are frequently victimized by sexual assault; perpetrators of sexual assault against minor girls are often members of, or otherwise close to or trusted by her family; girls who choose not to disclose their

victimization to family members frequently do so out of a reasonable fear that their family members will not respond in a manner that is supportive or helpful. On behalf of its individual clients and in support of its overall mission, CAASE advocates for the rights of victims of sexual assault and exploitation to have meaningful privacy and to be treated with fairness, dignity, and respect. CAASE is interested in seeing that Illinois' various laws further—and do not undermine—victim safety and equality, as well as efforts to hold perpetrators of sexual assault appropriately accountable for their actions.

The **Chicago Coalition for the Homeless** ("CCH") is a not-for-profit organization dedicated to advocating for public policies that curb and can ultimately end homelessness. CCH leads strategic campaigns, community outreaches, and public policy initiatives that target the lack of affordable housing in metropolitan Chicago and across Illinois. In addition, CCH presses for access to jobs, training, and public schools. CCH's community organizers, policy specialists, and public interest attorneys advocate with people affected by homelessness, including mothers with children, unaccompanied minors, ex-offenders, prostitution survivors, and low-wage workers. CCH has advocated for the needs of unaccompanied minors since it organized a Youth Committee in 1983, comprised of 30 youth providers in Chicago, the suburbs and downstate Illinois. The Youth Committee advocates for policies and programs serving unaccompanied minors.

Healthy Teen Network ("HTN") is a national not-for-profit membership organization representing some 5,000 professionals and organizations who work to support youth. For over 30 years, HTN has been devoted to making a difference in the lives of teens and young families by focusing on adolescent health and well-being with an emphasis on teen pregnancy prevention, teen pregnancy, and teen parenting. HTN

provides support to its member professionals and organizations through education, advocacy, and networking so that they can assist teens in accessing services and education that allow teens to make responsible choices about childbearing and family formation, and lead healthy sexual, reproductive, and family lives. HTN believes that in order for teens to be prepared to fully participate in modern life, they need generous opportunities to pursue education and other enrichments—opportunities which are enhanced by delaying and spacing childbearing through access to confidential contraceptive services.

The **Illinois Coalition Against Sexual Assault** ("ICASA") is a not-for-profit organization consisting of thirty-two community-based sexual assault centers throughout the state of Illinois and a central headquarters located in Springfield. Founded in 1977, the purpose of ICASA is to end sexual violence and to alleviate the suffering of its victims. To accomplish these goals, ICASA centers counsel victims, advocate for victims who choose to report the crime to medical and criminal justice personnel, present educational programs to the general public, provide information and referral services and promote public policies affecting sexual assault victims. In 2011 alone, ICASA sexual assault centers provided individual and group counseling, legal and medical advocacy, crisis intervention and hotline response to 18,896 victims of sexual assault and their significant others. Of these clients, 4,258 were under the age of 18. ICASA centers also provided prevention education to 427,034 minors. The ICASA administrative staff in Springfield also conduct trainings, maintain a resource library and advocate on a statewide level for the rights of victims of sexual abuse and sexual assault. ICASA has an interest in insuring that all minors, particularly minors who become pregnant as a

result of sexual assault or who have experienced sexual assault, have access to the reproductive health care they need, including abortion.

Established in 1955, the **National Association of Social Workers** ("NASW") is the largest association of professional social workers in the world with nearly 145,000 members and 56 chapters throughout the United States and internationally. The **NASW, Illinois Chapter** represents 6,372 members. With the purpose of developing and disseminating standards of social work practice while strengthening and unifying the social work profession as a whole, NASW provides continuing education, enforces the *NASW Code of Ethics*, conducts research, publishes books and studies, promulgates professional criteria, and develops policy statements on issues of importance to the social work profession. The NASW policy, *Adolescent Pregnancy and Parenting*, supports a range of services to help address teen pregnancy including "services and supports that are safe, legal, affordable, and confidential; comprehensive health education and services for all adolescents; a comprehensive approach to sexuality education for adolescents..." and "comprehensive family planning services for all adolescents..." SOCIAL WORK SPEAKS 8, 11 (9th ed., 2012), annexed hereto as B-187. NASW's policy statement, *Family Planning and Reproductive Choice*, opposes "limits and restrictions on adolescents' access to confidential reproductive health services, including contraceptive and abortion services, and the imposition of parental notification and consent procedures." SOCIAL WORK SPEAKS 129, 134 (9th ed., 2012), annexed hereto as B-192.

The **National Center for Youth Law** ("NCYL") is a private, non-profit organization devoted to using the law to improve the lives of poor minors nation-wide. For more than 40 years, NCYL has worked to protect the rights of minors in need and to

ensure that they have the resources, support, and opportunities they need for healthy and productive lives. NCYL has participated in litigation that has improved the quality of foster care in numerous states, expanded access to minors' health and mental health care, and reduced reliance on the juvenile justice system to address the needs of minors in trouble with the law. As part of the organization's adolescent health agenda, NCYL works to ensure that all minors in the United States have access to appropriate, quality health care. NCYL conducts trainings on the rights of minors to health and mental health care and the circumstances under which teens are entitled to confidential medical care.

The **Sargent Shriver National Center on Poverty Law** ("Shriver Center") provides leadership on the state and national level to promote justice and improve the lives and opportunities of people with low income. Access to affordable, comprehensive health coverage and health care is vital to the well-being and upward mobility of people with low income. The Shriver Center's Women's Law and Policy Project is particularly interested in justice for women and girls, including teens, with respect to fair and adequate treatment by the health care system -- this includes access to abortions. Teen pregnancy is epidemic, and too many of these pregnancies are the result of teen dating violence, sexual assault, or reproductive coercion. Teen pregnancy and the resulting parenthood has profound impact on the immediate ability of young women and girls to stay in school, succeed academically, and complete their education, and, in turn, their long-term economic well-being — all of which are at stake in the case before the Court.

Teen Living Programs ("TLP"), located in the Bronzeville Community in Chicago, is a not-for-profit organization providing housing, job training, educational support, mental health counseling, holistic health care, and life skills training to homeless

and precariously housed youth. For 36 years, TLP has been committed to providing comprehensive, long-term solutions to youth without homes who strive for self-sufficiency, housing stability and community connection. Each youth TLP serves has experienced trauma and at the same time is grappling with the tumultuous transition between childhood and adulthood. TLP is humbled by the resourcefulness of these youth and inspired by their hope and single-minded determination. TLP partners with youth to build a foundation of skills for independent living, fostering healthy relationships, finding and keeping employment, advancing their education, and creating positive lives.

UCAN is a not-for-profit social service organization serving approximately 12,000 disadvantaged minors and families living throughout the state of Illinois each year. "UCAN" stands for Uhlich Children's Advantage Network. Over the past 142 years, UCAN has evolved with the tremendous challenges facing its clients. UCAN's mission is to build strong youth and families through compassionate healing, education and empowerment. UCAN offers a full continuum of services which allow minors to move from one program to another as their needs change, yet spares them the transitions and gaps caused by moves from one agency to another. These programs include, but are not limited to, a therapeutic youth home, a therapeutic day school, extensive community and violence prevention programs, support for pregnant or parenting teens, counseling, foster care placement, vocational training, and internships for promising former wards of the state.

The Women's Center, Inc. ("TWC") is a not-for-profit organization serving seven southern Illinois Counties with its primary headquarters located in Carbondale. Founded in 1972, the purpose of TWC is to end domestic and sexual violence throughout

INTRODUCTION

In the seventeen years of litigation since the Parental Notice of Abortion Act was originally passed, little focus has been given to the social circumstances and conditions of the individuals affected by the Act. Who are the teenage women faced with unintended pregnancies in Illinois? How will the Act affect the way they address and deal with the extraordinarily difficult situation an unintended pregnancy creates? The *Amici* respectfully submit this research-based brief containing social science data[1] in order to assist the Court in understanding the realities of teenage women who must confront and make the life-altering decisions that result from an unintended pregnancy. Understanding the social circumstances of the teenage women[2] whose lives are affected by the Act is critical in determining whether the Act will serve its intended purpose to "further and protect the best interests of an unemancipated minor." *See* 750 ILCS 70/5

After establishing a baseline of the pregnant teenage population, this brief addresses why the two exceptions to parental notification -- (i) declaration of abuse or

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[1] Given the volume of the sources cited herein, the *Amici* have not provided the Court with copies of all referenced materials. Instead, only the most frequently cited sources have been annexed in Appendix B. All materials contained in Appendix B will be identified by Appendix page numbers cited as "B-__." The *Amici* would be happy to provide the Court with copies of any source cited in the brief upon request.

[2] The majority of teens seeking an abortion already voluntarily tell their parents. *See, e.g.,* Stanley H. Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions* 24 Fam. Plan. Persp. 196 (1992), annexed hereto at B-100 (in a 1991 study based on a nationally representative sample of more than 1,500 unmarried minors having an abortion, 61% of the respondents said that one or both of their parents (usually the mother) knew about the abortio) *and* Aida Torres, Jacqueline Darroch Forrest & Susan Eisman, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning Services*, 12 Fam. Plan. Persp. 284 (1980) (large clinic sample of minors obtaining abortions found that 75% of the minors under 15 had notified a parent).

neglect by the minor and physician certification of receipt of the declaration and (ii) judicial waiver of notice -- fail, as a practical matter, to provide viable alternatives to teens who make the informed decision not to notify a parent. Not only will the Act *fail* to "further and protect the best interests of an unemancipated minor," social science data demonstrates that, in reality, minors will be harmed by the Act. The Act will also adversely affect teenagers' willingness to access sexual health services generally due to concerns over confidentiality. For these reasons, the real and immediate harms teens will face far outweighs that Act's purported interest of protecting Illinois minors.

DISCUSSION

I. ILLINOIS' TEEN POPULATION

Although many teens face challenges in their lives, Illinois' most vulnerable teens -- including those who have been abused or neglected, who are homeless or in the custody of the state, or who are living below the poverty level -- frequently struggle over having even their most basic needs met. This population is significant. In 2010, there were more than 7,000 abused or neglected minors living in Illinois[3] and 57,529 homeless minors living in Illinois.[4] As of May 2012, 15,236 Illinois minors were in the custody of the state: 6,971 were in foster care, 6,371 were in placements with relatives, and the

[3] Child Abuse and Neglect Statistics Fiscal Year 2010, Illinois Department of Children and Family Services (2011), *available at* http://www.state.il.us/DCFS/docs/CANTS2010.pdf.

[4] The National Center on Family Homelessness, America's Youngest Outcasts 2010 38 (2011), *available at* http://www.homelesschildrenamerica.org/media/NCFH_AmericaOutcast2010_web_032812.pdf.

remaining 1,894 were in institutions or group homes.[5] In 2010, more than 600,000 Illinoisans[6] - or 19.4% of Illinoisans - under the age of 18 lived below the federal poverty level.[7] Poverty rates are consistently higher for African-American minors and Latino minors. In 2007-08, poverty rates among Illinois minors were under 10% among whites and Asians, but they were 22% for Latinos and 39% for African-Americans.[8]

This vulnerable sector of Illinois' population often has limited access to preventative health care. In fact, 34% of Illinois residents living below the poverty level are uninsured.[9] In 2009, 8% of minors in Illinois, or 281,300 minors, were uninsured.[10] Non-elderly African-American and Hispanic residents had much higher uninsured rates (23% and 28%, respectively) than white residents (12%).[11] The reality is that many of

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[5] Monthly Department of Children and Family Services Children Placed in Foster Care, Group Homes, or Institutions by Placement County and Zip Code, Illinois Department of Children and Family Services (2012), *available at* http://www.state.il.us/dcfs/library/com_communications_subcounty.shtml.

[6] Social IMPACT Research Center, *2011 Report on Illinois Poverty* (2011), *available at* http://www.heartlandalliance.org/research/annual-poverty-report/pr11_report_final.pdf.

[7] In 2010, the federal poverty level for a family of four was $22,314. *Id.*

[8] Illinois Kids Count 2010, Children and Families in a Time of Economic Crisis 14-15 (2010), *available at* http://www.voices4kids.org/publications-multimedia/kids-count-reports/illinois-kids-count-2010.

[9] The Kaiser Family Foundation, Illinois - Kaiser State Health Facts, *available at* http://www.statehealthfacts.org/profileglance.jsp?rgn=15.

[10] *Id.*

[11] *Id.*

these vulnerable teens do not have access to the same resources that the majority of Illinois youth have grown accustomed to enjoying.

II. CHARACTERISTICS OF PREGNANT TEENAGERS WHO ARE AFFECTED BY THE ACT

Unintended teen pregnancy is most commonly experienced by the most disadvantaged portion of Illinois' population. Certain risk factors increase the likelihood that particular teen groups will experience unintended pregnancies, including residing in dangerous neighborhoods, lower socioeconomic status, living with a single parent, being a minority and being a victim of abuse or neglect.[12] In fact, poor women are more than five times more likely than higher-income women to have an unintended pregnancy.[13] As the number of adverse childhood experiences (such as physical abuse, intimate partner

[12] *See* Brent C. Miller, Brad Benson & Kevin A. Galbraith, *Family Relationships and Adolescent Pregnancy Risk: A Research Synthesis*, 21 Developmental Rev. 1 (2001).

[13] *See* Lawrence B. Finer & Mia R Zolna, *Unintended pregnancy in the United States: incidence and disparities, 2006*, 84 Contraception 478 (2011), annexed hereto at B-62.

violence,[14] sexual abuse,[15] and household substance abuse or mental illness) increases, the likelihood of teenage pregnancy also increases.[16]

In the United States in 2006, 261,040 minor women became pregnant and 78,750 obtained an abortion.[17] The vast majority of teen pregnancies are unintended[18] and over 40% of those unintended pregnancies end in abortion.[19] African-American and non-white teenagers have the highest rate of teen pregnancy (126 and 107 per 1,000 women aged 15–19, respectively).[20] In Illinois in 2006, 11,480 teens aged 17 and younger

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[14] Intimate partner violence refers to violent acts committed by a stepfather or a mother's boyfriend, or violent acts committed against a stepmother.

[15] *See* Jennie G. Noll, Chad E. Shenk & Karen T. Putnam, *Childhood Sexual Abuse and Adolescent Pregnancy: A Meta-analytic Update*, 34 J. Pediatric Psychol. 366 (2008) (studies show that, on average, 4.5 out of 10 pregnant adolescents were subjected to childhood sexual abuse); Abbey B. Berenson et al., *Prevalence of Physical and Sexual Assault in Pregnant Adolescents*, 13 J. Adolescent Health 466, 468 (1992) (study found that 25% of young women presenting to a teen pregnancy clinic had experienced physical or sexual assault, and authors noted that "the prevalence of physical or sexual abuse detected in this study is lower than that reported in other specialized settings").

[16] Susan D. Hillis et al., *The Association Between Adverse Childhood Experiences and Adolescent Pregnancy, Long-Term Psychological Consequences, and Fetal Death*, 113 Pediatrics 320 (2004), annexed hereto at B-114.

[17] *See* Kathryn Kost, Stanley Henshaw & Liz Carlin, *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*, Guttmacher Institute (2010), a*vailable at* http://www.guttmacher.org/pubs/USTPtrends.pdf, annexed hereto at B-124.

[18] *See* Finer & Zolna (2011), B-62 (98% of pregnancies of those under age 15 are unintended and 79% of pregnancies of those between the ages of 15-17 are unintended).

[19] *See id.* (Among adolescents aged 15-17, 41% of unintended pregnancies end in abortion, and among minors under the age of 15, 49% of unintended pregnancies end in abortion.).

[20] *See* Kost, Henshaw & Carlin (2010), B-124.

became pregnant and 3,770 obtained an abortion.[21] As discussed in detail below, the majority of these women are subjected to many of these adverse childhood experiences.

A. Living Conditions of Pregnant Teens and Access to Health Care

Most teens who seek abortions do not live with both parents. In fact, in a nationally-representative sample of minors obtaining abortions, only 38% of the teens surveyed lived with both biological parents; 46% lived with their mothers alone and 5% lived with their fathers alone.[22] The remaining 12% of the sample lived with neither their mother nor their father, potentially complicating parental involvement requirements of notifying a parent or guardian.[23]

Young women in foster care are more than twice as likely to become pregnant by age 19 compared to young women not in foster care,[24] and youth who have aged out of the foster care system are at particular risk for homelessness.[25] Homeless youth are at risk for a variety of negative outcomes compared with the general population, including

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[21] *See id.*

[22] *See* Henshaw & Kost (1992).

[23] *See id.*

[24] *See* Heather D. Boonstra, *Teen Pregnancy Among Young Women in Foster Care: A Primer*, 14 Guttmacher Pol'y Rev. 8 (2011) *and* Amy Dworsky & Mark E. Courtney, *The risk of teenage pregnancy among transitioning foster youth: Implications for extending state care beyond age 18*, 32 Child. & Youth Serv. Rev. 1351 (2010) (1/3 of adolescents in the Midwest Evaluation of the Adult Functioning of Former Foster Children had been pregnant by ages 17 or 18 and half had been pregnant by age 19).

[25] *See* Jennifer P. Edidin et al., *The Mental and Physical Health of Homeless Youth: A Literature Review*, Child Psychiatry Hum. Dev. (Nov. 26, 2011), annexed hereto at B-15.

low academic achievement, exposure to violence and trauma,[26] health and mental health problems, and substance abuse.[27] This is of particular concern in Illinois, which has the highest rate of homelessness among pregnant women in the nation; 7% of Illinois women who give birth report that they have been homeless within the preceding year.[28] In terms of sexual health care, homeless pregnant women are less likely to receive prenatal care or checkups after birth, and their infants are more likely to be born with low birth weight and experience serious health problems.[29]

B. Trajectory of Teenage Parents and Children Born To Teenage Mothers

For those vulnerable teens in Illinois who struggle daily over where their next meal is coming from and whether they will have a place to sleep at night, the development of long-term strategies for breaking the cycle of poverty often take a backseat to the needs of daily survival. Compelling a teen to continue an unintended

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[26] *See* Timothy P. Johnson & Ingrid Graf, *Unaccompanied Homeless Youth in Illinois: 2005*, Survey Research Laboratory, College of Public & Urban Affairs, University of Illinois at Chicago *available at* http://www.srl.uic.edu/Publist/StdyRpts/youthreport.pdf (over 4,000 Illinois youth under the age of 21 were homeless in 2005 ("UHY") and a survey of the experiences of these UHY reports that 3 in 5 have been victims of violence, including physical and sexual assault, in the past year).

[27] *See* Edidin et al. (Nov. 26, 2011), B-15.

[28] *See* Rickelle Richards, Ray M. Merrill & Laurie Baksh, *Health Behaviors and Infant Health Outcomes in Homeless Pregnant Woman in the United States*, 128 Pediatrics 438 (2011), annexed hereto at B-150 (analyses of Pregnancy Risk Assessment Monitoring System data from 31 participating states from 2000 to 2007 shows homelessness disproportionately affects African-American and Hispanic women, and these women are more likely to experience low educational attainment, reliance on government assistance, lack of health insurance, and health problems such as underweight or obesity).

[29] *See* Richards, Merrill & Baksh (2011), B-150.

pregnancy will do very little to increase the likelihood that she will ever escape her socioeconomic circumstances and can affect the trajectory of her entire life.[30]

Research shows that teens who do not involve a parent in their decision to terminate a pregnancy have a range of valid reasons for not doing so, including fear that a parent would force the teen to continue the pregnancy against her will, fear of being evicted from the home, fear of abuse, fear of punishment or desire to avoid undue stress to the family.[31] A study of minors who decided not to notify a parent of their abortion reveals a variety of reasons they identified for selecting abortion over childbirth.[32] Specific reasons for their decisions included concern for future life plans such as educational goals, present life and financial circumstances, feeling unprepared for motherhood, and concern for the child's wellbeing.[33] The minors' cited reasons for concern are well-founded.[34] On average, teenage mothers complete fewer years of

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[30] *See* Suellyn Scarnecchia & Julie Kunce Field, *Judging Girls: Decision Making in Parental Consent to Abortion Cases*, 3 Mich. J. Gender & L. 75 (1995).

[31] *See* Henshaw & Kost (1992), B-100 (In a large sample study, 25% of the minors sampled who did not tell their mother and 12% of those who did not tell a father reported concern that the parent was already under too much stress; 18% feared being evicted from the home; 15% feared other punishment; 8% feared being beaten as a result of telling a parent. 14% of the minors who did not tell a mother and 8% of those who did not tell a father feared the parent would force them to continue the pregnancy against their will).

[32] *See* Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision Without Involving Their Parents*, 18 Berkeley Women's L.J. 61 (2003).

[33] *See id.*

[34] *See* Susan D. Hillis et al. (2004), B-114 (women who experienced several adverse childhood experiences and who had children as teenagers were likely to report current problems with their family, job, and finances, as well as, high stress and an inability to

school and are less likely to receive a high school diploma[35] or to go on to college or graduate studies than women who postpone child bearing.[36] As a result, women who have children as teenagers receive higher levels of government assistance than other women throughout their lives.[37] Out-of-wedlock teenage birth and failure to graduate high school are the two biggest indicators of whether a woman and her children will live in poverty.[38]

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control anger later in life) *and* Laurie Schwabb Zabin, Marilyn B. Hirsch & Mark R. Emerson, *When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy*, 21 Fam. Plan. Persp. 28 (1989), annexed hereto at B-178 (urban teens that choose abortion over childbearing experience no negative educational, economic, or psychological effects at two years).

[35] *See* Zabin, Hirsch, & Emerson (1989), B-178 (teens who give birth are significantly less likely to graduate high school or stay on grade-level during this period).

[36] *See* Rebecca A. Maynard, ed., Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy 145-80 (Urban Institute Press, 1st ed. 1997) (Only 61% of teen mothers obtain a high school diploma or GED by the time they are 30. At age 30, women who had children as teenagers earn an average of $18,544 compared with $32,935 earned by women who delayed childbearing, representing a 58% disparity).

[37] *See* Illinois Kids Count 2010, *supra* note 8, at 54 (In 2008, median earnings for women college graduates in Illinois were 80% higher than those with just a high school diploma, and lack of a high school diploma was associated with 32% lower earnings among women.). *See also* Scarnecchia & Field (1995); Zabin, Hirsch & Emerson (1989), B-178; David M. Fergusson, Joseph M. Boden & L. John Horwood, *Abortion Among Young Women And Subsequent Life Outcomes*, 39 Persp. on Sexual & Reprod. Health 6 (2007).

[38] *See* Sandra L. Hofferth, Lori Reid & Frank L. Mott, *The Effects of Early Childbearing On Schooling over Time*, 33 Fam. Plan. Persp. 259 (2001) (women with teen births complete 1.9-2.2 fewer years of schooling than a women with no birth by age 30); *id.* (29% of teenage mothers will attend college, compared to 70% of those who delay childbearing until their late 20s); Saul D. Hoffman, E. Michael Foster & Frank F. Furstenberg Jr., *Reevaluating the Costs of Teenage Childbearing*, 30 Demography 1, 6 (1993) (teen birth lowers a woman's income-needs ration by 30%, nearly doubles the chance that she is poor, and halves the probability that she is middle class); *id.* (only 54%

Research demonstrates that the cycle of poverty continues to the children of teen mothers. The reality is that many of the children born to young teens face life experiences that will make rising out of poverty difficult. Children of teens are less likely to graduate from high school than children of adults,[39] and daughters of teen mothers are more likely themselves to be teen mothers.[40]

III. THE ACT DOES NOT ACCOUNT FOR THE REALITIES OF PREGNANT TEENS

A. The Act's Abuse Exception is Unworkable and Ignores all Available Research Regarding Victims of Abuse

One of the most terrifying realities of sexual abuse of minors is it is most often shrouded in secrecy. From the outset of abuse, studies[41] show that the only consistent and meaningful impression gained by the minor is one of danger and fear based on the perpetrator's threats which are premised on secrecy: "This is our secret; nobody will understand." "Don't tell anybody." "Don't tell your mother; (a) she will hate you, (b) she will hate me; (c) she will kill you, (d) she will kill me, (e) it will kill her, (f) she will send you away, (g) she will send me away, (h) it will break up the family." "If you tell anyone (a) I won't love you anymore, (b) I'll hurt you, (c) I'll kill someone you love, or

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of sampled teenage mothers were high school graduates, author estimates that, controlling for observed family background, figure would rise by more than 30 percentage points if these women delayed childbearing until at least age 20).

[39] *See* Maynard, *supra* note 36, at 55-94.

[40] *See* Constance Dallas, Tony Wilson & Vanessa Salgado, *Gender Differences in Teen Parents' Perceptions of Parental Responsibilities*, 17 Pub. Health Nursing 423 (2000) (parenting teens in a low-income Chicago area tended to report having little or no involvement with their own biological fathers).

[41] *See* Roland C. Summit, *Child Sexual Abuse Accommodation Syndrome*, 7 Child Abuse & Neglect 177 (1983), annexed hereto as B-161.

(d) I'll kill you."[42] Such threats make it unlikely that a minor will disclose the abuse to anyone.[43]

A minor's fears are compounded when the perpetrator of abuse occupies a role of trust or authority, because a minor is helpless and subordinate to the adult within authoritarian relationships. If the minor does not seek immediate protective intervention, the minor must learn to accept the situation and learn to survive. In these cases, there is no way out, no place to run. Disclosure of sexual abuse is also unlikely due to feelings of responsibility and shame[44] and factors related to post-traumatic stress disorder.[45] The abuse exception contained in the Act[46] ignores these realities and is wholly inadequate to protect abused minors. In fact, forcing a minor to disclose such abuse (even to a healthcare provider) could result in harming some minors who it is intended to protect.

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[42] *See id.*

[43] *See* Maria Sauzier, Disclosure of Child Sexual Abuse. For Better or For Worse, 12 Psychiatric Clinics N. Am. 455 (1989).

[44] David Finkelhor et al., *Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors*, 14 Child Abuse & Neglect 19 (1990); Sharon Lamb, *Treating sexually abused children: Issues of blame and responsibility*, 56 Am. J. Orthopsyciatry 303 (1986).

[45] *See* Catherine Koverola & David Foy, *Post-traumatic stress disorder symptomatology in sexually abused children: Implications for legal proceedings*; 2 J. Child Sexual Abuse 119 (1993).

[46] The Act does not require parental notice if "the minor declares in writing that she is a victim of sexual abuse, neglect or physical abuse by an adult family member as defined in the Act." 750 ILCS 70/20(4). Once a minor declares in writing that she is a victim of abuse or neglect, the attending physician must certify receipt of the declaration in the patient's medical record, and the physician must report the abuse of neglect, *see* 325 ILCS 5 (Abused and Neglected Child Reporting Act), after the minor receives an abortion.

Most crimes in which minors are the victims are not reported to authorities (including their healthcare providers), and most minors do not access victim services.[47] The numbers are even lower for sexual assault crimes involving minors. A review[48] of police reporting of crimes involving minors indicates that only 28% of crimes victimizing minors are reported,[49] and less than 15% of sexual and 35% of physical assault crimes against minors are reported.[50] Moreover, 54% of minors whose sexual abuse involves intercourse do not tell anyone about the abuse, making this one of the less likely forms of abuse to be disclosed.[51]

The prevailing reality for many minor victims of sexual abuse is a relentlessly progressive intrusion of sexual acts by an overpowering adult in a one-sided victim-perpetrator relationship. The fact that the perpetrator is often in a trusted and apparently loving position only increases the imbalance of power and underscores the helplessness

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[47] *See* Kamala London et al., *Disclosure of child sexual abuse: What Does the Research Tell Us About the Ways That Children Tell?*, 11 Psychol. Pub. Pol'y & L. 194 (2005) (studies indicate that only 1/3 of adults who experienced child sexual abuse disclosed the abuse to anyone during childhood).

[48] *See* David Finkelhor, Janis Wolak & Lucy Berliner, *Police Reporting and Professional Help Seeking for Child Crime Victims: A Review*, 6 Child Maltreatment 17 (2001), annexed hereto as B-85.

[49] *See* David Finkelhor & Richard Ormand, *Reporting Crimes Against Juveniles*, Juvenile Justice Bulletin (Office of Juvenile Justice and Delinquency Prevention, U.S. Dep't of Justice), November 1999.

[50] *See* Dean G. Kilpatrick & Benjamin E. Saunders, Prevalence and Consequences of Child Victimization: Results from the National Survey of Adolescents (Office of Justice Programs, U.S. Dep't of Justice 1997).

[51] *See* Mary L. Paine & David J. Hansen, *Factors influencing children to self-disclosure sexual abuse*, 22 Clinical Psychol. Rev. 271 (2002) (citations omitted).

of the minor, making it unlikely that the minor will disclose the abuse.[52] Studies show that the individual perpetrating the abuse is often a parent or parent-figure,[53] and the perpetrator is frequently in a position of power and authority over the minor and/or charged with providing for the minor's care.[54] It is not surprising that rates of reporting are the lowest for sexual assault and crimes perpetrated by a family member.[55] In fact, clinicians have observed that minors who are sexually abused by a close family member are particularly hesitant to disclose their abuse.[56] In one study[57] of 286 adult women describing their disclosures of incest, 64% never disclosed their abuse until adulthood.

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[52] *See* Catalina M. Arata, *To tell or not to tell: Current functioning of child sexual abuse survivors who disclosed their victimization*; 3 Child Maltreatment 63 (1998).

[53] *See* Lucy Berliner & John R. Conte, *The effects of disclosure and intervention on sexually abused children*, 19 Child Abuse & Neglect 19, 371–384 (1995), annexed hereto as B-1; Kathleen Coulborn Faller, *Characteristics of a clinical sample of sexually abused children: how boy and girl victims differ*, 13 Child Abuse & Neglect 281 (1989) (89.1% of female victims were categorized as intrafamilial sexual abuse, i.e., blood relationship between the victim and offender or a relationship by marriage between the offender and the victim's family or the offender lived within the household).

[54] *See* Berliner & Conte (1995), B-1; Michel Elliott, Kevin Browne & Jennifer Kilcoyne, *Child sexual abuse prevention: what offenders tell us*, 19 Child Abuse & Neglect 579 (1995).

[55] *See* Finkelhor, Wolak & Berliner (2001), B-85.

[56] *See* Margaret Rieser, *Recantation in child sexual abuse cases*, 70 Child Welfare 612 (1991); Summit (1983), B-161; Tina B. Goodman-Brown et al., *Why children tell: a model of children's disclosure of sexual abuse*, 27 Child Abuse & Neglect 525 (2003) (older children who have been abused by a family member and who felt responsible for the abuse and feared negative consequences of disclosure, had the longest delays in reporting their sexual abuse).

[57] *See* Thomas A. Roesler & Tiffany Weissmann, *Telling the Secret: Adult Women Describe Their Disclosures of Incest*; 9 J. Interpersonal Violence 327, 333 (1994) (Their reasons for not disclosing included fear for their own safety (33%), shame and self-blame

This well-documented research demonstrates that it is unreasonable to expect that minor victims of abuse will disclose such abuse to healthcare providers in order to obtain an abortion. And while it is without debate that increased reporting of such crimes is universally desired, there is no evidence to indicate disclosure of abuse to a healthcare provider to obtain an abortion will encourage the reporting of abuse. In fact, given that minors do not report ongoing abuse even when reporting would likely stop such abuse, it is highly unlikely that a minor's desire to obtain an abortion will outweigh her fear of revealing her secret.

The abuse exception also fails to account for minors who may not have suffered any prior abuse, but have good reason to believe that if they disclose their pregnancy they will become the victim of abuse. *See, e.g.*, Affidavit of Ann Baker, M.A., in Support of Plaintiffs' Motion for Injunctive Relief, C00171,[58] ¶ 19 (although teen had not been abused by her father, she feared abuse if forced to disclose because of her father's reaction to older sister's teen pregnancy, i.e., father beat older sister and kicked her out of home upon learning of pregnancy and plans for abortion); Affidavit of Robin Stein, L.C.S.W., in Support of Plaintiffs' Motion for Injunctive Relief, C00233-34, ¶¶ 9,10. As recounted by minors who have already witnessed the abuse firsthand, fear of future abuse is a legitimate concern for these teens.

(33%), anticipated futility (19%), feared impact on their family (14%), and feelings of loyalty to the offender (4%).).

[58] Citations to the six volume, common law record appear as "C_."

B. The Act's Judicial Bypass Imposes Insurmountable Barriers to Access for Minors

While the Act's judicial bypass procedure may provide an alternative to parental notification for teenagers who have the resources and wherewithal to navigate the Court system,[59] it will impose enormous burdens on many others. Teens without healthy relationships with their parents or other authority figures or adequate emotional or financial resources, or even those that have little or no exposure to the judicial system will likely be intimidated to avail themselves to this option. At the same time, a pregnant minor in Illinois who is informed[60] of the judicial bypass procedure will encounter a series of formidable obstacles before even appearing in any courtroom before a judge. Any one of these obstacles could prevent her from using the judicial bypass and from obtaining an abortion. The reality is that the Act's judicial bypass exception provides little meaningful relief for many of the teens who seek an abortion.

Because minors' attitudes toward the legal system are shaped by their own experiences with the law and by the experiences with the law of those around them,[61]

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[59] *See* Robert Wm. Blum, Michael D. Resnick & Trisha Stark, *Factors Associated with the Use of Court Bypass by Minors to Obtain Abortions*, 22 Fam. Plan. Persp. 158 (1990), *available at* http://www.jstor.org/stable/2135606 (study of minors obtaining abortions in Minnesota found that 85% of minors in the sample using the judicial bypass were 16 or older); Patricia Donovan, *Judging Teenagers: How Minors Fare When They Seek Court-Authorized Abortions*, 22 Fam. Plan. Persp. 158 (1990), (overwhelming majority of adolescents going before a judge to petition for an abortion in three states with parental notification laws were white and middle-class).

[60] The Act does not require physicians to notify minors of their right to seek a judicial bypass of the notice requirement.

[61] *See* Jeffrey Fagan & Tom R. Tyler, *Legal Socialization of Children and Adolescents*, 18 Soc. Just. Res. 3 (2005), annexed hereto as B-36.

many of Illinois' most vulnerable teens do not view the court system as an ally, and will not likely turn to the court system for assistance in obtaining an abortion. One study showed that when minors perceive their interactions with courts and police as poor, they develop weak ties toward the law and low confidence in its fairness.[62] Given that there is significant overlap between the population of minors more likely to experience unintended teen pregnancies and the population that has higher levels of distrust of the court system and authority,[63] *see supra* Part II, many pregnant teens will likely have a negative attitude or fear of the court system. For these Illinois teenagers, the prospect of turning to court, where they have to discuss the most intimate aspects of their lives - sex, pregnancy, their thoughts and feelings about having a child, and their relationship with their parents - is particularly daunting. Early research of Illinois teens' responses to the Act's judicial bypass procedure supports these perceptions. In a study conducted by the Section on Family Planning and Contraceptive Research at the University of Chicago, consisting of interviews with pregnant minors seeking abortions in Chicago regarding their understanding of the proposed judicial bypass procedure, suggests that minors consider the judicial bypass "confusing, logistically difficult to manage, humiliating, and stressful."[64] Moreover, the teens considered the requirement of the judicial bypass procedure to be overwhelming and difficult for them to access.[65]

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[62] *See id.*

[63] *See* Robert J. Sampson & Dawn Jeglum Bartusch, *Legal Cynicism and (Subcultural?) Tolerance of Deviance: The Neighborhood Context of Racial Differences*, 32 L. & Soc'y Rev. 777 (1998).

[64] *See* Research Brief, Requiring Parental Notice of Abortion in Illinois: The Perspective of Pregnant Teens, University of Chicago Section of Family Planning & Contraceptive

Significant barriers exist to accessing the courts for poor and vulnerable *adult* residents of Illinois. Indeed, poor and vulnerable *minors* residing in Illinois face even greater barriers in accessing the Illinois courts. This reality was recently acknowledged by this Court through the newly promulgated Illinois Supreme Court Rule 10-100 which established the Illinois Supreme Court Commission on Access to Justice (the "Commission"). Ill. Sup. Ct. R. 10-100 (eff. June 13, 2012). The Commission is charged with various duties including "creating standardized forms for simpler legal problems and basic procedural functions" and "addressing language problems in the courtroom." *Id.* at (c)(4-5).[66] It is these identified barriers that create just a few of the obstacles a minor will face when she attempts to exercise her rights under the Act, but for many minors there are many hurdles that must be addressed before they even reach the courtroom door.

Filing the petition means that the minor would need to physically appear at a courthouse. This requirement is especially burdensome for those minors living outside of metropolitan areas, especially those without a driver's license or with little or no access to public transportation. *See* Ill. Sup. Ct. R. 10-100(c)(6) (eff. June 13, 2012) (Commission is charged with duty of "addressing the issue of accessibility to the courts, particularly in rural areas of Illinois"). According to a January 2006 Report to the Governor and General Assembly of Illinois by the Illinois Interagency Coordinating Committee on Transportation, in rural areas of the state, 27 counties do not have any

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Research (2011), *available at* http://familyplanning.uchicago.edu/policy/publications-resources/Teen%20Perspective%20on%20%20Parental%20Notice%20Law.pdf.

[65] *See id.*

[66] Given the Commission's infancy, it has not yet been able to fulfill these duties.

access to public transportation and another 12 counties have limited access as service is provided only in the major town or city where a public transportation grant reside.[67]

Given a court's hours of operation,[68] a minor enrolled in school will likely have to miss class in order to get to court to file her petition. In addition, a minor will have to leave school once again in order to attend her hearing. These absences threaten a minor's confidentiality because most Illinois school districts alert parents to a student's absence from school. *See e.g.,* 105 ILCS 5/26-13; 23 Ill. Admin. Code 1.290(c); *see also* *Planned Parenthood of Central N.J. v. Farmer*, 762 A.2d 620, 636 (N.J. 2000) ("[A minor] may well have to be absent from school and risk her parents finding out that she has been truant in order to attend a judicial proceeding."). For some minors, this risk of disclosure will foreclose the judicial bypass procedure as an option.

IV. The Act Will Impose Significant Unanticipated Harm to Minors by Placing Additional Barriers to Minor's Access to Sexual Health Services

Enforcement of the Act will impose an additional harmful barrier which will discourage teenagers from accessing sexual health services due to confidentiality concerns. More than 40% of minors in the United States have had sex by age 18[69] and, as

[67] Pub. Act 93-0185 (eff. Jul. 11, 2003) Report of Intreragency Coordinating Comm. on Transp. at 11 (2006) *available at* http://www.iira.org/outreach/pdf/ICCT%20Report%201%2030%2006.pdf.

[68] *See* Donovan (1983) (Few courts are open to hear abortion petitions at times when minors would be able to easily access them (evenings or weekends), thus, despite being entitled to an expeditious court process, minors have been reported to have to wait as long as seven days for their petitions to come before a judge).

[69] *See* Gladys Martinez, Casey E. Copen & Joyce C. Abma, *Teenagers in the United States: Sexual Activity, contraceptive use, and childbearing, 2006-2010 National Survey of Family Growth,* National Center for Health Statistics, 23 Vital and Health Statistics (2011).

discussed in Section I above, in 2006, there were 261,040 pregnancies among women under the age of 18, most unintended. In addition, even though 15 to 24-year-olds account for only ¼ of the sexually active population, they account for nearly half of all new sexually transmitted diseases, including HIV, diagnosed annually in the United States.[70] These facts and related research findings support laws allowing minor consent for reproductive health services.

Studies have shown that the ability to seek confidential care is important to young people.[71] Confidentiality protections can improve the chances that teens will receive needed care, while privacy concerns can serve as a barrier to access and teens may forego needed health care due to concerns about privacy and confidentiality.[72] Delays and foregone care associated with the loss of confidentiality may also result in higher rates of teen pregnancies and sexually transmitted diseases, along with associated economic costs.[73] For these reasons, numerous leading professional medical organizations,

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[70] *See* Sexually Transmitted Disease Surveillance 2010, U.S. Department of Health & Human Services, Centers for Disease Control and Prevention at 63 (2011), *available at* http://www.cdc.gov/std/stats10/default.htm; Hillard Weinstock, Stuart Berman & Willard Cates, Jr., *Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000*, 36 Persp. on Sexual & Reprod. Health 6 (2004).

[71] *See* Appendix A for a list of sources that have studied and commented on these confidentiality concerns.

[72] *See id.*

[73] *See* Luisa Franzini et al., *Projected Economic Costs Due to Health Consequences of Teenagers' Loss of Confidentiality in Obtaining Reproductive Health Care Services in Texas*, 158 Archives Pediatrics & Adolescent Med. 1140 (2004) (study of the projected number of additional pregnancies, births, abortions, and untreated sexually transmitted infections and resulting pelvic inflammatory disease and associated potential costs resulting from parental consent and law enforcement reporting requirements in Texas were estimated at 43.6 million dollars (range, 11.8 million dollars to 56.6 million dollars) for girls younger than 18 years currently using publicly funded services).

including the American Medical Association, the American College of Obstetricians and Gynecologists, and the Society of Adolescent Health and Medicine support confidential reproductive healthcare for minors.[74]

In Illinois, the legislature has recognized the importance of minors' access to sexual health care services through the passage of laws such as the Consent by Minors Medical Procedures Act, 410 ILCS 210, and the Birth Control Services to Minors Act, 325 ILCS 10. *See* 410 ILCS 210/4 (allows a minor 12 years of age or older to "consent to the furnishing of medical care or counseling related to the diagnosis or treatment of [a sexually transmitted disease]."); 325 ILCS 10 (allows doctors to provide birth control services and information to any minor "as to whom the failure to provide such services would create a serious health hazard"). Notwithstanding the foregoing, a recent survey of African-American teens between the ages of 14-17 currently attending one of three Chicago charter schools located on the south side of Chicago concluded that youth need *more* information about their ability to access reproductive healthcare services.[75]

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[74] *See* Center for Adolescent Health & the Law, Policy Compendium on Confidential Health Services for Adolescents 33 (Madlyn C. Morreale et al. eds., 2d ed. 2005); American Public Health Association, Resolution 9001: Adolescent Access to Comprehensive, Confidential Reproductive Health Care, 81 Am. J. Pub. Health 241 (1991); Carol Ford, Abigail English & Garry Sigman, *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 J. Adolescent Health 160 (2004); Council on Scientific Affairs, American Medical Association, *Confidential Health Services for Adolescents*, 269 J. Am. Med. Ass'n 1420 (1993); American Medical Association Code of Medical Ethics, Opinion 5.055 - Confidential Care for Minors (1994).

[75] *See* Policy Brief, *Youth Awareness of a Minor's Right to Access Reproductive Health Services Independently*, University of Chicago Section of Family Planning & Contraceptive Research (2011) (40% of the respondents did not correctly identify that minors could obtain contraception services without involving a parent).

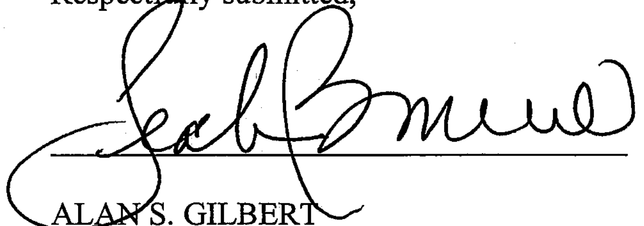
Contrary to these findings, the Act creates further unnecessary obstacles for minors who need essential, life-altering health care services. Given the challenges faced by the effected minors, a comprehensive approach to sexual healthcare services and family planning must be the ultimate goal -- one that allows for complete access to all options, both prevention of unintended pregnancies and alternatives to abortion. These interests outweigh any of the cited justifications for enforcement of the Act.

CONCLUSION

For the forégoing reasons, *Amici* respectfully urge this Court to affirm the decision of the Appellate Court.

July 18, 2012

Respectfully submitted,



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Appendix A

Scott J. Spear & Abigail English, *Protecting confidentiality to safeguard adolescents' health: finding common ground*, 76 Contraception 73, 75 (2007) ("Looking back over the past half century and reviewing the research findings about the effect of limiting confidentiality on health-seeking behaviors and health outcomes for adolescents, together with the policies and ethical guidelines of health care professionals and the long-standing legal framework for confidentiality, we can see that there is a remarkable consensus about the important role of confidentiality protections in safeguarding the health of adolescents.").

Abigail English, *Sexual and Reproductive Health Care for Adolescents: Legal Rights and Policy Challenges*, 18 Adolescent Med. 571 (2007).

Rachel K. Jones et al., *Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception*, 293 J. Am. Med. Ass'n 340 (2005) (national study of minors seeking reproductive health services at family planning clinics reports that if legislation passed mandating parental notification for contraception 46% of minors would switch to using condoms, one in five teens would use no contraception and rely on withdrawal method and 7% reported they would stop having sex).

Jonathan D. Klein et al., *Access to Medical Care for Adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls*, 25 J. Adolescent Health 120 (1999) (national study examined the factors associated with access to health care among in-school minors in 5th through 12th grade found that nearly a third of the 6748 minors surveyed had missed needed care and the most common reason for missing care was not wanting a parent to know (35%)).

Diane M. Reddy, Raymond Fleming & Carolyne Swain, *Effect of Mandatory parental notification on adolescent girls' use of sexual health care services*, 288 J. Am. Med. Ass'n 710 (2002) (59% of female minors reported that they would delay or discontinue reproductive health services such as contraceptive visits or STD testing or treatment if parents were notified of contraceptive decisions).

Laurie S. Zabin, Heather A. Stark & Mark R. Emerson, *Reasons for Delay in Contraceptive Clinic Utilization: Adolescent Clinic and Non-Clinic Populations Compared*, 12 J. Adol. Health Care 225 (1991) (in a school-based sample, students reported that confidentiality concerns were important in their decision about whether to attend a family planning clinic, particularly among those who had never attended).

Andrea Marks et al., *Assessment of health needs and willingness to utilize health care resources of adolescents in a suburban population*, 102 *The Journal of Pediatrics* 456 (1983) (study of 649 students in grades 9 through 12 living in a middle-class suburb

reports that a majority of students would not choose to go to a private physician for care related to sexuality, substance abuse, or emotional upset, and would not be willing to seek care for these problems with their parents' knowledge).

Tina L. Cheng et al., *Confidentiality in Health Care*, 269 J. Am. Med. Ass'n 1404 (1993) (study of 1295 rural, suburban, and urban high school students in central Massachusetts reported that 58% had health concerns that they wished to keep private from their parents; 25% reported that they would forgo health care in some situations if their parents might find out).

Carol A. Ford et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care*, 278 J. Am. Med. Ass'n 1029 (1997) (study of 562 California suburban high school students who listened to a standardized audiotape depiction of an office visit during which they heard a physician who assured unconditional confidentiality, a physician who assured conditional confidentiality, or a physician who did not mention confidentiality reports assurances of confidentiality increased the number of teens willing to disclose sensitive information about sexuality, substance use, and mental health from 39% (68/175) to 46.5% (178/383) (beta=.10, P=.02) and increased the number willing to seek future health care from 53% (93/175) to 67% (259/386) (beta=.17, P<.001). When comparing the unconditional with the conditional groups, assurances of unconditional confidentiality increased the number of teens willing to return for a future visit by 10 percentage points, from 62% (122/196) to 72% (137/190) (beta=.14, P=.001)).

Jocelyn A. Lehrer et al., *Forgone Health Care among U.S. Adolescents: Associations between Risk Characteristics and Confidentiality Concern*, 40 J. Adolescent Health 218 (2007) (population of U.S. minors who forgo health care due to confidentiality concern is particularly vulnerable and in need of health care services; minors who report health risk behaviors, psychological distress and/or unsatisfactory communication with parents have an increased likelihood of citing confidentiality concern as a reason for forgone health care, as compared with minors who do not report these factors).

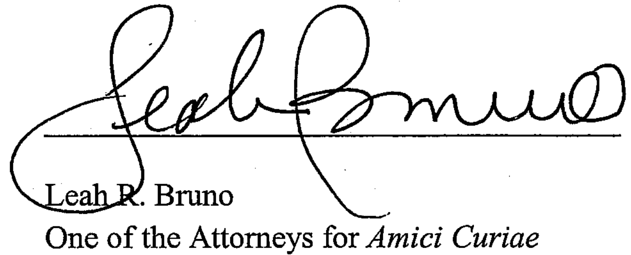
Appendix B

Frequently Cited Sources

CERTIFICATE OF COMPLIANCE

I, Leah R. Bruno, certify that this brief conforms to the requirements of Rules 341(a) and (b). The length of this brief, excluding the pages containing the Rule 341(d) cover, the Rule 341(h)(1) statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342(a), is 28 pages.

July 18, 2012



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One of the Attorneys for *Amici Curiae*

CERTIFICATE OF SERVICE

I, Leah R. Bruno, certify that on July 18, 2012, I caused true and correct copies of the foregoing Brief of Chicago Alliance Against Sexual Exploitation, Chicago Coalition for the Homeless, Healthy Teen Network, Illinois Chapter of National Association of Social Workers, Illinois Coalition Against Sexual Assault, National Association of Social Workers, National Center for Youth Law, Sargent Shriver National Center on Poverty Law, Teen Living Programs, UCAN and The Women's Center, Inc. as *Amici Curiae* in Support of Plaintiffs-Appellees to be filed and served as follows:

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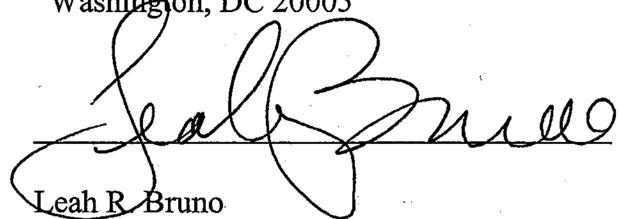

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