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Bearing Injustice:

Foster Care, Pregnancy Prevention, and the Law

Taylor I. Dudley†

ABSTRACT

The state has numerous responsibilities to children and youth in, and emancipating from, foster care. Ensuring a foster child's medical welfare is among the most imperative of the state's obligations. Pregnancy prevention is a unique component of medical welfare and long-term well-being. Indeed, it stands out as a responsibility that the State must fulfill to counteract the likelihood of diminished life outcomes that so many former foster children face. However, like many problems facing foster children, pregnancy is noticed, yet unaddressed; contemplated, yet unresolved.

The state's failure to adequately address pregnancy prevention among youth in foster care is unconstitutional under the due process clause of the Fourteenth Amendment to the United States Constitution and demonstrates a significant need for reform. States must proactively address pregnancy prevention among foster children and provide age-appropriate medical care to all youth in foster care. State efforts at preventing pregnancy should be measured by the federal Child and Family Services Review, so as to ensure that states make appropriate prevention efforts and reduce the number of pregnancies among current and former foster children.

† This Paper was written while Taylor Dudley served as the Robin Nash Post-Graduate Fellow in Law at the Barton Child Law and Policy Center at Emory University School of Law. Dudley is currently an attorney at the Alliance for Children's Rights in Los Angeles. To the community of child welfare professionals in Georgia, thank you for your warm welcome and devotion to children. To Michelle and Andy Barclay, Melissa D. Carter, and Barbara Bennett Woodhouse, my admiration and gratitude for each of you overflows; your brilliant passion for system reform, generous hearts, patient instruction, and unwavering support will be with me for a lifetime. This paper is dedicated to the children of Georgia.

INTRODUCTION

At age seventeen, Miranda, who had lived in more than ten California foster homes, became pregnant.[1] Another seventeen-year-old who had spent her life in foster care became pregnant in Louisiana.[2] Michelle, a sixteen-year-old foster youth with a history of depression, placement instability, and drug abuse, had frequently run away from her foster homes before becoming pregnant.[3] After being placed in foster care at age twelve, Bella ran away, lived on the streets, and also became pregnant at sixteen.[4] She dropped out of school because of morning sickness.[5] Katrena, a foster child from infancy until age eighteen, had

1. Amy Sullivan, *Teen Pregnancy: An Epidemic in Foster Care*, TIME (July 22, 2009), http://www.time.com/time/nation/article/0,8599,1911854,00.html.
2. *In re* D.L., 457 So. 2d 141, 142 (La. Ct. App. 1984).
3. *In re* S.D., No. B228043, 2011 WL 1288141, at *1 n.3 (Cal. Ct. App. Apr. 6, 2011).
4. *Helping Foster Kids Escape the Cycle of Teenage Pregnancy*, CAL. REP. (Jan. 18, 2011), http://www.californiareport.org/archive/R201101180850/b.
5. *Id.*

a baby shortly after she was emancipated.[6] Unemployed and dependent on food stamps, she lived on friends' couches throughout her pregnancy.[7] Jonnie, a former foster child, believed that having a baby would help her form the family she never had and became pregnant after exiting foster care.[8]

Much has been written about the rights of youth in foster care who are parents.[9] However, little attention has been paid to foster youths' rights to appropriate medical care and sex education in order to prevent pregnancy. Children in foster care already face an increased likelihood of early pregnancy due to the societal factors and system failures that influence the lives of foster youth, and the abuse that resulted in their state care in the first place.[10] Despite the constitutional and statutory guarantees of medical care—which include access to contraception and sex education—and existing policies in place to ensure the delivery of such services, few states adequately address pregnancy prevention within the foster care system.[11] Failure to do so violates the substantive due process rights of foster youth as guaranteed by the Fourteenth Amendment to the United States Constitution.

This article recognizes that there are unique difficulties in addressing pregnancy prevention among foster youth that are not present among their non-foster peers due to the state's involvement as legal custodian. This article,

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6. *Report: Foster Kids Face Tough Times After Age 18*, NAT'L PUB. RADIO (Apr. 7, 2010), http://www.npr.org/templates/story/story.php?storyId=125594259. "Emancipation" refers to a young person turning the age of eighteen, becoming a legal adult, and thus becoming free from foster care. *See* HUMAN RIGHTS WATCH, MY SO-CALLED EMANCIPATION, FROM FOSTER CARE TO HOMELESSNESS FOR CALIFORNIA YOUTH 1 (2010), *available at* http://www.hrw.org/sites/default/files/reports/us0410webwcover.pdf.
7. *Id.*
8. DVD: A Crucial Connection: Working Together to Address Teen Pregnancy Among Youth in Foster Care (The National Campaign to Prevent Teen & Unplanned Pregnancy), *available at* http://www.thenationalcampaign.org/fostercare/crucialconnection.aspx.
9. *See, e.g.*, Sarah Katz, *When the Child is a Parent: Effective Advocacy for Teen Parents in the Child Welfare System*, 79 TEMP. L. REV. 535 (2006); Eve Stotland & Cynthia Godsoe, *The Legal Status of Pregnant and Parenting Youth in Foster Care*, 17 U. FLA. J.L. & PUB. POL'Y 1 (2006).
10. Although this Paper primarily discusses female youth, its principles are easily extended to male youth where appropriate. Very little research has been done regarding the male role in adolescent pregnancy. *See* Robert F. Anda et al., *Adverse Childhood Experiences and Risk of Paternity in Teen Pregnancy*, 100 OBSTETRICS & GYNECOLOGY 37 (2002); Helen Britton, *Link Exists Between Child Abuse and Adolescent Pregnancy*, 11 AM. ACAD. PEDIATRICS NEWS 13 (1995).
11. In April 2009, Arizona, Colorado, Illinois, Maryland, Massachusetts, Michigan, Oklahoma, and Virginia, with the support of the National Campaign and the Annie E. Casey Foundation undertook a state-based effort to reduce pregnancies among teens in and aging out of foster care. *See* Shay Bilchik & Renee Wilson Simmons, *Preventing Teen Pregnancy Among Youth in Foster Care*, POL'Y & PRAC., Apr. 2010, at 16, 18, *available at* http://www.thenationalcampaign.org/press/PDF/2010/APHSPA_4.10a.pdf; *see also* Amy Dworsky, Senior Researcher, Chapin Hall, Preventing Pregnancy among Youth in Foster Care (July 16, 2009) (transcript available at http://www.thenationalcampaign.org/policymakers/PDF/DworskyFosterPregnancy.pdf) (noting that "[a]lthough many state and local child welfare systems have programs to address the special needs of foster youth who are pregnant or parenting, comparatively little has been done to help foster youth avoid teen pregnancy and early parenthood.").

therefore, addresses this important subject matter and devises a framework for improving access to the healthcare and education that youth in foster care need, given their heightened susceptibility to early and unplanned pregnancies in comparison to the general adolescent population. However, this article does not advocate for mandated contraception within the foster system. Rather, it encourages pregnancy prevention efforts that are fully informative and inclusive of all children's life experiences and personal preferences.

Part I provides background on pregnancy among youth in and emancipating from foster care. Part II offers a geographically diverse sampling of state laws and policies regarding the delivery of medical care to youth in foster care. Part III demonstrates that, despite the system's best intentions, foster care often fails children and youth due to institutional barriers and reactive, instead of proactive, case management. Part IV explains that foster youth have a substantive due process right under the Fourteenth Amendment to medical care, which includes access to contraception and sex education. Part V suggests that the Child and Family Services Review (CFSR)—the federal government's program for measuring the performance of state child welfare agencies in relation to services rendered and positive outcomes achieved—does not adequately assess pregnancy prevention efforts for youth in foster care. Accordingly, modifications to the CFSR are suggested to encourage data collection and reform in the delivery of prevention services among states. Finally, this Paper offers additional suggestions for reform at federal, state, and local levels.

I. BACKGROUND

Early pregnancy in the United States is a significant problem for foster youth and non-foster youth alike. Unfortunately, the problem is even worse among foster youth. Foster youth experience pregnancy at rates 2.5 times greater than youth not in foster care.[12] This disparity can be explained by societal factors, such as abuse, and institutional barriers, including poor case management and inadequate training of foster parents and social workers. The outcomes associated with being a teen parent for youth in, or formerly in, foster care[13] are catastrophic, resulting in low levels of educational attainment, homelessness, poverty, and, often times, state removal of the baby. Furthermore, while the pecuniary costs to society are extraordinary, even worse are the human costs for youth and their children who experience diminished life outcomes as a result of early pregnancy.

12. The Nat'l Campaign to Prevent Teen & Unplanned Pregnancy, *Foster Care Youth*, SCI. SAYS at 1 (2006), *available at* http://www.thenationalcampaign.org/resources/pdf/SS/SS27_FosterCare.pdf.

13. There are various circumstances that result in a person's becoming a "former foster youth." A youth may reunify with their parent(s), become adopted, or emancipate from care because he or she has turned eighteen. When discussing former foster youth, this article's focus is on emancipated youth.

A. By the Numbers

In 2008,[14] there were 4,247,694 births in the United States, representing a decline of 2 percent from the record numbers reported in 2007.[15] Of those births, 434,758 were to teen mothers.[16] Among teenagers ages fifteen to nineteen the birth rate fell 2 percent, to 41.5 per 1,000 teens—reversing a two-year increase that interrupted a long term decline in teen births between 1991 and 2005.[17] From state to state, teen birth rates differed significantly, ranging from 19.8 in New Hampshire to 65.7 in Mississippi (per 1,000 teens ages fifteen to nineteen).[18] 2009 data revealed that the U.S. birth rate declined again between 2009 and 2010 "to a record low" of thirty-four births per 1,000 teens."[19] Nevertheless, despite the decline, the teen birth rate in the United States is typically far higher than in Western Europe, where "more realistic approaches to birth control" are credited for the various countries' low adolescent pregnancy rates.[20]

The Center for Disease Control and Prevention (CDC) conducts the National Youth Risk Behavior Survey which "monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social

14. 2008 data will be used for purposes of consistency with other publications using similar data. As this article was being printed, the preliminary data on births in the United States during 2011 were released. *See* Brady E. Hamilton et al., *Births: Preliminary Data for 2011*, 61 NAT'L VITAL STATS. REPS. 1 (Oct. 3, 2012), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf.
15. Joyce A. Martin et al., *Births: Final Data for 2008*, 59 NAT'L VITAL STATS. REPS. 1, 4 (Dec. 8, 2010), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf.
16. *50 State National Comparisons*, THE NAT'L CAMPAIGN TO PREVENT TEEN PREGNANCY, http://www.thenationalcampaign.org/state-data/state-comparisions.asp?id=4&sID=29 (last visited Dec. 1, 2012).
17. Martin et al., *supra* note 15, at 7.
18. The Division of Vital Statistics reports that "[c]ontributing to the variation in state-specific teen birth rates are persistent differences in teenage birth rates among race and Hispanic origin groups. . . . Nationally, birth rates are significantly higher for Hispanic and non-Hispanic black teenagers than for non-Hispanic white teenagers." *Id*. According to the Division, "[i]t follows that states with a large proportion of Hispanic or non-Hispanic black teenagers would tend to have higher overall teen birth rates." *Id.*
19. Guttmacher Inst., *New Government Data Finds Sharp Decline in Teen Births: Increased Contraceptive Use and Shifts to More Effective Contraceptive Methods Behind this Encouraging Trend*, GUTTMACHER INST. MEDIA CTR. (Dec. 1, 2011), http://www.guttmacher.org/media/inthenews/2011/12/01/index.html. Teen births continue to decline; at the time of printing, new data was released demonstrating that the teen birth rate is the lowest that it has been since the 1940s. *See* Nat'l Campaign to Prevent Teen and Unplanned Pregnancy, *US Teen Birth Rates Reach Lowest Level Since the 1940's*, NAT'L CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY PRESS ROOM (Oct. 3, 2012), http://www.thenationalcampaign.org/press/press-release.aspx?releaseID=236. However, there is no new data available to demonstrate a decline in birth rates among foster youth.
20. Mike Stobbe, *Even at Lowest U.S. Teen Birth Rate Far Higher than W. Europe*, WASH. POST, Dec. 30, 2010, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2010/12/30. For a breakdown of teenage birthrates in various countries, see *Japan Has Lowest Teen Birth Rate*, UNICEF, http*://www.unicef.org/pon96/inbirth.htm* (last visited Oct. 3, 2012).

problems among youth and adults in the United States."[21] In its most recent survey,[22] 47 percent of high school teens reported engaging in sexual intercourse.[23] Among students who were sexually active at the time of the survey, 60 percent reported using a condom during their last sexual intercourse; 23 percent reported using birth control pills, injectable birth control such as Depo-Provera, birth control rings, implants, or an intrauterine device (IUD).[24]

On September 30, 2008, there were approximately 463,000 children in foster care nationwide; nearly half were female.[25] According to a Chapin Hall Study, approximately 100,000 female foster youth were at high risk of becoming pregnant.[26] However, it is difficult to establish with certainty how many female foster youth actually become pregnant, as states are not required to report data.[27] Yet, an important study on youth transitioning out of foster care revealed that "[b]y age 19, nearly half of young women in foster care have been pregnant, compared to a fifth of their peers not in foster care. Said another way, those in foster care are 2.5 times more likely than those not in foster care to have been pregnant by age 19."[28] Moreover, "[b]y age 19, 46% of teen girls in foster care who have been pregnant have had a subsequent pregnancy, compared to 29% of their peers outside the system."[29]

B. The Reasons Behind the Numbers

Recent studies have sought to determine why youth in foster care become pregnant. One expert at Chapin Hall has explained that although information

21. CENTERS FOR DISEASE CONTROL & PREVENTION, YOUTH RISK BEHAVIOR SURVEY, TRENDS IN THE PREVALENCE OF SEXUAL BEHAVIORS AND HIV TESTING: NATIONAL YRBS: 1991-2011, *available at* http://www.cdc.gov/HealthyYouth/yrbs/pdf/us_sexual_trend_yrbs.pdf.
22. *Id.* This survey is conducted every other year, during odd numbered years.
23. CTRS. FOR DISEASE CONTROL AND PREVENTION, YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM: 2011 NATIONAL OVERVIEW, *available at* http://www.cdc.gov/HealthyYouth/yrbs/pdf/us_overview_yrbs.pdf.
24. *Id.*
25. U.S. Dep't of Health and Human Servs., *The AFCARS Report, Preliminary FY 2008 Estimates as of October 2009*, http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report16.htm) (last visited Dec. 29, 2010).
26. Dworsky, *supra* note 11.
27. *Id.* at 1. This may soon change following implementation of the National Youth in Transition Database, which is intended to track youth as they transition from care to adulthood; the data collected will include information on childbearing and contraceptive use. Initial reports were due in May 2011 to the Administration for Children and Families. *See also* Heather D. Boonstra, *Teen Pregnancy Among Young Women in Foster Care: A Primer*, 14 GUTTMACHER POL'Y REV. 8, 12–13 (2011), *available at* http://www.guttmacher.org/pubs/gpr/14/2/gpr140208.pdf. Results are not available at the time of this writing. No national results are available, but the report says that regional studies are now available.
28. NAT'L CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY, Foster Care Youth, SCI. SAYS, Aug. 2006, *available at* http://www.thenationalcampaign.org/resources/pdf/SS/SS27_FosterCare.pdf. The sample includes approximately 700 foster children from Iowa, Wisconsin, and Illinois. *Id.*
29. *Id.*

about pregnancy prevention and birth control are essential, this information is not sufficient to address the needs of foster youth.[30] She explains:

> We can provide youth in care with all the contraception in the world, but pregnancy rates among this population will remain exceptionally high unless the factors that motivate so many of these adolescents to become pregnant are addressed. For some youth in foster care, having a child may be seen as a way to create a family of their own, a family who will love them and who they can love, or to demonstrate that they can do a better job of parenting than their birth parents had. Addressing these motivations means giving teens in foster care a reason to delay pregnancy and childbearing. They need to believe that they can complete their education, find a good job and succeed in life.[31]

There is no question that, with respect to foster youth, "a deeper understanding of the root causes of early child bearing" is necessary.[32] Abuse appears to be a significant factor.[33] Placement in foster care may also be influential, though studies are inconclusive.[34] The absence of a parent may also play a role.[35]

The Brookings Institute and Princeton University identified numerous societal factors associated with what it calls "fragile families," which include children born to teen mothers.[36] Among the Brookings Institute factors, the following are significant to female foster youth: (1) few positive alternatives to motherhood; (2) the notion that parenthood confers meaning upon one's life; (3) ambivalence toward becoming pregnant; (4) lack of knowledge about contraception; (5) limited access to contraception; and (6) difficulty using contraception.[37] Other adolescent pregnancy predictors common to youth in foster care are poverty, membership in a racial or ethnic minority group, having an older boyfriend, being young at menarche, and dropping out of school.[38] The following sub-sections examine the effects of child abuse and the influence of foster care on young people in additional detail.

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30. Boonstra, *supra* note 27, at 13.
31. *Id*.
32. *Id*. Additionally, a deeper understanding of the interplay between poverty, race, foster care, and unplanned pregnancy would likewise be of value. These topics, however, are beyond the scope of this article.
33. Britton, *supra* note 10.
34. Sigrid James et al., *Sexual Risk Behaviors Among Youth in the Child Welfare System*, 31 CHILDREN & YOUTH SERVICES REV. 990 (2009). ("Whether out-of-home placement . . . presents an added risk factor or an opportunity for resilience remains a matter of debate.") (citations omitted).
35. Bill Albert, *With One Voice: America's Adults and Teens Sound Off About Teen Pregnancy*, THE NAT'L CAMPAIGN TO PREVENT TEEN & UNPLANNED PREGNANCY, Dec. 2010, at 1, 5, *available at* http://www.thenationalcampaign.org/resources/pdf/pubs/wov_2010.pdf (explaining that parents most influence teens' decisions about sex).
36. Isabel Sawhill et al., *An Ounce of Prevention: Policy Prescriptions to Reduce the Prevalence of Fragile Families*, 20 THE FUTURE OF CHILDREN 133, 136 (2010).
37. *Id*.
38. Sara C. Carpenter et al., *The Association of Foster Care or Kinship Care with Adolescent Sexual Behavior and First Pregnancy*, PEDIATRICS, Sept. 1, 2001, at 1, 2.

1. Child Abuse, Foster Care, and the Consequences

Child abuse, including physical and sexual abuse, neglect, and the outcomes associated with such abuse, renders children and youth more likely to engage in sexual risk taking that can lead to adolescent pregnancy. The American Academy of Pediatrics has reported that "[a] significantly higher incidence of childhood sexual or physical abuse has been reported in the backgrounds of teens who become pregnant."[39] Other studies have confirmed this finding, noting that a combination of neglect and physical abuse gives rise to an increase in the frequency of teenage parenthood among both males and females.[40] Child victims of sexual abuse are also more likely to engage in activities that give rise to an increased likelihood of pregnancy, such as initiating early sexual activity, failing to use contraception, having multiple sexual partners, and engaging in substance abuse.[41] Younger males who experience sexual abuse and other adverse childhood experiences also have an increased risk of subsequently impregnating another teen.[42]

Because child abuse rarely occurs in a vacuum, researchers looked at the effect of adverse childhood experiences on sexual risk taking, including physical, sexual, and verbal abuse, domestic violence, incarceration of family members, household substance abuse, and household mental illness.[43] They found that each adverse childhood experience was linked with increases in sexual risk taking.[44] As frequency of exposure to multiple categories of adverse experiences increased, sexual risk taking also increased, thereby heightening the likelihood of pregnancy.[45] Together, the findings of these studies establish that child abuse, including the family dysfunction surrounding and often contributing to it, is deeply correlated with adolescent pregnancy.

According to several studies from the 1990s, living in foster or kinship

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39. Britton, *supra* note 10; *see also* James et al., *supra* note 34, at 990 (noting that youth who become involved in the child welfare system "present with risk factors, such as histories of maltreatment, family instability and dysfunction, parental substance abuse, and poverty that are believed to increase their vulnerability for health-risking behaviors") (internal citations omitted).
40. Ellen C. Herrenkohl et al., *The Relationship Between Early Maltreatment and Teenage Parenthood*, J. ADOLESCENCE 300 (1998).
41. *Id.* at 6.
42. R.F. Anda et al., Adverse *Childhood Experiences and Risk of Paternity in Adolescent Pregnancy*, 100 OBSTETRICS & GYNECOLOGY 37, 37–45 (2002).
43. Susan D. Hillis et al., *Adverse Childhood Experiences and Sexual Risk Behaviors in Women: A Retrospective Cohort Study*, 33 FAMILY PLANNING PERSPECTIVES 206, 208 (2001); *see also* Elizabeth Weil, *Puberty Before Age 10: A New 'Normal'?*, N.Y. TIMES (Mar. 30, 2012) http://www.nytimes.com/2012/04/01/magazine/puberty-before-age-10-a-new-normal.html?pagewanted=all (discussing early puberty among female children and explaining that in one adolescent health clinic in San Francisco, half of the patients have been in foster care where "in the outlines of their early-developing bodies [are] the stresses of their lives—single parent or no parent, little or no money, too much exposure to violence.").
44. *Id.* at 208–09.
45. *Id.* at 206.

care[46] may also be associated with high-risk sexual behaviors.[47] In a 2001 study, youth in foster care had more sexual partners than youth not in foster care and experienced their first conception at a younger age.[48] Youth in kinship care were similarly impacted.[49] The Georgia Cold Case Project is representative: in examining 214 different cases of children with extended stays in foster care, it found that 10 percent of the children in the study reported[50] they were consensually sexually active.[51] Of those children, only one in five was using birth control.[52] Four of the females were pregnant or had given birth, including one who was pregnant for a second time.[53]

Research suggests that parents play an important role in the decisions youth make about sexual risk-taking behavior.[54] The National Campaign to Prevent Teen and Unplanned Pregnancy (the National Campaign) has reported that 46 percent of teens say their parents "most influence their decisions about sex."[55] However, because the relationships that youth in foster care have with their parents may be compromised due to abuse and out-of-home placement, sexual risk-taking behavior, and thus adolescent pregnancy, is more likely to occur. At the very least, these studies illustrate how youth in foster care engage in sexual risk taking and, as a consequence, often become pregnant as teenages.

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46. Kinship care is the full-time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. Kinship Care: Fact Sheet, CHILD WELFARE LEAGUE OF AMERICA, http://www.cwla.org/programs/kinship/factsheet.htm (last visited Oct. 10, 2012).
47. Carpenter et al., *supra* note 38, at 1, 4–5. According to the study, however, out-of-home placement cannot be implicated as the direct cause of high-risk behavior, but is rather a marker that reflects the high-risk homes from which children in the study were removed.
48. *Id.* at 1, 4. In 1995, youth in foster care, on average, were 16.8 years old at first voluntary sexual intercourse; youth not in foster care were 17.4 years old. *Id.* at 3.
49. *Id.* at 1, 4. In 1995, youth in kinship care, on average, were 16.4 years old at first voluntary sexual intercourse; youth not in foster care were 17.4 years old. *Id.* at 3.
50. Studies addressing youth sexual behavior must account for an unwillingness to honestly report. *See also* James et al., *supra* note 34, at 997, noting that:

> [F]ear of loss of privacy, concerns about repercussions and issues of social desirability may undermine accurate reporting on sensitive personal behaviors. Such concerns might be amplified for youth involved with the child welfare system that may have experienced first-hand that revelation of personal events can have significant consequences, namely intervention by a public institution in the form of continued monitoring and supervision, and in some cases removal from the biological family.

51. APPLIED RESEARCH SERVS., INC., THE GEORGIA COLD CASE PROJECT 22, 47 (June 2010), *available at* http://w2.georgiacourts.org/cj4c/files/The%20Georgia%20Cold%20Case%20Project_2010%281%29.pdf (last visited Oct. 10, 2012).
52. *Id.* at 22.
53. *Id.*
54. James et al., *supra* note 34, at 998.
55. Albert, *supra* note 35, at 5; *see also Parent-Child Connectedness in Our Communities*, PLANNED PARENTHOOD (Planned Parenthood Minn., N.D., S.D.) 2011, at 1, *available at* http://www.plannedparenthood.org/mn-nd-sd/files/MinnesotaNorthDakotaSouthDakota/PCC_final_v.2_all-in-one.pdf ("Strong [parent-child connectedness] protects against 33 negative adolescent outcomes such as unintended pregnancy.").

2. Societal Factors

The circumstances of abuse, foster care, and the absence of family members are compounded by other societal factors that negatively impact youth in foster care. For example, these adolescents may feel that they have few positive alternatives to motherhood.[56] The future of a foster teen may seem to lack opportunities; therefore, becoming a teen mother may not appear to further diminish such prospects.[57] Jane Fonda, founder of the Georgia Campaign for Prevent Adolescent Pregnancy Prevention, spoke to this very issue, urging that "[i]f we are to see substantial declines in teen pregnancy in Georgia . . . changing the circumstances for some of our most vulnerable young people must be a priority."[58] According to Fonda, "hope is the best contraceptive."[59] Yet, for those living in foster care, there seems to be hope in motherhood. Being a mother means being needed by another person and, for many youth in foster care, being needed seems like a fulfilling experience. According to one former foster youth, "[y]ou know your child is going to love you no matter what. And it's having something you never had."[60] Experts agree that many youth in foster care intend to have a child to fill a void.[61]

Despite this longing for hope and affection, ambivalence and fatalism toward becoming pregnant are also common factors among pregnant and parenting teens. This suggests that adolescent pregnancy may have nothing to do with youth making a conscious decision to become pregnant. Rather, in a 2010 survey by the National Campaign, 34 percent of teens ages twelve to nineteen agreed with the statement: "it doesn't matter whether you use birth control or not, when it is your time to get pregnant, it will happen."[62] Furthermore, one-third of teens believed "pregnancy is subject to influences outside of basic biology and birth control technology."[63]

Adding to the problem of ambivalence toward becoming pregnant is a lack of education about and access to contraception. Strong evidence suggests that individuals at risk of unintended pregnancies lack adequate information about reproductive health.[64] When surveyed, 43 percent of teens ages twelve to nineteen replied that teens have unprotected sex because "they don't think

56. Sawhill et al., *supra* note 36, at 136.
57. *Id.*
58. Jane Fonda, *To Prevent Teen Pregnancy, Teach Girls They Have a Future*, ATLANTA J. CONSTIT., Dec. 13, 2010, *available at* http://www.ajc.com/opinion/to-prevent-teen-pregnancy-775073.html.
59. *Id.*
60. A Crucial Connection, *supra* note 8.
61. Lois Thiessen Love et al., *Fostering Hope: Preventing Teen Pregnancy Among Youth in Foster Care*, THE NAT'L CAMPAIGN TO PREVENT TEEN & UNPLANNED PREGNANCY 13 (2005), *available at* http://www.thenationalcampaign.org/resources/pdf/pubs/FosteringHope_FINAL.pdf.
62. Albert, *supra* note 35, at 5.
63. *Id.* at 27.
64. Sawhill et al., *supra* note 36, at 138–39.

anything will happen to them."[65] Thirteen percent responded that teens have unprotected sex because "they don't know where/how to get birth control or protection."[66] Nevertheless, 52 percent of teens "agree strongly" with the statement: "I have all the information I need to avoid an unplanned pregnancy."[67] Young people have explained that the disconnect between this statement and the stated lack of knowledge they have about contraception and protection[68] may be due to embarrassment.[69] Reportedly, "many young people are uncomfortable asking for more information on topics they feel they *should* know."[70]

C. The Harmful Outcomes and Effects of Pregnancy in or Following Foster Care

"[F]oster children have a substantive due process right to be free from [an] unreasonable risk of harm, including a risk flowing from the lack of basic services."[71] Pregnancy during, after exiting, or soon after emancipating from foster care can be both devastating and harmful to the young person involved, the baby, and others. Youth in foster care commonly experience low educational attainment,[72] unemployment,[73] homelessness,[74] and high rates of interaction with the criminal justice system.[75] These outcomes are made even more likely for

65. Albert, *supra* note 35, at 18.
66. *Id.*
67. *Id.* at 26.
68. Half of teens ages twelve to nineteen admit they know little or nothing about condoms. *Id.* at 25.
69. *Id.* at 26.
70. *Id.*
71. Braam *ex rel*. Braam v. Washington, 81 P.3d 851, 857 (Wash. 2003).
72. Steve Christian, *Educating Children in Foster Care*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/default.aspx?tabid=4245 (last visited July 31, 2012). "Numerous studies have confirmed that foster children perform significantly worse in school than do children in the general population. The educational deficits of foster children are reflected in higher rates of grade retention; lower scores on standardized tests; and higher absenteeism, tardiness, truancy and dropout rates." *Id. See also* Mark E. Courtney et al., *The Educational Status of Foster Children*, CHAPIN HALL CTR. FOR CHILDREN: ISSUE BRIEF 1–5 (Dec. 2004), http://www.chapinhall.org/sites/default/files/publications/152.pdf.
73. Jennifer L. Hook et al., *Employment of Former Foster Youth as Young Adults: Evidence from the Midwest Study*, CHAPIN HALL CTR. FOR CHILDREN: ISSUE BRIEF 2 (Mar. 2010), http://www.chapinhall.org/sites/default/files/publications/Midwest_IB3_Employment.pdf. ("Foster youth who age out of care are less likely to be employed and earn lower wages than other youth, even when compared to demographically similar low-income youth.").
74. *See generally* HUMAN RIGHTS WATCH, MY SO-CALLED EMANCIPATION: FROM FOSTER CARE TO HOMELESSNESS FOR CALIFORNIA YOUTH (2010), *available at* http://www.hrw.org/reports/2010/05/12/my-so-called-emancipation (documenting the struggles of California foster youth who become homeless after "aging out" of State care, not having received sufficient preparation for adulthood).
75. Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 21*, CHAPIN HALL CTR. FOR CHILDREN 64–67 (Dec. 2007), http://www.chapinhall.org/sites/default/files/ChapinHallDocument_2.pdf; *see also Youth After Foster Care*, CHILD WELFARE LEAGUE OF AM, http://www.cwla.org/programs/fostercare/factsheetafter.htm (last visited July 31, 2012).

foster youth who experience early pregnancy.[76] Babies born to young mothers in foster care may not have had prenatal care[77] and may even enter the foster system themselves,[78] thus contributing to an endless cycle of life in the child welfare system. The harms experienced by both young parents and their children also come at a great expense to society: teen childbearing cost the United States nearly $10.9 billion in 2008, with child welfare system expenses accounting for $2.8 billion of this amount.[79] Worse, however, are the human costs of a lost childhood and a displaced future due to circumstances that could have been prevented with proper medical care and sex education.

This Paper argues that the harms incidental to pregnancy in foster care can and must be avoided through the delivery of proper services, including medical care and sex education. While a state cannot limit the free will of young people, in accordance with various statutory guarantees, it must inform and equip those in its charge with the resources necessary to make informed choices about their reproductive health.

II. STATE LAW AND POLICY ON MEDICAL CARE FOR CHILDREN IN FOSTER CARE

A number of state laws and policies addresses the provision of medical care to foster children. Although all states have differing policies on the provision of medical care, each state must provide a baseline level of services to children in foster care because of their status as recipients of Medicaid. Generally, the provision of care is delegated to the state agency charged with caring for dependent children. To demonstrate the responsibility that states have to provide medical care and, thus, reproductive health care, a diverse sampling of states' laws and policies follow.

A. Georgia

In Georgia, custody is "a legal status created by court order embodying . . . [t]he right and the duty to protect, train, and discipline the child . . . [and the] responsibility to provide the child with . . . ordinary medical care."[80] The policies of the Department of Family and Children Services (DFCS), the state agency

76. Amy Dworsky & Jan DeCoursey, *Pregnant and Parenting Foster Youth: Their Needs, Their Experiences*, CHAPIN HALL AT THE UNIV. OF CHI. 34 (2009), http://www.chapinhall.org/sites/default/files/Pregnant_Foster_Youth_final_081109.pdf.

77. *Id.* at 33–34; *see also* Wendy L. Constantine et al., *Sex Education and Reproductive Health Needs of Foster and Transitioning Youth in Three California Counties*, PUB. HEALTH INST. 18 (Mar. 2, 2009), http://crahd.phi.org/FTYSHNA-FullReport-3-2-09.pdf (indicating that responsibility for connecting youth to prenatal care varies among social workers, foster parents, or "someone else").

78. Dworsky & DeCoursey, *supra* note 76, at 34.

79. *Counting it Up*, NAT'L CAMPAIGN TO PREVENT TEEN & UNPLANNED PREGNANCY, COUNTING IT UP (June 2011), http://www.thenationalcampaign.org/costs/pdf/counting-it-up/key-data.pdf.

80. GA. CODE ANN. § 49-5-3(12)(B)-(C) (2011).

charged with the care of dependent children,[81] reflect this responsibility. Within ten days of entering care, children are required to have a "health check."[82] According to DFCS policies, a health check consists of "a comprehensive unclothed physical examination, a comprehensive health and developmental history, developmental assessment, anticipatory guidance, measurements, vision and hearing tests, certain laboratory procedures and lead risk assessment. [Additionally], [a]ll of the age appropriate components must be completed for each screening visit."[83] Timely follow-up by the case manager on recommendations made and periodic preventative services are likewise required.[84] As a matter of practice, the case manager must ensure that all age appropriate components of medical care are completed and that the foster family and case manager "help children and teens learn about and respond to matters related to sexual development and sexuality."[85] By state law, judges can ensure enforcement of these requirements by ordering the child to be examined by a physician.[86]

B. California

In California, "whenever a child is removed from a parent's or guardian's custody, the juvenile court shall order the social worker to provide child welfare services."[87] Counties are required to provide services to children through various agencies, such as the county public welfare department.[88] There, the regulations provide that a child shall receive a medical examination within thirty days of their initial placement in a foster home.[89] Youth must also be "given the opportunity to learn about" contraception.[90] The case manager should likewise

81. Georgia refers to dependent children as "deprived"; however, to align with the national trend, the term "dependent" is used in this article. *See* GA. CODE ANN. § 15-11-2(8)(A)-(D) (2011) (defining a "deprived child" as a child "without proper parental care or control, subsistence, education as required by law[,] . . . [who] [h]as been placed for care or adoption[,] . . . [who] [h]as been abandoned by his or her . . . legal custodian[,] . . . [or who is] without a parent, guardian, or custodian").

82. *Foster Care Services: Needs of the Child*, GA. DEP'T OF HUMAN SERVS., DIV. OF CHILDREN & FAM. SERVS. 5 (Dec. 2007), http://www.childwelfare.net/DHR/policies/3060_pdf/1011.pdf.

83. *Id.* at 7.

84. *Id.* at 5.

85. *Id.* at 7.

86. GA. CODE ANN. § 15-11-12(b) (2011).

87. CAL. WELF. & INST. CODE § 361.5 (2011).

88. *Id.* at § 16500; *see also* Diane F. Reed & Kate Karpilow, *Understanding the Child Welfare System in California (2d ed.)*, CAL. CTR. FOR RESEARCH ON WOMEN & FAMILIES 2, 7–8 (2009), *available at* http://www.ccrwf.org/wp-content/uploads/2009/03/final_web_pdf.pdf.

89. L.A. DEP'T OF CHILD & FAM. SERVS., CHILD WELFARE SERVS. HANDBOOK: INITIAL CASE PLAN § 0080-502.10, at 11 (2011), http://dcfs.co.la.ca.us/policy/hndbook%20cws/0080/default.htm#0080-000.

90. L.A. DEP'T OF CHILD & FAM. SERVS., CHILD WELFARE SERVS. HANDBOOK: YOUTH DEV.: REPROD. HEALTH § 0600-507.10, at 5 (2011), http://dcfs.co.la.ca.us/policy/hndbook%20cws/0600/default.htm#0600-000.

be prepared to address safe sex and pregnancy prevention with youth above the age of eleven.[91] Additionally, the Los Angeles County Department of Children and Family Services (DCFS) has a policy that youth must be supported in making a decision to continue or terminate pregnancy.[92] These policies reflect a California state law that provides: "[a] foster care provider, in consultation with the county case manager, shall be responsible for ensuring that adolescents who remain in long-term foster care . . . receive age-appropriate pregnancy prevention information."[93]

C. South Carolina

South Carolina's child protection laws are devised to "safeguard the well-being and development of endangered children," and to protect "children from injury and harm while living in . . . [the] agencies and institutions meant to serve them."[94] Accordingly, upon taking legal custody, the State has "the right and the duty to provide . . . ordinary medical care."[95] The responsibility to provide medical care is delegated to the Department of Social Services, which maintains the authority to consent to most medical care where parents are unavailable and where the youth is under sixteen years old.[96] Reproductive medical care is required through the State's independent living program, which starts at age thirteen.[97] Information about sexually transmitted infections and family planning must also be provided.[98]

D. Illinois

In Illinois, the Juvenile Court Act of 1987 provides that when legal custody of a child is created by a court order, the custodian has an obligation to provide the child with ordinary medical care.[99] Through the state's Department of Children and Family Services, family planning is provided to "Department clients who are old enough to have children regardless of sex, marital status, parenthood, or the religious affiliation or personal belief of any Department or child welfare agency employee."[100] According to Department policy, "[f]amily planning services are provided to enable the client to determine the number of

91. *Id.*
92. *Id.* at 6.
93. CAL. WELF. & INST. CODE § 16521.5 (West 2011).
94. S.C. CODE ANN. § 63-7-10(B)(2), (5) (2011).
95. *Id.* § 63-7-20(13).
96. S.C. DEP'T OF SOC. SERVS., HUMAN SERVS. POL'Y AND PROC. MANUAL, ch. 8, § 835.
97. *Id.* § 832. However, some youth have explained that starting sex education at age thirteen is "too little, too late." Love et al., *supra* note 61, at 15. By statute, youth in South Carolina are permitted to learn about contraception after the fifth grade, thus bringing the Department's policies and state law into conflict. *See* S.C. CODE ANN. § 59-32-10(4)(c) (2011).
98. S.C. DEP'T OF SOC. SERVS., HUMAN SERVICES POLICY AND PROCEDURE MANUAL, ch. 8, § 832
99. 705 ILL. COMP. STAT. 405/1-3(9) (2009).
100. ILL. ADMIN. CODE tit. 89, § 302.350 (2011).

children or the spacing of children through the postponement or prevention of conception."[101] All minors of childbearing age may access family planning services, including "information concerning medical care and contraceptives."[102] Moreover, clients have the right to either accept or reject these services without seeking parental consent.[103]

E. New York

In New York, the agency responsible for the child's care is also responsible for the child's comprehensive health care.[104] Foster children are required to undergo periodic medical exams, which include an age-appropriate, comprehensive physical examination.[105] Upon request, family planning services must be provided to persons of childbearing age, including sexually active minors.[106] In addition, foster parents providing care to youth over twelve must be advised annually that family planning services are available to any adolescents in their care.[107] Sex education, as well as medical services, must be provided within thirty days of request, and services must be rendered without regard for the recipient's age.[108]

III. SYSTEM FAILURE

Despite the mandatory provision of reproductive healthcare to children in foster care, pregnancy is more than twice as prevalent among foster youth than it is among other youth.[109] System failure is to blame. System failure refers to a malfunction in the delivery of services that is necessary to the healthy upbringing of children, and primarily manifests in three ways: (1) poor case management; (2) social workers' discomfort with and lack of training on pregnancy prevention; and (3) social workers' conscientious objection to family planning and sex education, which often occurs due to political forces. The result of these failures is a general unwillingness among caseworkers to discuss contraception, and accounts for the lack of funding for pregnancy prevention efforts. However, because caseworkers are responsible for managing each child's case, they must also ensure that children receive proper care. When foster youth do not receive adequate care, the societal reasons for pregnancy in foster care are aggravated, often resulting in pregnancy.

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101. *Id.*
102. *Id.*
103. *Id.*
104. *See* N.Y. COMP. CODES R. & REGS. tit. 18, § 441.22 (2012).
105. *Id.*
106. *Id.* § 463.1.
107. *Id.* § 463.2.
108. *Id.* §§ 463.3, 463.5, 463.6(a).
109. Love et al., *supra* note 61, at 7.

A. Poor Case Management

Poor case management exacerbates the existing barriers to foster youth's receipt of adequate health care: lack of a consistent medical provider; difficulty accessing records for case workers, foster parents (where permitted), and medical providers; delay in health insurance enrollment; delayed and inadequate needs assessments; lack of follow-through in addressing needs; lack of access to health services, including special education, mental, and dental health services; poor coordination among systems of care; and diffusion of authority and responsibility among persons in the child's life.[110] Social workers' large caseloads, high turnover rates, low pay, and a lack of appreciation for the complex needs of foster youth contribute to poor case management and prevent the receipt of adequate health care, including pregnancy prevention.

Large caseloads often result in youth "falling through the cracks."[111] According to the National Association of Social Workers, "[t]he number of cases a social work case manager can realistically handle is limited to the degree to which caseloads consist of acute, high-risk, multi-need clients."[112] Children's cases are especially challenging, as their needs are almost always varied. The Child Welfare League of America recommends that one social worker supervise twelve to fifteen cases.[113] Nevertheless, in many places, caseworkers are expected to handle upwards of fifty cases.[114] Each case may be riddled with challenging issues, such as Medicaid disputes, difficulty arranging family visits, and special education needs. Accordingly, it may be difficult to ensure pregnancy prevention is addressed during each visit. Likewise, high caseloads

110. *Healthy Foster Care America: Addressing Barriers to Good Care*, AM. ACAD. OF PEDIATRICS, http://www.aap.org/fostercare/addressing_barriers.html (last visited Oct. 28, 2012).

111. *Caseload and Workload Management*, CHILD WELFARE INFO. GATEWAY (Apr. 2010), http://www.childwelfare.gov/pubs/case_work_management/case_work_management.pdf.

112. Case Mgmt. Standards Work Grp., *NASW Standards for Social Work Case Management*, NAT'L ASS'N OF SOC. WORKERS (June 1992), http://www.naswdc.org/practice/standards/sw_case_mgmt.asp#9.

113. *Recommended Case Load Standards*, CHILD WELFARE LEAGUE AM., http://www.cwla.org/newsevents/news030304cwlacaseload.htm (last visited Oct. 28, 2012).

114. *See* Diane Riggs, *Workforce Issues Continue to Plague Child Welfare*, ADOPTALK, Summer 2007, http://www.nacac.org/adoptalk/WorkforceIssues.html ("Palm Beach County caseloads [were] 35 [per worker] in 2007. One Indiana county reported that its two case managers were saddled with about 50 cases each . . . . In Texas this spring, a county worker quit after her caseload rose past 60."); *see also* First Am. Compl. at 2, Kenny A. *ex rel.* Winn v. Barnes, No. 1:02-cv-01686-MHS (N.D. Ga. Aug. 18, 2003), 2003 WL 25682412, complaining that

> [v]ulnerable foster children in Fulton and DeKalb Counties are victims of a foster care system that is dangerously overburdened, mismanaged and out of control. . . . Caseworkers are responsible for a dangerously large number of foster children. Although national standards limit caseloads of foster care caseworkers to 12-15 cases, DeKalb County caseworkers are consistently expected to handle 35-50 cases, and Fulton caseworkers are assigned as many or even more foster children. Because of these excessive caseloads, it is impossible for caseworkers to adequately monitor the safety and care of the foster children assigned to them, and foster children in these counties regularly go six months or more without a visit from their caseworker.

often result in missed visits by the social worker, so pregnancy prevention may easily go unaddressed at a time when a young person needs to hear about it most.

Low pay and high turnover rates are also common problems among social workers. In 2000, the *Atlanta Journal-Constitution* reported that entry-level Georgia child welfare workers were making approximately ten dollars an hour, at a salary of about $21,000 per year.[115] At that time, child welfare workers were making less than garbage truck drivers in Atlanta.[116] In West Virginia and Alaska, salaries ranged from $19,764 to $37,908, respectively.[117] In May 2011, the United States Department of Labor estimated that child, family, and school social workers made an annual median wage of $40,680.[118] The combination of low pay and stressful work results in high turnover rates.[119] For children, the consequences of having a new caseworker are devastating: children "fall through the cracks" and experience other negative trends, such as a lower likelihood of finding a permanent family[120] and an inability to form a trusting relationship with their caseworker. These aspects of foster care are to blame for the increased vulnerability to pregnancy faced by youth within the system.

B. Minimal Training, Discomfort, and Ambivalence

In 2005, the Uhlich Children's Advantage Network (UCAN) conducted a survey among child welfare agencies in Chicago on pregnancy prevention.[121] Fifty-nine percent of respondents noted that they do not have a specific plan for pregnancy prevention.[122] Caseworkers who participated in the survey reported sparse training, although they still reported talking with their clients about pregnancy prevention.[123] According to the survey, service providers are in need of particularized training about preventing pregnancy among youth in foster care on: (1) sex and relationships; (2) addressing an adolescent's interest in having a baby; (3) sexual impulse control, especially among young men; and (4) meeting

115. Jane O. Hansen, *Georgia's Forgotten Children: State's Child Caseworkers Among Lowest-Paid in the Nation*, ATLANTA J. CONST., Feb. 6, 2000, at A1.

116. *Id.*

117. *Id.*

118. *Occupational Employment and Wages, May 2011: Child, Family, and School Social Workers*, BUREAU OF LAB. STATS., http://www.bls.gov/oes/current/oes211021.htm (last modified Mar. 27, 2012).

119. *Caseload and Workload*, *supra* note 111.

120. In a review of Milwaukee County's turnover situation, researchers found that permanency was inversely correlated with high turnover. Of children who entered care and exited to permanency between January 2003 and September 2004, 74 percent had just one worker. As the number of workers increased, the likelihood of permanence plummeted—17.5 percent of children with two workers found permanence; 5.2 percent with three; 2.2 percent with four; and 0.1 percent with six or seven. Riggs, *supra* note 114.

121. Love et al., *supra* note 61, at 19.

122. *Id.*

123. *Id.* at 20 ("Fifty-eight percent say they have not received sufficient training to work with teens or caregivers on preventing teen pregnancy, including 43 percent of staff in programs for pregnant and parenting youth.").

the educational needs of teens, foster parents, and birth parents.[124]

The UCAN survey is revealing. Despite the state's policies on family planning for youth in foster care, conversations about pregnancy prevention in Chicago foster care are happening sporadically. One service provider affirmed that "[i]t's too easy to assume that someone else will be dealing with this issue. Communication needs to be open and clear between all of those involved in our kids' lives."[125] Training for case managers is minimal, and, as a result, case managers are unable to adequately inform the adult influences in a child's life, including foster parents, about pregnancy prevention.[126] This trend is prevalent in other states as well. For example, in California, unclear policies and a lack of training are obstacles to addressing prevention among foster youth.[127] Discomfort with the subject matter may be the reason.[128] Moreover, for many social workers, the lack of training on or a mandate to discuss sex education and family planning likely translates into ambivalence toward ensuring youth have information about prevention.

C. Political Forces and Conscientious Objection

The Child Welfare League of America has shown that political forces, including the lack of support from local politicians, create an obstacle to sex education and family planning services, and constrain various state agencies.[129] These obstacles may be exacerbated by the current fiscal crisis. Foster children are often recipients of Medicaid and rely on it for a variety of health care services, including family planning. However, according to the Guttmacher Institute, state and federal budget cuts to child welfare and publicly subsidized contraceptive services may preclude access to reproductive health care.[130]

Caseworkers, foster parents, and other agency personnel may likewise conscientiously object to discussing contraception and sex education with youth. For example, in California, some foster youth reported that while in state care, it was not permissible to participate in sex education at school or in programs offered through independent living placements.[131] Caseworkers, foster parents, and other personnel may also object to addressing issues associated with

124. *Id.* at 21.
125. *Id.*
126. *Id.*
127. Constantine et al., *supra* note 77, at 21–23, 28–30.
128. See *infra* notes 135–39 and accompanying text.
129. BRONWYN MAYDEN, SEXUALITY EDUCATION FOR YOUTHS IN CARE 19, 20 (1996) ("Concerned about retaliation from politicians, many child welfare agencies have made conscious decisions not to develop written policies and are content to ignore [sexuality education and family planning]. One respondent stated that establishing a written policy might jeopardize existing programs and threaten program expansion.").
130. Guttmacher Inst., *Publicly Subsidized Family Planning Services Are Indispensable for Many Women*, http://www.guttmacher.org/media/nr/2011/06/06/index.html (last visited July 31, 2012).
131. Constantine et al., *supra* note 77, at 24.

sexuality, including a young person's sexual orientation.[132]

Perhaps most disappointing, however, is the failure of the system and its workers to proactively address adolescent pregnancy—a widely known risk facing children and youth. It is no surprise that teenagers, even those who have not experienced child abuse, experiment with risky behavior. Without a parent or trusted loved one to guide them, youth lack the advice and direction that would otherwise keep them from harm. And yet, child welfare systems fail to mitigate the most obvious risks, including pregnancy. In attempting to protect parental rights, policies and laws are written to keep adolescent mothers with their babies.[133] Though these measures are both legally important and necessary, the system fails by merely responding to the problems it encounters, instead of being proactive. It relegates the children in its care to adolescent parenthood and the cycle of harm that typically follows.

IV. FOSTER CHILDREN AND THEIR RIGHTS UNDER THE FOURTEENTH AMENDMENT

Various principles extracted from the Supreme Court's jurisprudence on medical care and reproductive rights establish that youth in foster care have a substantive due process right to access resources that can help them prevent pregnancy. According to state law, case managers are responsible for ensuring children receive reproductive health care upon reaching the appropriate age. However, for the reasons discussed above, they oftentimes do not, giving rise to constitutional concerns.

A. Reproductive Rights

A long line of cases has discussed three cornerstones of reproductive autonomy: the right to procreate, the right to purchase and use contraceptives, and the right to an abortion. However, no cases have touched on the rights of foster youth as related to sex education and reproductive health care. Even so, "[a] child, merely on account of his minority, is not beyond the protection of the Constitution."[134] Therefore, failing to ensure access to sex education and reproductive health care, or otherwise interfering with the reproductive freedom

132. *See generally* LAMBDA LEGAL, YOUTH IN THE MARGINS 9–21 (2001), *available at* http://data.lambdalegal.org/pdf/28.pdf (discussing unaddressed problems involving LGBT youth in foster care) (last visited Oct. 23, 2012).

133. *See, e.g.*, Sarah Katz, *When the Child is a Parent: Effective Advocacy for Teen Parents in the Child Welfare System*, 79 TEMP. L. REV. 535, 548-552 (2006) (discussing the legal rights of pregnant and parenting youth in foster care); L.A. DEP'T OF CHILD & FAM. SERVS., CHILD WELFARE SERVS. HANDBOOK, Youth Development: Reproductive Health § 507.10, at 5-11 (Jan. 28, 2008), http://dcfs.co.la.ca.us/policy/hndbook%20cws/0600/default.htm#0600-000 (discussing the programs and services for pregnant and parenting foster youth in Los Angeles County, California); Second Chance Homes, GA. CAMPAIGN FOR ADOLESCENT PREGNANCY PREVENTION, http://www.gcapp.org/second-chance-homes (providing shelter for female foster youth and their babies) (last visited Oct. 23, 2012).

134. Bellotti v. Baird, 443 U.S. 622, 633 (1979).

of youth in care, gives rise to serious constitutional concerns.

Skinner v. Oklahoma stands for the proposition that reproduction is "one of the basic civil rights of man."[135] In *Griswold v. Connecticut*,[136] the Court laid the foundation for an additional aspect of reproductive freedom: the right to purchase and use contraceptives. Later, in *Carey v. Population Services International*, the Court addressed contraceptive use among teenagers.[137] The appellants in *Carey* contended that a New York statute that barred the sale and because it regulated the morals of minors and furthered "the State's policy against promiscuous sexual intercourse among the young."[138] The appellants also argued that the state's interests were served because easier access to contraceptives would lead to increased sexual activity among young people.[139]

The Court, however, rejected these arguments, finding that "the right to privacy in connection with decisions affecting procreation extends to minors as well as to adults."[140] The Court affirmed the lower court's finding that the statute in question was unconstitutional in its entirety under the First and Fourteenth Amendments.[141] *Bellotti v. Baird* built upon *Carey* and the principles of *Roe v. Wade*,[142] and it held that when a state requires a pregnant minor to obtain parental consent to an abortion, it must also provide an alternative procedure whereby an abortion can be obtained.[143] These principles establish that minors, including those in foster care, have a right to access reproductive medical care in its many forms, including contraception, sex education, and where desired, services to terminate a pregnancy.

B. Medical Care and Due Process

The right to medical care in foster care has been articulated through a series of cases discussing substantive due process and institutionalized persons, including foster children. In *DeShaney v. Winnebago County Department of Social Services*, the Supreme Court held that the State's failure to provide a child with protection from the abuse his father inflicted upon him did not violate the

135. 316 U.S. 535, 541 (1942). It is important to note that even in light of the State's responsibility to provide youth with the means necessary to prevent pregnancy, youth in foster care still have the right to become pregnant if they so choose. The role of prevention and counsel to wait until the youth has a stable life, however, cannot be underestimated.

136. 381 U.S. 479, 485 (1965) (holding that a Connecticut law forbidding use of contraceptives unconstitutionally intruded upon marital privacy). In *Eisenstadt v. Baird*, the Court extended the right to use contraceptives to the married and unmarried alike. 405 U.S. 438, 453 (1972).

137. Carey v. Population Servs. Int'l, 431 U.S. 678, 681 (1977).

138. *Id.* at 692.

139. *Id.* at 694.

140. *Id.* at 693.

141. *Id.* at 681.

142. 410 U.S. 113, 154 (1973) (concluding "that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation").

143. Bellotti v. Baird, 443 U.S. 622, 643 (1979).

child's rights under the substantive due process clause.[144] The Court reasoned that the due process clause does not "require[] the State to protect the life, liberty, and property of its citizens against invasion by private actors."[145] The circumstances in *DeShaney*, however, are distinguishable from the circumstances of a young person placed in foster care by the State. Indeed, the *DeShaney* Court spoke to the possibility of such circumstances, noting that, "[o]f course, the protections of the Due Process Clause, both substantive and procedural, may be triggered when the State, by the affirmative acts of its agents, subjects an involuntarily confined individual to deprivations of liberty which are not among those generally authorized by his confinement."[146]

Under the Supreme Court's holding in *Youngberg v. Romero*, individuals in state custody have a right to medical care.[147] In relation to foster care, the federal courts have addressed the issue of substantive due process to varying degrees.[148] However, numerous courts have found that being in foster care is analogous to being involuntarily committed to an institution or a prison.[149] The State's affirmative duty to provide medical care therefore "arises . . . from the limitation which [it] has imposed on [the child's] freedom to act on [her] own behalf."[150] *Andrea L. v. Children and Youth Services of Lawrence County* provides a particularly interesting set of facts through which the due process

144. DeShaney v. Winnebago Cnty. Dept. of Social Servs., 489 U.S. 189, 191 (1989).

145. *Id.* at 195.

146. *Id.* at 200 n.8.

147. Youngberg v. Romero, 457 U.S. 307, 315–16 (1982) (holding that the substantive component of the Due Process Clause of the Fourteenth Amendment requires the State to provide medical care to involuntarily committed mental patients with services that are necessary to ensure their reasonable safety); *see also* Estelle v Gamble, 429 U.S. 97, 103 (1976) (holding prisoners have a right to adequate medical care under the Eighth Amendment).

148. Taylor *ex rel.* Walker v. Ledbetter, 818 F.2d 791, 797 (11th Cir. 1987) (noting that the risk of harm to foster children is great enough to bring them "under the umbrella of protection afforded by the [F]ourteenth [A]mendment"); B.H. v. Johnson, 715 F. Supp. 1387, 1395 (N.D. Ill. 1989) ("holding that a child who is in the state's custody has a substantive due process right to be free from unreasonable and unnecessary intrusions on both its physical and emotional well-being"); Charlie H. v. Whitman, 83 F. Supp. 2d 476, 507 (D.N.J. 2000) (noting that children have a substantive due process right to freedom from harm, but such right does not entitle a child to an "optimal level of care").

149. *See, e.g.*, *Taylor*, 818 F.2d at 796 (finding a child's involuntary placement in a foster home is similar to a prisoner being involuntarily placed in an institution, such that similar rules of law should be applied); Jordan v. City of Philadelphia, 66 F. Supp .2d 638, 646 (E.D. Pa. 1999) ("Numerous courts have imposed a constitutional duty to protect foster children by analogy to involuntarily institutionalized individuals."); Andrea L. v. Children & Youth Servs. of Lawrence Cnty., 987 F. Supp 418, 422 (W.D. Pa. 1997), stating:

> While the environment may be demonstrably less confining than institutionalization, the foster child is monitored and supervised by state agents, even if from a distance. . . . The foster child does not have the freedoms from state involvement that a non-foster child has, which freedoms are protected by the same Due Process Clause, in the latter instance operating in defense of family unity. We thus accept that foster status constitutionally entitles a child to certain protections that the state must insure.

(internal citation omitted).

150. *DeShaney*, 489 U.S. at 200.

right of children in foster care to access medical care can be explored. Though the court held that Andrea's substantive due process rights were not violated, the court's reasoning offers a helpful foundation for future litigants by addressing whether a minor child in foster care could bring a successful claim for failure to provide medical care and sexual education.

Fourteen-year-old Andrea was taken into foster care and placed in a foster home with three boys, ages sixteen, fourteen, and twelve.[151] The foster mother wrote to social services and explained that Andrea was sexually active and needed close supervision.[152] In response, Andrea was given a psychological test that revealed "an extremely strong libido."[153] Shortly before her fifteenth birthday, Andrea became pregnant; the seventeen-year-old son of her foster parents was the father.[154] Andrea was subsequently transferred from the foster home into an institution.[155]

Andrea brought suit against Children and Youth Services, the county, and various social workers under 42 U.S.C. § 1983, alleging a violation of her rights under the Fourteenth Amendment.[156] Andrea's complaint stated that the defendants acted with "intentional disregard . . . for her safety" and that by "failing to protect Andrea from becoming pregnant at age fourteen, [defendants] violated her constitutional rights to liberty and substantive due process of law."[157] Andrea further contended that defendants should have protected her from becoming pregnant by preventing her from engaging in "teenage sex."[158] The court regarded the right at stake as a fourteen-year-old foster child's right "to be protected from conditions under which she might become pregnant."[159]

The court reasoned that foster care gives rise to a special relationship between the state and child, and that as such, the state has certain duties under the Due Process clause to protect children in care from physical or psychological injury.[160] Noting how "[p]regnancy dramatically affects a woman's body and mind,"[161] the court declined to find that Andrea's resultant pregnancy amounted to an injury in the absence of coercion[162] or force.[163] Accordingly, the motion to

151. *Andrea L.*, 987 F. Supp at 419.
152. *Id.*
153. *Id.*
154. *Id.*
155. *Id.*
156. *Id.*
157. *Id.* at 420.
158. *Id.* at 422.
159. *Id.* at 420.
160. *Id.* at 423–24.
161. *Id.* at 424.
162. The court explained that "nothing in Andrea's [c]omplaint even suggests that her sexual congress with Ricky Moyer was abusive, coerced, or unwanted." *Id.* at 422. The court went on to note that Andrea also "cited no cases involving a state's duty to protect a foster child from voluntary sexual congress and the resultant risk of pregnancy." *Id.* at 424.
163. The court explained that Andrea's complaint did not make any mention of force and that "neither law nor custom" demanded that her act be treated as lacking consent. *Id.* at 424. *But*

dismiss Andrea's complaint averring violation of her substantive due process rights was granted.[164]

Absent from the court's opinion is a discussion of the state's policy regarding sex and pregnancy among foster children.[165] Nowhere in the record does it appear that Andrea alleged that the state failed to provide her adequate access to medical care, including contraception and sex education. However, based on the court's analysis, if Andrea was denied medical care and sex education, and alleged that as a result the State failed to protect her from conditions under which she might become pregnant, it is plausible the court would have declined to grant the motion to dismiss. Instead of looking to whether Andrea experienced an injury, the court's analysis would have likely stopped at its finding that medical care—a right conclusively granted to foster children—was denied. It is therefore plausible that foster youth who are denied access to medical care and sex education could bring an action under 18 U.S.C. § 1983 against the State alleging a violation of their rights. The success of the action, however, might turn on the standard applied by the court.

C. Deliberate Indifference and Professional Judgment

In *DeShaney*, the Court explained that "[w]hile the State may have been aware of the dangers that [the child] faced in the free world, it played no part in their creation, nor did it do anything to render him any more vulnerable to them."[166] Failing to ensure a young person receives adequate medical care, which is required under state law because of the special relationship that results from foster care, renders youth more vulnerable to the known dangers of the free world. Accordingly, failure to provide proper medical care could result in legal recourse.

The United States Supreme Court articulates two different standards that courts invariably use to determine whether suit can be successfully brought against a state actor under section 1983 in cases involving foster care.[167] Some courts have applied a "deliberate indifference" standard. This standard looks to whether the "officials were aware of facts from which an inference could be drawn that a substantial risk of serious harm existed and the officials actually

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see, e.g., People v. Cross, 190 P.3d 706, 710 (Cal. 2008) (holding pregnancy without medical complications that results from unlawful but nonforcible intercourse can support a finding of great bodily injury); Jordan v. City of Philadelphia, 66 F. Supp. 2d 638 (D. Pa. 1999) (holding claimants, who were sexually abused as children by teenage son of foster parents and sued social service agencies who placed them, had sufficiently stated a claim that their substantive due process rights were violated).

164. 987 F. Supp at 425.

165. *Id.* at 424.

166. *DeShaney*, 489 U.S. at 201.

167. *See* Cnty. of Sacramento v. Lewis, 523 U.S. 833 (1998) (applying a deliberate indifference standard); Youngberg v. Romeo, 457 U.S. 307 (1982) (applying a professional judgment standard); Mark Strasser, *Deliberate Indifference, Professional Judgment, and the Constitution: On Liberty Interests in the Child Placement Context*, 15 DUKE J. GENDER L. AND POL'Y 223, 226 (2008).

drew that inference."[168] Other courts have used a "professional judgment" standard. Under this standard, "the proper inquiry is whether the State's conduct falls substantially short of the exercise of professional judgment, standards, or practices."[169] Under both the deliberate indifference and professional judgment standards, plaintiff must establish proximate cause.[170] These standards offer important guidance to child welfare agencies that should take note of their legal obligation to ensure children receive proper care, particularly related to pregnancy prevention.

1. Deliberate Indifference

The deliberate indifference standard looks to the subjective knowledge of the child welfare worker.[171] It is "found only if the officials were aware of facts from which an inference could be drawn that a substantial risk of serious harm existed and officials actually drew that inference."[172] In *Doe v. New York City Department of Social Services*, the Second Circuit applied the deliberate indifference standard to a case involving a child whose foster father, a police man, beat the child "with his hands and belt all over her body, threw her down the stairs, and . . . lacerated her with a hunting knife . . . confined her to her room for days at a time, and ultimately forced her to have intercourse and oral sexual relations with him."[173] In explaining the level of culpability required, the court reasoned that there is a "subtle yet pivotal distinction between ordinary negligence and grossly negligent or reckless conduct."[174] Deliberate indifference requires the latter.[175]

In *Taylor v. Ledbetter*, a comatose child "suffered severe and permanent personal injuries as a result of being 'willfully struck, shaken, thrown down, beaten, and otherwise severely abused by the foster mother'" while in foster care.[176] The Eleventh Circuit agreed with the Second Circuit in *Doe v. New York City Department of Social Services*, and reasoned that:

> Defendants may be held liable under 1983 if they . . . exhibited deliberate indifference to a known injury, a known risk, or a specific duty and their

168. James v. Friend, 458 F.3d 726, 730 (8th Cir. 2006) (holding Department of Family Services personnel were not liable for child's death under § 1983 for substantive due process violation).

169. *Braam*, 81 P.3d at 858 (vacating an injunction relating to the placement of children in foster care).

170. *See* Doe v. New York City Dep't of Soc. Servs., 649 F.2d 134, 145 (2d Cir. 1981); *see also Taylor*, 818 F.2d at 797; Wendy H. v. City of Philadelphia, 849 F. Supp. 367, 373 (E.D. Pa. 1994).

171. Strasser, *supra* note 167, at 233.

172. *Friend*, 458 F.3d at 730.

173. *Doe*, 649 F.2d at 137.

174. *Id.* at 144.

175. *Id.* at 143.

176. *Taylor*, 818 F.2d at 792.

> failure to perform the duty or act to ameliorate the risk of injury was a proximate cause of plaintiff's deprivation of rights under the Constitution.[177]

Accordingly, the court reversed and remanded the child's claim that state officials were deliberately indifferent to her rights.[178]

More recently, the standard articulated in *Doe* and *Taylor* was applied in *Nicini v. Morra*[179] and *Jacobs v. Impact Project.*[180] In *Nicini v. Morra*, an abused and suicidal fifteen-year-old, Anthony Nicini, was provided with drugs and alcohol while in the custody of the Division of Youth and Family Services, and sexually assaulted by Edward Morra, his "para-foster care" parent.[181] Anthony did not tell his case manager or attorney about the assaults, despite visits and interviews.[182] However, Anthony brought suit under the Fourteenth Amendment, alleging his case manager "deprived him of 'the right to be free from the infliction of unnecessary pain or abuse . . . and the fundamental right to physical safety.'"[183] In looking to whether the case manager was deliberately indifferent to the child's safety, the court noted that the case manager performed a perpetrator check on Morra, which did not reveal a record of sexual abuse.[184] The court, therefore, affirmed that "a jury could not permissibly conclude that [the case manager's] investigation was so inadequate as to manifest deliberate indifference to Anthony's rights."[185] Summary judgment was granted.[186]

In her dissent, however, Judge Rendell reasoned that "more than one reasonable inference can be drawn from the facts, including an inference of deliberate indifference that shocks the conscience."[187] Looking to the thirteen-page, single-spaced report provided by the psychologist in the case, Judge Rendell found it was "glaringly obvious that some investigation was necessary before placing a suicidal teenager in a home where children were permitted to 'drink and party.'"[188] She reasoned that the child's problems went beyond those of the "average troubled juvenile," and that as a result, "[Anthony] required a heightened level of attention by those charged with responsibility for his care."[189] She further noted that based on the psychologist's report it was clear to the case manager that the foster parent needed to provide a stable and supportive environment to the child.[190] Nevertheless, the case manager exerted little or no

177. *Id.* at. 797.
178. *Id.* at 800.
179. 212 F.3d 798, 810 (3d Cir. 2000).
180. 2005 WL 1459333, at *1 (E.D.Pa. 2005).
181. *Nicini*, 212 F.3d at 801, 804.
182. *Id.* at 813.
183. *Id.* at 806.
184. *Id.* at 802.
185. *Id.* at 814.
186. *Id.* at 815.
187. *Id.* at 816 (Rendell, J., dissenting).
188. *Id.* at 817.
189. *Id.*
190. *Id.* at 818.

effort to determine whether the Morra home was appropriate.[191] Judge Rendell therefore concluded that the majority "short-circuited" the process of addressing the troubled Anthony's due process rights.[192]

In *Jacobs*, while in foster care, twelve-year-old Matthew Jacobs was struck by a locomotive and killed.[193] Matthew's representative brought suit against the caseworker who placed Matthew in foster care for a violation of his Fourteenth Amendment substantive due process right to placement in a foster home that provided appropriate supervision.[194] The court found the plaintiff did not prove the case manager knew of and disregarded "an excessive risk of serious harm," such that her conduct "shock[ed] the conscience."[195] At most, the court found she may have been negligent.[196] Summary judgment was granted.[197]

Despite the various outcomes of the foregoing cases, the courts apply the same standard—whether deliberate indifference to a known injury, a known risk, or a specific duty resulted in the plaintiff's harm.[198] When it comes to preventing pregnancy in foster care, the state has a duty to provide proper medical care, including family planning and sex education. Where such medical care is not provided, whether due to poor case management, case worker ambivalence, minimal training, political barriers, or conscientious objection, deliberate indifference to the rights of youth in foster care can be established.

The facts in *Andrea L.* are illustrative in this regard. In that case, fourteen-year-old Andrea was known by social services to be sexually active.[199] Despite this knowledge, the only action by social services to assist Andrea was the administration of a psychological test.[200] The administration of a psychological test on its own was not enough; something more, such as family planning services were required. Under the standard articulated in *Taylor*, Andrea's case worker exhibited deliberate indifference to a known risk: pregnancy. Assuming other medical care, such as contraception, was not made available, Andrea's case worker failed to mitigate the known risk. Moreover, because Andrea's case worker had knowledge of her sexual activity, there was more than enough information to draw an inference that pregnancy could occur, particularly after a psychological test revealed that Andrea had a "strong libido." In a court employing the deliberate indifference standard and upon the inclusion of different and additional facts demonstrating failure to provide medical care, Andrea could have likely been successful in a section 1983 suit for a violation of her Fourteenth Amendment rights.

191. *Id.*
192. *Id.* at 821.
193. *Jacobs*, 2005 WL 1459333, at *1.
194. *Id.*
195. *Id.*
196. *Id.*
197. *Id.*
198. *Taylor*, 818 F.2d at 797.
199. *Andrea L.*, 987 F. Supp. at 419.
200. *Id.*

More generally, when case managers' caseloads exceed a manageable limit, their attention to specific duties, as required by state statutes and policies, cannot be fulfilled. Because an inference can be drawn that there is a risk to a child if they do not have proper medical care, if the failure of case workers to fulfill their proper duties includes the failure to ensure all clients have obtained proper and age-appropriate medical care, then the substantive due process rights of those young people have been violated. As another example, if a political barrier prevents youth from learning basic human development through sex education, then those youths' substantive due process rights have been violated because most, if not all, people involved with children in the foster care system are aware of the negative outcomes associated with early pregnancy, especially for foster children. In each instance, the state's deliberate indifference toward providing proper medical care to those in its custody has caused harm for which a remedy is afforded under section 1983 and the Fourteenth Amendment.

2. Professional Judgment

The professional judgment standard looks to whether professional judgment was made in accordance with accepted standards or practices.[201] One commentator has remarked that this standard assesses what the defendants knew or should have known in determining liability for harm.[202]

In *LaShawn v. Dixon*, a class action was brought on behalf of children in foster care, as well as children not in State custody but who were known to the Department of Human Services because of previous abuse or neglect.[203] The court applied the professional judgment standard, noting that

> [t]he foster children that make up the plaintiff class in this case have done society no wrong and they deserve no punishment. It would be inappropriate to force them to endure constitutional deprivations absent a showing of "deliberate indifference" by their caretakers. At the same time, it would be inappropriate to hold caretakers liable for constitutional deprivations when those caretakers had exercised their professional judgment in determining the best course of conduct.[204]

The court therefore applied the professional judgment standard to the defendants' alleged violations, which included failure to place plaintiffs appropriately, prepare case plans, monitor placements, and ensure permanent homes, among other things.[205] The court noted that the child welfare system's "outrageous deficiencies" and failures were not the result of "choosing among

201. *Braam*, 81 P.3d at 859.
202. Strasser, *supra* note 167, at 233.
203. LaShawn v. Dixon, 762 F. Supp. 959, 960 (D.D.C. 1991).
204. *Id.* at 996.
205. *Id.*

several professionally acceptable alternatives."[206] Rather, the failures were "the result of making no choices at all."[207] Accordingly, defendants were held liable for violating the federal and local statutory rights of the children in the plaintiff class.[208]

In *Wendy H. v. City of Philadelphia*, involving sexual abuse of a child in foster care, the court also applied the professional judgment standard.[209] The court reasoned that, in making out a constitutional violation, plaintiffs could "employ evidence of misconduct which is not predicated on actual knowledge of harm or risk."[210] The court also noted that those working under the professional judgment standard are "constitutionally required not just to respond to danger . . . which they have been put on notice to, but to act in a manner which avails them of that notice."[211]

The court in *Kara B. v. Dane County* also held that the professional judgment standard was appropriate in a case involving two children who were sexually abused while in foster care.[212] The children brought a section 1983 claim brought against the Department of Human Services, its agents, and the woman charged with running the foster home.[213] The court reasoned that the professional judgment standard was appropriate because foster children, like the involuntarily committed,[214] are generally not at fault for their circumstances and, as such, are entitled to more considerate treatment than is applied to criminals under the deliberate indifference standard.[215]

In *Jordan v. City of Philadelphia*, three sisters brought suit under state law and the Due Process Clause against several individuals, including employees of a foster care agency, for alleged instances of forced sexual activity by their foster parent's teenage son.[216] In applying the professional judgment standard, the court found that "Defendants' alleged conduct of ignoring warnings and reports of abuse prior to and during the placement process could constitute a failure to adhere to the 'professional judgment' standard."[217] The court went on to find that actual knowledge of harm or risk was not required; rather, evidence of "simple misconduct" was enough.[218] Defendants' motion to dismiss plaintiff's

206. *Id.* at 997.
207. *Id.*
208. *Id.* at 998.
209. Wendy H. *ex rel* Smith v. City of Philadelphia, 849 F. Supp. 367, 370 (E.D.Pa. 1994).
210. *Id.* at 374.
211. *Id.* at 373.
212. Kara B. v. Dane Cnty., 555 N.W.2d 630, 631 (Wis. 1996).
213. *Id.*
214. *See* Jordan v. City of Philadelphia, 66 F. Supp. 2d 638, 646 (E.D.Pa. 1999) ("The required 'professional judgment' standard for the state's care in mental institutions is extended as well to the proper duty of care owed to a foster child."); *see also Wendy H.*, 849 F. Supp. at 372.
215. *Kara B.*, 555 N.W.2d at 637–38.
216. *Jordan*, 66 F. Supp. 2d at 641.
217. *Id.* at 646.
218. *Id.*

"compelling claim" under the Fourteenth Amendment was denied.[219]

The court in *Braam v. Washington* reasoned similarly and applied the professional judgment standard to the Department's conduct in a class action suit brought against it to reduce the number of times foster children were moved while in care.[220] The court explained that "[f]oster children are entitled to a high standard. Something more than refraining from indifferent action is required to protect these innocents."[221] Moreover, "[f]oster children need both care and protection. The state owes these children more than benign indifference and must affirmatively take reasonable steps to provide for their care and safety."[222] Accordingly, the court held that foster children have substantive due process rights to be free from an unreasonable risk of harm.[223]

As applied to *Andrea L.*, the professional judgment standard dictates that Andrea's case manager who responded to known sexual activity with a psychological test failed to comply with accepted standards of practice. As a young teen in foster care, Andrea was entitled to age-appropriate medical care that should have addressed her needs related to preventing pregnancy. A psychological test did not meet these needs. Moreover, Andrea's case worker was informed that Andrea was sexually active and, accordingly, knew or should have known she was at risk of pregnancy. Consequently, if the facts had shown that the state did not provide Andrea with pregnancy prevention services, Andrea could have prevailed under the professional judgment standard in a suit alleging violation of her substantive due process rights under section 1983.

Generally, case workers know or should know that pregnancy rates are high among children in foster care. Tracing the court's reasoning from *Wendy H.*, where the court explained that case workers must work in a manner that not only responds to danger, but is also on notice of common dangers, case workers and child welfare agencies must not only respond to pregnancy when it occurs, but must actively ensure that youth are equipped to prevent it. Moreover, case workers know or should know that outcomes among former foster youth are often poor, and that such outcomes become even worse for pregnant and parenting youth. This is the kind of benign indifference toward foster children that the *Braam* court found impermissible.

Under both the deliberate indifference and professional judgment standards, foster children have an actionable claim against the offending agency when system failure occurs. To prevent the circumstances that lead to these claims, to advance the welfare of children, and to avoid early and unplanned pregnancy in foster care, many reforms are necessary. Suggestions for reform follow.

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219. *Id.*
220. *Braam*, 81 P.3d at 859.
221. *Id.*
222. *Id.*
223. *Id.* at 715.

V. FEDERAL, STATE, AND LOCAL REFORM

Despite the ongoing struggles of children in foster care, improvements have been made and the system is ever evolving. The Child and Family Services Review (CFSR) is one way improvements are encouraged and evaluated. The purpose of the CFSR is to "(1) ensure conformity with [f]ederal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist States to enhance their capacity to help children and families achieve positive outcomes."[224] After a state completes the CFSR, they create a Program Improvement Plan to address areas in need of improvement.[225]

However, the broad nature of assessing physical health in the CFSR results in the reproductive health and medical care associated with pregnancy prevention being frequently overlooked. The CFSR focuses on three primary categories: safety, permanency, and child and family well-being.[226] Within those three primary areas, seven outcomes are assessed by measuring twenty-three "items."[227] Under the category addressing child and family well-being, the CFSR measures whether children are receiving adequate services to meet their physical and mental health needs.[228] Specifically, under "Item 22," the CFSR assesses the physical health of the child.[229] Reviewers are asked if the agency ensured that "appropriate services were provided to the child to address all identified physical health needs."[230]

This article proposes that the CFSR should account specifically for a state's pregnancy prevention efforts and the number of children born to mothers in care. [231] By adding a provision that accounts for pregnancy prevention, the

224. U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN & FAMILIES, CHILDREN'S BUREAU, CHILD AND FAMILY SERVICES REVIEWS, http://www.acf.hhs.gov/programs/cb/monitoring/child-family-services-reviews (last accessed Oct. 24, 2012).

225. *Id.*

226. U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN & FAMILIES, CHILDREN'S BUREAU, CHILD AND FAMILY SERVICES REVIEWS, ONSITE REVIEW INSTRUMENT AND INSTRUCTIONS 1 (2008), *available at* http://www.acf.hhs.gov/sites/default/files/assets/onsitefinal.pdf.

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

231. Most states do not track or report pregnancies among youth in foster care and thus it is unclear how many foster youth become pregnant and have children. LOVE et al., *supra* note 61, at 25. Repeatedly, the lack of data is cited as a prominent problem. *See* Boonstra, *supra* note 27, at 8 ("part of the problem may be lack of awareness and information about this high-risk population when it comes to teen pregnancy"). The NCJFCJ judges surveyed reported that only 17 percent obtain data on teen pregnancies in their jurisdictions. NAT'L CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY, CRITICAL JUDGMENT: HOW JUVENILE AND FAMILY COURT JUDGES CAN HELP PREVENT TEEN AND UNPLANNED PREGNANCY 9 (2009), *available at* http://www.thenationalcampaign.org/resources/pdf/pubs/critical_judgment.pdf [hereinafter *Critical Judgment*]; THE NAT'L CAMPAIGN TO PREVENT TEEN AND UNPLANNED

CFSR could track states' efforts and measure whether there is a reduction in pregnancy and child bearing among foster youth. To be clear, only efforts should be tracked; states should not subject youth to coercive tactics or mandated birth control in order to reduce pregnancy rates in foster care. By accounting for pregnancy prevention efforts in the CFSR, states would be required to prioritize access to medical care and sex education. Including prevention efforts in the CFSR would also encourage states to ensure that "system failure," regardless of the reason, does not occur.

Moreover, because the CFSR looks at child welfare services, accounting for prevention efforts and pregnancy could encourage the development and application of tailor-made, evidence-based programs for youth in foster care. Given that "teen pregnancy prevention initiatives seldom focus on the special needs of youth who have spent time in the foster care system,"[232] accountability in the CFSR would necessitate broad programmatic change, leading to fewer pregnancies in care. Fewer pregnancies may result in fewer infants being brought into foster care, which is a common result in many states when a child is born to a foster youth. Finally, accountability in the CFSR would be consistent with the federal Department of Health and Human Services' efforts to help populations at high risk of teen pregnancy, including youth in foster care.[233]

If states were held accountable for their efforts at pregnancy prevention among foster youth, state agencies would be encouraged to implement new evidence-based programs, as well as collaborate with community partners and other stakeholders to prevent pregnancy among foster youth. Doing so would not only help prevent pregnancy but also improve the lives and outcomes of youth in foster care, a key goal of the CFSR. The following sections detail some ways in which states could implement prevention efforts.

A. Fostering Connections

The Fostering Connections to Success and Increasing Adoptions Act of

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PREGNANCY, SCIENCE SAYS: FOSTER CARE YOUTH 1 (2006), *available at* http://www.thenationalcampaign.org/resources/pdf/SS/SS27FosterCare.pdf ("[E]xact rates of teen pregnancy and teen childbearing among foster care youth are not known."); Dworsky, *supra* note 11, at 1 ("[W]e don't really know how many foster youth become . . . pregnant.").

232. Boonstra, *supra* note 27, at 11.

233. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., SECRETARY'S STRATEGIC INITIATIVES & KEY INTER-AGENCY COLLABORATIONS 17, *available at* http://www.hhs.gov/secretary/about/secretarialstrategicinitiatives2010.pdf (explaining that reducing teen and unintended pregnancy is among the Secretary of Health and Human Services' "key inter-agency collaborations"). Accordingly, the efforts of the federal Department of Health and Human Services

> will focus on demographic groups who have the highest teen pregnancy rates, including Hispanic, African-American, and American Indian youth, and will target services to high-risk, vulnerable, and culturally underrepresented youth populations. Such populations include youth in foster care, runaway and homeless youth, youth with HIV/AIDS, youth living in areas with high teen birth rates, delinquent youth, and youth who are disconnected from usual service delivery systems.

Id.

2008 (Fostering Connections) has been regarded as "the most significant federal child welfare reform in more than a decade."[234] Fostering Connections' purpose is "to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access [and] improve incentives for adoption."[235] Fostering Connections is far reaching and includes four primary mechanisms that could effectively assist states with pregnancy prevention. First, Fostering Connections altered federal law by providing states with the option of reimbursement for Title IV-E foster care, adoption, or guardianship for youth up to age twenty-one.[236] Second, Fostering Connections requires states to implement a transition plan for youth emancipating from foster care.[237] Third, Fostering Connections requires states to plan for ongoing oversight and coordination for youth in foster care.[238] Finally, Fostering Connections increases the reimbursement rate for training people involved in the child welfare system, such as attorneys, social workers, and prospective guardians.[239]

Implementing the requirements of Fostering Connections may prevent pregnancies of youth who stay in foster care after turning eighteen and those who emancipate out of the foster care system. To extend foster care beyond age eighteen under Fostering Connections, the participating youth must be (1) completing their secondary education or a program leading to an equivalent credential; (2) enrolled in an institution that provides post-secondary or vocational education; (3) participating in a program or activity designed to promote, or remove barriers to, employment; (4) employed for at least eighty hours per month; or (5) incapable of doing any of the activities above as the result of a documented medical condition.[240] In one study, researchers at Chapin Hall found that allowing female youth to remain in care after age eighteen may reduce the risk of becoming pregnant.[241] This finding may require more research, but initial studies are nevertheless promising; at the very least, the additional time in care allows for more time to prepare young people to transition to adulthood.[242]

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234. *See* Rob Geen, *The Fostering Connections to Success and Increasing Adoptions Act: Implementation Issues and a Look Ahead at Additional Child Welfare Reforms* 2 (Child Trends, Working Paper, 2009), *available at* http://www.fosteringconnections.org/tools/assets/files/CT_Whitepaper_Rob_Geen_09.pdf.

235. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 § 201, 122 Stat. 3949 (2008).

236. *Id.* § 201, 122 Stat. 3957-58.

237. *Id.* § 202, 122 Stat. 3959.

238. *Id.* § 205, 122 Stat. 3961.

239. *Id.* § 203, 122 Stat. 3959-60.

240. *Id.* § 201, 122 Stat. 3958.

241. MARK E. COURTNEY, CALIFORNIA'S FOSTERING CONNECTIONS TO SUCCESS ACT AND THE COST AND BENEFITS OF EXTENDING FOSTER CARE TO 21 8 (2009), *available at* http://www.cafosteringconnections.org/pdfs/Courtney,%20Dworsky,%20&%20Peters%20%282009%29%20FC%20to%2021.pdf.

242. Dworsky, *supra* note 11, at 4.

If extending care beyond eighteen is not a viable option for a state, implementing the Fostering Connections transition plan for children "aging out" of care is another means of equipping youth to avoid pregnancy in early adulthood. During the ninety-day period prior to the foster youth's eighteenth birthday, a caseworker and other representatives of the child must help the child develop a personalized transition plan that includes "specific options on housing, health insurance, education, local opportunities for mentors and continuing support services" among other things.[243] The National Campaign suggests that federal regulations should require states to include access to reproductive health services among the options provided in the transition plan.[244] The National Campaign has likewise recommended that states include sex education in the transition plan, and that case workers distribute resources on "sexual health, healthy relationships, the consequences of early pregnancy and parenting, and pregnancy prevention."[245] Some states, such as South Carolina, have already included a watered-down version of this suggestion in their transition plan.[246] However, it is unclear whether the policies translate to services rendered.

Fostering Connections also requires states to consult with pediatricians, experts in child welfare and recipients of child welfare services, and develop a plan for the oversight and coordination of health care services for children and youth in foster care.[247] Importantly, this provision of Fostering Connections requires consultation with youth, since they are the recipients of child welfare services.[248] Involving youth in decisions about child welfare services is imperative not only because their perspectives matter but also because it can result in more effective, age-appropriate services, ensuring that early or unplanned pregnancy can be effectively avoided.[249]

Finally, Fostering Connections also put in place increased reimbursement rates for training those involved in the delivery of child welfare services, including attorneys, case workers, foster parents, and state-licensed agencies.[250] This provision represents a prime opportunity for states to take steps to educate anyone involved in child welfare services, as each person involved in a child's

243. Pub. L. No. 110-351 § 202, 122 Stat. 3959 (2008). As discussed in the footnote above, these efforts may be "too little, too late." *See* LOVE et al., *supra* note 61, at 15.

244. NAT'L CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY, BRIEFLY . . . : OPPORTUNITIES TO HELP YOUTH IN FOSTER CARE: ADDRESSING PREGNANCY PREVENTION IN THE IMPLEMENTATION OF THE FOSTERING CONNECTIONS TO SUCCESS AND INCREASING ADOPTIONS ACT OF 2008 (2009), *available at* http://www.thenationalcampaign.org/resources/pdf/Briefly_Youth_Foster_Care.pdf.

245. *Id.*

246. S.C. DEP'T OF SOC. SERVS., HUMAN SERVICES POLICY & PROCEDURE MANUAL 180, *available at* https://dss.sc.gov/content/library/manuals/foster_care.pdf.

247. Pub. L. No. 110-351 § 205, 122 Stat. 3961 (2008).

248. *Id.*

249. Barbara Bennett Woodhouse, *The Courage of Innocence: Children as Heroes in the Struggle for Justice*, 2009 U. ILL. L. REV. 1567, 1580-1585 (2009); *see generally* Erik S. Pitchal, *Where Are All the Children? Increasing Youth Participation in Dependency Proceedings*, 12 U.C. DAVIS J. JUV. L. & POL'Y 233, 233–62 (2008).

250. Pub. L. No. 110-351 § 203, 122 Stat. 3959 (2008).

life has a responsibility to help prevent pregnancy. Training could be especially beneficial for foster parents.[251] Foster youth echo this sentiment, noting that "it would help if foster parents were trained on how to deal with teenagers and sex."[252]

Judges are also key to pregnancy prevention. As reported by the National Campaign and the National Council of Juvenile Court and Family Court Judges (NCJFCJ), in 2009, 73 percent of judges surveyed agreed that teen pregnancy is a concern to them in their professional roles.[253] However, only 4 percent were conducting system-wide trainings on preventing pregnancy in the dependent court system.[254] Members of a focus group within NCJFCJ felt that information and training on prevention would best be distributed through the model courts or, in larger states such as California and Florida, at statewide trainings.[255] Case workers have also explained that they need training on pregnancy prevention, adolescent development, and teen sexual behaviors.[256] To address these concerns, the National Campaign has suggested that states not only take steps to educate staff and guardians, but also to rely on appropriate community partners to provide education and services related to pregnancy prevention.[257] Fostering Connections can be a source of funds for states to carry out training that is widely seen as a need among those who work in child welfare. If states were to properly implement Fostering Connections and account for their efforts and outcomes in the CFSR, pregnancy among foster youth could be effectively reduced.

B. Sex Education

In many states, medical care includes sex education for children in foster care. Sex education must be accessible and comprehensive, such that it is age-appropriate and includes instructions on preventing pregnancy. For foster children to experience truly comprehensive sex education, their unique needs, emotional stressors, and experiences with abuse must be adequately considered and addressed. Emphasis on mental health and substance abuse must also be included. Additionally, sex education must be inclusive of all youth, including those who are lesbian, gay, bisexual, transgender, or questioning their sexual

251. For an example of training materials, see NAT'L CAMPAIGN TO PREVENT TEEN PREGNANCY, 10 TIPS FOR FOSTER PARENTS TO HELP THEIR FOSTER YOUTH AVOID TEEN PREGNANCY (2006), *available at* http://www.thenationalcampaign.org/resources/pdf/pubs/10TipsFoster_FINAL.pdf.

252. Love et al., *supra* note 61, at 15.

253. *Critical Judgment*, *supra* note 231, at 6.

254. *Id.* at 9.

255. *Id.* at 11–13.

256. *Id.* at 25; American Public Human Services Association, *Briefly . . . It's your Responsibility to Talk to Youth: Pregnancy Prevention for Youth in Foster Care: A Tool for Caregivers and Providers*, (Mar. 2010), *available at* http://www.thenationalcampaign.org/resources/pdf/Briefly_ItsYourResponsibility.pdf.

257. NAT'L CAMPAIGN, BRIEFLY, *supra* note 244.

orientation.[258] Currently, Power Through Choices is the only curriculum designed with the needs of youth in foster care in mind, and it should be considered for use among more youth in care.[259] This curriculum is designed to help youth prevent pregnancy and sexually transmitted infections, including HIV. It specifically engages youth to help them build self-empowerment and decision making skills.[260] The development of other programs addressing the unique needs of foster children may likewise be beneficial.[261]

In addition to being comprehensive, sex education must be accessible. Sex education for foster youth could be improved by guaranteeing accessibility to all teens and young adults. However, there are myriad reasons why foster youth might not access sex education while in care. Although some youth access sex education through independent living services, some do not participate in independent living programs and others may be too young.[262] Sex education should, therefore, be offered prior to and separate from independent living services.

School is an obvious access point to sex education, although many schools still lag behind in providing age appropriate, comprehensive programming. Additionally, despite being more likely than the average population to experience an unintended pregnancy or sexually transmitted disease, youth in foster care are less likely to access sex education in school because of the transient nature of foster care and placement instability.[263] For youth in foster care, missing school is common, due to frequent court proceedings or truancy, or because the youth transfers to a new school after a change in placement. As a result, foster youth may also miss sex education even if the school does provide

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258. Even if pregnancy is not a possibility with a same-sex partner, caregivers for youth in foster care must consider that gay or lesbian youth have the same emotional needs as their heterosexual peers, and therefore may choose an opposite-sex partner as a means of becoming pregnant. LAMBDA LEGAL, YOUTH IN THE MARGINS (2001), *available at* http://data.lambdalegal.org/pdf/29.pdf. Additionally, like all youth, LGBTQ youth also need counsel and education related to sexually transmitted diseases. *Id.*

259. CA ADOLESCENT HEALTH COLLABORATIVE, PROMOTING THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS IN FOSTER CARE (2012), *available at* http://www.californiateenhealth.org/download/FosterCareBrief4-2web.pdf; Marla G. Becker & Richard P. Barth, *Power Through Choices: The Development of a Sexuality Education Curriculum for Youths in Out-of-Home Care*, 79 CHILD WELF. LEAGUE OF AM. 269 (2000).

260. Becker, *supra* note 259.

261. For instance, there is no program designed specifically to address the longstanding effects of sexual abuse on foster youth. Other programs designed to evaluate the development and academic growth of foster children may also be beneficial. The timing and length of a program should also be considered for purposes of its effectiveness.

262. Constantine et al., *supra* note 77, at 14.

263. *Id.* at 4; *see, e.g.*, SAN LUIS OBISPO COUNTY DEP'T OF SOC. SERVS., A SNAPSHOT OF CHILDREN IN FOSTER CARE 6 (2010), http://www.slocounty.ca.gov/Assets/DSS/Reports/FC_Snapshot.pdf (indicating that 15% of children in foster care in San Luis Obispo County, California, had more than six placements in one year); *see also* Charles L. Usher et al., *Placement Patterns in Foster Care*, 73 SOC. SERV. REV. 1, 23 (1999), http://www.jstor.org/stable/pdfplus/10.1086/515794.pdf?acceptTC=true (discussing the harm children experience due to multiple placements).

an age appropriate, comprehensive program in the first place. Some youth may get sex education one year, but miss it the next, or have it for one day, but miss the rest of the series.

Alternatively, some youth may not access sex education because they are placed in a faith based group home or religious foster family, which frequently refuse to sign the permission slips required for sex education. In these cases it is difficult to assure that education has been offered because records on the subject matter are rarely kept. If foster parents are not providing or supplementing sex education, youth in foster care are unlikely to obtain it. At the very least, youth must be equipped with information to make informed decisions about their bodies.

Poor access to quality sex education is a serious problem among youth in foster care. Sex education has been shown to help protect youth from risky sexual behavior.[264] Addressing this systemic shortcoming by assuring access to comprehensive, age-appropriate education and delivering uniquely tailored programming would go a long way toward reducing pregnancies among youth in foster care. States could be motivated to provide such education to youth in foster care if the CFSR measured pregnancy rates among foster youth and if states documented their efforts at pregnancy prevention, including sex education.

C. State Law and Policy

A young person's status as a foster child must not prevent consistent application of current law and policy that effectively promotes access to reproductive medical care.[265] Consent and confidentiality laws are the foundation for ensuring access to reproductive medical care for all persons, including youth in foster care. In most states, a minor, even if he or she is in foster care, is permitted under law to consent to contraceptive services: as of July 2011, twenty-one states and the District of Columbia allow all minors to consent to contraceptive services.[266] Twenty-five states have policies allowing minors to consent to contraceptive services under various circumstances.[267] Four states—North Dakota, Ohio, Rhode Island, and Wisconsin—have no explicit policy on minor consent to contraception.[268] These laws must not be applied differently to youth in foster care. Moreover, youth in foster care must be educated about their state-specific rights.

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264. Trisha Muller et al., *The Association Between Sex Education and Youth's Engagement in Sexual Intercourse, Age at First Intercourse, and Birth Control Use at First Sex*, 42 J. OF ADOLESCENT HEALTH 89, 95 (2008).

265. Some studies have questioned the stringent application of statutory rape laws to reduce pregnancy as ineffective. *See* Cynthia Dallard, *Statutory Rape Reporting and Family Planning Programs: Moving Beyond Conflict*, 7 GUTTMACHER REPORT ON PUBLIC POLICY 10, 10-12 (2004), http://www.guttmacher.org/pubs/tgr/07/2/gr070210.html.

266. Guttmacher Inst., *State Politicies in Brief: Minors' Access to Contraceptive Services*, (Oct. 1, 2012), http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf.

267. *Id.*

268. *Id.*

State confidentiality laws, however, may not afford minors the protection they need to feel comfortable accessing reproductive health services. For example, in Georgia, a female minor may consent to reproductive medical care.[269] However, the health care provider may inform the minor's custodian that services have been rendered "even over the express refusal of the minor patient."[270] The federal Health Insurance Portability and Accountability Act (HIPAA) does not fully protect minors in this instance because the privacy rule allows parents to access medical records when such access is not inconsistent with state law, like that in Georgia.[271]

However, some resources do exist to provide reproductive medical care to minors without interference from non-consenting custodians. For example, HIPAA protects minors from disclosure of confidential health information to a minor's parent when the minor has been subject to abuse or neglect.[272] This provision of the law may present a loophole for youth in foster care to obtain confidential services.[273] Title X clinics also offer confidential services to minors that cannot be eroded by state law.[274] These clinics provide access to contraception and services for all who want them, with priority given to low-income individuals.[275] Services must be rendered without regard for a minor's status as a foster child. Finally, some states require that services rendered under State Children's Health Insurance Programs (CHIP) and Medicaid, which insure children in foster care, are confidential.[276]

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269. GA. CODE ANN. § 31-9-2(a)(5) (2011).

270. GA. CODE ANN. § 31-17-7(b).

271. U.S. Dep't of Health & Human Servs., *Does the HIPAA Privacy Rule Allow Parents to See Their Children's Medical Records?*, (Oct. 22, 2012), http://www.hhs.gov/hipaafaq/personal/227.html.

272. *Id.*

273. *Id.* ("A provider may choose not to treat a parent as a personal representative when the provider reasonably believes . . . that the child has been or may be subjected to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.").

274. Rebecca Gudeman & Sara Madge, *The Federal Title X Family Planning Program: Privacy and Access Rule for Adolescents*, YOUTH LAW NEWS, Jan.-Mar. 2011, http://www.youthlaw.org/publications/yln/2011/jan_mar_2011/the_federal_title_x_family_planning_program_privacy_and_access_rules_for_adolescents/; 42 C.F.R. § 59.11 (2011), stating:

> All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals.

See also County of St. Charles v. Missouri Family Health Council, 107 F.3d 682 (8th Cir. 1997), *reh. denied* 1997 U.S. App. LEXIS 6564, *cert. denied* 522 U.S. 859 (1997)*; see* Does 1-4 v. Utah Dep't of Health, 776 F.2d 253 (10th Cir. 1985); Planned Parenthood Assoc. of Utah v. Matheson, 582 F. Supp. 1001, 1006 (D. Utah 1983); Doe v. Pickett, 480 F. Supp. 1218, 1220-21 (D.W.Va. 1979).

275. Office of Population Affairs, *Title X Family Planning*, (Oct. 22, 2012), http://www.hhs.gov/opa/title-x-family-planning/.

276. Rachel Benson Gold & Adam Sonfield, *Reproductive Health Services for Adolescents under*

Nevertheless, the state agencies responsible for children in foster care often have their own policies, which may diverge from or conflict with state law. For instance, in South Carolina, a minor sixteen and older may consent to contraceptive services.[277] Minors under sixteen may access health services when deemed necessary by a health care provider.[278] However, under the Department of Social Services' policies, parents may be given the opportunity to consent whenever possible.[279] Thus, a minor under sixteen may be eligible to receive medical care, such as family planning services, because it has been deemed necessary, but a parent could easily withhold consent under DSS policy. Georgia's Department of Human Services has a similar policy, which provides that parents should be involved with decisions surrounding contraception and dating if parental rights have not been terminated.[280] These conflicting policies are ripe for reform. States should align their foster care polices with state laws and better account for the reproductive health needs of youth in foster care, including the confidential delivery of services.[281]

There are other opportunities for reform in current law and policy. Examples include specific legislation that addresses the provision of reproductive health care,[282] or improves access to sex education and contraception for youth in foster care. States without a clear statement defining foster youths' rights may consider creating a foster care bill of rights that includes the right to access reproductive medical care. Several states have codified or otherwise enacted such laws.[283] It is important to note that

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the State Children's Health Insurance Program, 33 FAMILY PLANNING PERSPECTIVES 81, 83-84 (2001), http://www.guttmacher.org/pubs/journals/3308101.pdf.

277. S.C. CODE ANN. § 63-5-340 (2011).

278. S.C. CODE ANN. § 63-5-350 (2011) ("Health services of any kind may be rendered to minors of any age without the consent of a parent or legal guardian when, in the judgment of a person authorized by law to render a particular health service, such services are deemed necessary.").

279. *Foster Care Services, Needs of the Child*, *supra* note 82, at 7-8; S.C. DEP'T SOCIAL SERVS., HUMAN SERVICES POLICY AND PROCEDURE MANUAL, *available at* https://dss.sc.gov/content/library/manuals/index.aspx.

280. FOSTER CARE SERVICES, NEEDS OF THE CHILD § 1015.18 (2007), http://www.childwelfare.net/DHR/policies/3060_pdf/1015.pdf.

281. *SAM Position Statement: Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 J. ADOLESCENT HEALTH 160, 160 (2004), http://www.adolescenthealth.org/AM/Template.cfm?Section=Position_Papers&Template=/CM/ContentDisplay.cfm&ContentID=2597.

282. *See, e.g.*, CAL. WELF. & INST. CODE § 16521.5(a) (2011) ("A foster care provider, in consultation with the county case manager, shall be responsible for ensuring that adolescents who remain in long-term foster care, as defined by the department, receive age-appropriate pregnancy prevention information to the extent state and county resources are provided.").

283. SHANNON DOUGHERTY, RIGHTS OF CHILDREN IN FOSTER CARE (2005), *available at* http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/rights-children-foster-care.pdf; *see, e.g.*, CAL. WELF. & INST. CODE § 16001.9 (2011) (it is the policy of the state that children in foster care shall receive medical services); FLA. STAT. § 39.4085 (2011) (children in foster care shall enjoy their dignity and have their legal rights protected, and shall have medical assessments and access to medical services); N.J. STAT. ANN. § 9:6B-4*(o)*; R.I. GEN. LAWS § 42-72-15 (1979); LAWYERS FOR CHILDREN, YOUR RIGHTS IN FOSTER CARE (2011), *available at* http://www.lawyersforchildren.org/siteFiles/foster-care-docs/toc_Foster.htm;

articulating the rights of children in foster care in a specific bill of rights may fail to resolve the problems with pregnancy prevention care, given that many states already have policies and laws enforcing such rights and still fail to provide proper services. On the other hand, the notion that all children, including those in foster care, should have access to medical care has long been an argument advanced by child advocates.[284] In this regard, a general bill of rights respecting the rights of all children would help pregnancy prevention.[285]

CONCLUSION

Abuse and neglect is a devastating and often life-threatening occurrence for children. Foster care is often equally difficult to endure. Child abuse, neglect, and the ensuing time in state foster care is made even worse by an early or unplanned pregnancy. The constitutional and statutory guarantees of medical care in foster care are intended to improve outcomes; however, youth in foster care are significantly more likely than other youth to become pregnant and bear children. This must change.

The CFSR is one way to measure states' efforts at prevention and should be used for this purpose. However, it is not the only means available to facilitate progress in the area of foster care pregnancy prevention. States should be encouraged to adopt pregnancy prevention solutions that are evidence-based, proven to work, and are adaptable to the local community's needs. Input from experts and foster youth must be part of these solutions, and willing participation by youth must be emphasized. Together, these efforts could make a significant difference in the lives of current and former foster youth and better achieve the stated goals of the child welfare system.

YOUTH LEADERSHIP ADVISORY TEAM, MAINE YOUTH IN CARE BILL OF RIGHTS (2012), *available at* http://www.ylat.org/assets/rights/youth_bill_rights.pdf; TEX. DEP'T OF FAMILY & PROTECTIVE SERVS., RIGHTS OF CHILDREN AND YOUTH IN FOSTER CARE (2011), *available at* http://www.dfps.state.tx.us/child_protection/foster_care/rights.asp; MASS DEP'T OF CHILDREN & FAMILY RIGHTS, FOSTER CHILD BILL OF RIGHTS (2012), *available at* http://www.mass.gov/Eeohhs2/docs/dss/foster_child_rights.pdf.

284. CHILDREN'S DEFENSE FUND, POLICY PRIORITIES: HEALTH COVERAGE FOR ALL CHILDREN CAMPAIGN (Oct. 22, 2012), http://www.childrensdefense.org/policy-priorities/childrens-health/health-coverage-for-all-children-campaign/.

285. For an example of a proposed bill of rights, see Henry H. Foster, Jr. & Doris Jonas Freed, *A Bill of Rights for Children*, 19 FAM. L.Q. 343 (1985).