

# Social Services for Pregnant and Parenting Adolescents

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Anne Dellinger

INSTITUTE OF GOVERNMENT  
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# Preface

THIS GUIDEBOOK FOR DEPARTMENTS OF SOCIAL SERVICES (DSS) is one in a series explaining the law to pregnant and parenting adolescents, their parents, and the professionals who work with them. Knowing what choices are open, caseworkers, supervisors, directors, and attorneys should be better able to help these clients. While the legal issues discussed are relevant to any minor, the book draws attention to the youngest girls, those under fifteen, for two reasons: They present the legal issues most starkly, and they are arguably the neediest.

A note about terminology: No single name for pregnant and parenting female adolescents has seemed to me sufficiently accurate and respectful. I use both “girls” and “young women” in order to recognize the considerable differences in age and maturity within the group. Many sources, including the American Academy of Pediatrics’ Committee on Adolescence, are comfortable with the word “girls.” One admirable North Carolina practitioner uses it “to remind myself not to treat them as miniature adults.” Another practitioner, Judith S. Musick, wrote, “At 13, 14, 15, and 16 years old they may be mothers, but they are not yet women.”

Robert Coles’s book<sup>1</sup> on teen parents shows the range of views. Its text refers to “woman,” “young woman,” “mother,” “young mother,” and “youths.” One of the book’s photographers, though, almost always writes of “girls,” while the other uses “teenager,” “adolescents,” and “parents.” Most interestingly, when a male subject refers to himself, his mate, and other young parents as “boys and girls,” Coles suggests to him that they are “men and women.” The teen father emphatically rejects the suggestion.

Initially, I expected the “right” term to become clear to me, but after years, it has not. I now accept the verbal dilemma as a useful reminder of the

1. ROBERT COLES ET AL. *THE YOUNGEST PARENTS: TEENAGE PREGNANCY AS IT SHAPES LIVES* (1997).



ambivalence with which I—and most other adults—view adolescent sexuality and its consequences.

The choice of topics for the legal guides emerged from four kinds of research. First, the co-director of the Adolescent Pregnancy Project, Arlene Davis, who is a nurse as well as a lawyer, reviewed 186 medical records of girls pregnant when under fifteen years of age and 15 medical records, selected at random, of infants born to them. Most of these patients had delivered at a hospital in North Carolina after receiving prenatal care at a local health department. A smaller number had an abortion performed at the hospital or, in more cases, at a private urban clinic in the state. This review provided information about the medical and social problems affecting these patients both during pregnancy and sometimes for years to come; suggested the nature of their interactions with family members and health care providers; and gave an idea of what legal questions providers most want answered.

Second, I researched these questions in state and federal law.

Third, we interviewed more than 100 North Carolinians with some knowledge of adolescent pregnancy. They included nurses, nurse practitioners, physicians, and social workers in schools, hospitals, health departments, medical faculties, community outreach programs, nonprofit agencies, and private practice settings; maternity care coordinators; an owner, directors, and staff members of two abortion clinics; a counselor in a pregnancy support center; domestic violence and adoption specialists; judges, attorneys, and prosecutors; several parents of girls who became pregnant as young teens; two court-appointed guardians for such girls; and several adult women who had given birth as minors. To protect their privacy, we made no effort to contact pregnant girls or their partners. However, Arlene Davis observed two sessions at a teen prenatal clinic, and we listened for fifteen hours to telephone counselors as they staffed a national abortion referral line. I also saw, in person and on videotape, presentations that a dozen pregnant and parenting teens made in the Johnston County schools.

Fourth, we gathered data on facilities, programs, individuals to contact, written material, and other types of assistance available to adolescents and

DSS staff. It is available at [www.adolescentpregnancy.unc.edu](http://www.adolescentpregnancy.unc.edu) under the heading “DSS Resource List.”

We do not vouch for or endorse any resource; and the book offers information, not legal advice. For legal advice, readers must consult an attorney. In addition, because the law is constantly in flux, readers or their legal advisors must check statutes or regulations that are cited to see whether they have since been repealed or amended as well as any court decision for relevant subsequent decisions.

Besides the primary support provided by the Institute of Government at The University of North Carolina at Chapel Hill, I gratefully acknowledge the financial support of the Z. Smith Reynolds Foundation, the Karl and Anna Ginter Foundation, and the Mary Norris Preyer Fund in the research and writing of this book. The Z. Smith Reynolds Foundation and the Institute of Government generously funded its printing and distribution. In addition, I deeply appreciate the collaborative contributions of the Adolescent Pregnancy Project’s advisory committee and of many others who reviewed drafts of this publication and those who graciously talked with us or assisted the project in other ways. I thank those kind people who commented on drafts; Jill Moore, for the valuable section that concludes this book; Jane Thompson, child welfare attorney for the North Carolina Department of Justice, for her substantial assistance with the sections on adoption and on children in DSS custody; and many colleagues at the Institute of Government—above all Janet Mason, who saved me from many errors.

Anne Dellinger

July 2002



# Introduction

PREGNANT AND PARENTING GIRLS aged seventeen and younger are challenging clients. As a group they can benefit from considerable help from local departments of social services. Even a young woman who is mature, bright and competent for her age usually lacks some of the resources needed now or for the future—sufficient income and education, housing, transportation, health care, employment, child care and child support, among others. As a minor, she lacks the ability under law to control most—though not all—of her decisions. For these clients, as well as their parents, partners and children, DSS is a crucial source of assistance.

Under state law DSS may be called on to protect the minor from abuse, neglect, or dependency; to pass along to law enforcement information about domestic violence or other crimes that may have physically harmed a minor; perhaps to act as a minor's custodian, consenting to her medical care or other important matters; to seek termination of her parents' rights or of her own rights as a parent; to find a home for her and perhaps a child; or to help her place a child for adoption. For minors who need less support, DSS may still be the gateway to essential services such as Work First, child support, day care, Medicaid, or WIC. Another possibility is that DSS will encounter a minor solely as a parent when it undertakes for her child some of the obligations mentioned above.

Federal law also requires that DSS work with pregnant teens and pre-teens. Most directives are contained in the Welfare Reform Act of 1996, in which Congress points to early and out-of-wedlock pregnancy as serious social ills and charges the states with discouraging them in numerous specific ways.

This book is intended for DSS directors, caseworkers, and supervisors, and it may be of interest to their attorneys. It explains what the law asks DSS to do for these clients and tries to answer these professionals' legal questions as well as some that teens and their parents might ask. The guide's utility is

limited by the fact that state law governing DSS's relationship with children and families is sometimes unclear. Consider these examples: First, attorneys who specialize in DSS law disagree about such important matters as whether DSS must pass on information about statutory rape to law enforcement; whether DSS must place a minor mother's child with her in foster care—and if so, whether DSS must have custody of the younger child; and when DSS should share information about minor clients with their parents. Second, the word *custody*, which is central to DSS's relationship to some minors, has quite different meanings under the law. State statutes refer to DSS having “physical custody,” “temporary custody,” “legal custody,” and, when parental rights are terminated, “custody” with rights as extensive as guardianship over a minor. Yet, North Carolina statutes and regulations do not define custody or differentiate one form of it from another. Finally, lawmakers seem rarely to have contemplated the situation presented by minor parents, where DSS has the interests of two children—mother and child—to consider.

The information presented here is of several types. I explain reasonably clear legal requirements relevant to adolescents, but also offer an interpretation of less-clear issues, and sometimes venture predictions about unresolved legal questions. I refer to the literature on adolescent pregnancy and relay advice on practice from social services and medical organizations, treatises, and individuals. In addition, I make observations based on interviews with North Carolina DSS personnel and health providers and on the review of medical records of early adolescent patients. The goal is to make caring for this group of adolescents easier and to ensure that these young clients benefit as much as possible from their contact with DSS.

# Safety

THERE IS CONSIDERABLE EVIDENCE that pre- and early-teen sexual activity is often involuntary.<sup>1</sup> For that reason, the safety of pregnant adolescents,<sup>2</sup> especially the youngest girls, is a primary concern. A young female ordinarily has less power and experience than her partner and, in addition, may have been directly coerced. A substantial age difference “may make it hard for the young woman to resist [a partner’s] approaches and even more difficult for her to insist that contraceptives be used to prevent STDs and pregnancy.”<sup>3</sup> Judith Musick, a teen pregnancy researcher who also works with teen mothers, states that, while girls may appear to be eager initiators of sex, that “is probably not the case for many girls who become mothers in their teens, and it is surely not the case for those who become pregnant in their very early teens.”<sup>4</sup>

One study found that 61 percent of teen mothers reported at least one coercive sexual experience. Almost 30 percent reported coercion by a family member, and more than 50 percent reported coercion by a male friend. 46

1. Teens report rape and other sexual assaults at a higher rate than any other age group. Forty-four percent of victims in the rapes reported to police are girls under 18. Two-thirds of imprisoned rapists and sex offenders report having victims under 18 and 58 percent say they had a victim 12 or younger. Lawrence A. Greenfeld, *Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault*. NCJ163392, U.S. Dep’t of Justice (Feb. 1997). Available at [www.ojp.usdoj.gov/bjs](http://www.ojp.usdoj.gov/bjs).

2. In this book, “adolescent” means a girl or young woman under age eighteen, that is, those younger than the legal age of adulthood. The term includes pre-teens as well as teens.

3. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA’S TEENAGERS* 74 (1994). See also DAVID J. LANDRY & JACQUELINE DARROCH FORREST, *How Old Are U.S. Fathers?* 27 *FAM. PLAN. PERSP.* 159, 165 (1995). For a general discussion of the legal context, see SHARON ELSTEIN & NOY DAVIS, *ABA CTR. ON CHILDREN AND THE LAW, SEXUAL RELATIONSHIPS BETWEEN ADULT MALES AND YOUNG TEEN GIRLS: EXPLORING THE LEGAL AND SOCIAL RESPONSES* (1997).

4. JUDITH MUSICK, *YOUNG, POOR, AND PREGNANT: THE PSYCHOLOGY OF TEENAGE MOTHERHOOD* 74 (1993).

percent of the males involved in this study were more than ten years older than their partners.<sup>5</sup> In a sample of North Carolina girls pregnant before age 15, ten of 186 girls who sought medical care reported that they had been raped.<sup>6</sup> Coercion is almost certainly more common than this number indicates, since the health providers did not always record the patients' age at first intercourse, the number and age of their partners, or other sexual history that might have led to a discussion of coercive experiences.<sup>7</sup>

In light of this evidence, DSS employees working with any pregnant adolescent should

1. recognize the possibility of dependency, abuse, neglect, sexual assault, or domestic violence and be prepared to counsel the client about or report these conditions if appropriate;
2. educate and encourage other professionals or institutions that may have a legal obligation to assist or report; and
3. convey to law enforcement information that DSS receives about certain crimes.

Minor parenting also raises safety issues. These young women may be mistreated themselves or, like any other parent, they could neglect or abuse their child<sup>8</sup> or be unable to provide necessities.

5. Harold P. Gershon et al., *The Prevalence of Coercive Sexual Experience among Teenage Mothers*, 4 J. INTERP'L VIOLENCE 204 (June 1989).

6. Arlene M. Davis, co-director of the Adolescent Pregnancy Project, reviewed these records between April 1996 and December 1998. See the preface for a fuller description of them.

7. 133 of the 186 records did not list the girl's age at first intercourse; 134 did not state how many partners she had had; 101 did not state the age of the father of the pregnancy (FOP). When FOP's age was given, it was 18 or older more than half the time.

8. Some research indicates that young mothers are more prone to abuse their children than other mothers, Mary Overbeck et al., *Risk Factors for Infant Homicide in the United States*, 339 NEW ENG. J. MED. 1211–16 (Oct. 22, 1998).

The categories of child maltreatment as a civil matter are reviewed below in light of the special circumstances of adolescent pregnancy. Child maltreatment can also be a crime.<sup>9</sup>

## **ABUSE**

Under North Carolina statute, it is abuse for parents<sup>10</sup> to inflict serious physical injury on a child or treat a child in a way that produces serious emotional damage. Parents who create or allow a risk of that type of injury are also abusive. Using cruel or grossly inappropriate discipline is abuse<sup>11</sup> and so is condoning a child's delinquent acts.<sup>12</sup> Other definitions of abuse may be particularly relevant to pregnant adolescents. Sexual involvement between a minor and a caretaker is abuse,<sup>13</sup> as are certain sex-related acts that a parent permits or encourages, including "taking indecent liberties with a child regardless of the age of the parties."<sup>14</sup> Thus a parent who allows or encourages a child to engage in sex with a person of any age is, by definition, abusive. Other acts that qualify as abuse are first- and second-degree rape, sexual offense or sexual exploitation; incest; and involvement with pornography and obscenity.

9. Criminal statutes concerning caretakers' behavior toward children include North Carolina General Statute (hereafter G.S.) 14-316.1, Contributing to delinquency and neglect by parents and others; G.S. 14-318.2, Child abuse a Class I misdemeanor; and G.S. 14-318.4, Child abuse a felony.

10. With respect to abuse and neglect, "parent" includes "guardian, custodian, or caretaker," with the last two defined by statute, G.S. 7B-101.

11. G.S. 7B-101(1)c. A clinic owner described an instance of such abuse. Arriving at the clinic for an abortion, a patient told staff that her parents had locked her inside for a week and made threats to get her to agree to the procedure. The staff called DSS, which took custody of the girl. Interview with staff, Raleigh Women's Health Organization (Sept. 4, 1996).

12. G.S. 7B-101(1)f.

13. G.S. 7B-101(1)d.

14. G.S. 7B-101(1)d.



## NEGLECT

Parents may be unaware of an adolescent’s sexual activity or may be unable to control it. However, if they are indifferent to or seem to approve of the child’s behavior, they could be considered abusive (see above) or neglectful. Neglect includes a parent’s lack of “care, supervision, or discipline,” or allowing a child to live in a harmful environment.<sup>15</sup> A parent who allows a child’s partner to live in the family home,<sup>16</sup> for example, or who allows the minor to live out of the home with the partner might fit the definitions of abuse and neglect.

## DEPENDENCY

When a young woman has no parent<sup>17</sup> or when no parent is able to care for and supervise her, and no appropriate alternative arrangement exists, then the North Carolina juvenile code calls her *dependent*.<sup>18</sup> Pregnant or parenting minors are dependent in a number of circumstances. A significant number of homeless girls are pregnant, for example. These girls may have left home because of the pregnancy or become pregnant on the street where young people are often sexually exploited.<sup>19</sup>

Pregnant girls are also over-represented among runaways.<sup>20</sup> State law calls runaway youth “undisciplined,”<sup>21</sup> but individual youngsters can be dif-

15. G.S. 7B-101(15).

16. The medical records of pregnant girls under age 15 that Arlene M. Davis reviewed contained several instances.

17. In this guide the word “parent” should always be understood to include a legal guardian and often, as here, as a custodian as well.

18. G.S. 7B-101(9).

19. Telephone conversation with Julie Bosland, Special Assistant to the Commissioner, Administration on Children, Youth and Families, U.S. Dep’t of Health and Human Services, Washington, D.C. (Feb. 2, 2000).

20. *Id.*

21. G.S. 7B-1501(27).

difficult to classify. While some runaways abandon a safe home, others leave because of abuse, neglect, dependency—or a combination of the three. As the U.S. Department of Justice notes, “Runaways can be distinguished from throwaways in theory, but distinguishing between them in practice is very difficult because many episodes of both result from some sort of family conflict.”<sup>22</sup>

DSS also works with dependent young women who have entered the United States without family and perhaps without the family’s knowledge or approval. Some observers report that their numbers are increasing.

### **SEXUAL ASSAULT BY NON-CARETAKERS**

Since a minor’s sexual activity is usually not with a caretaker, and parents are usually unaware of the activity or disapprove of it, DSS rarely will conclude that a minor’s pregnancy results from abuse or neglect. However, depending on the age of the partners, the activity may be a sexual assault and the assailant can be charged.

The following sexual activities involving minors are criminal in North Carolina:

- Vaginal intercourse between someone 12 or younger and a person at least 12 and at least four years older than the victim is first-degree rape.<sup>23</sup>
- Other sex acts—for example, fellatio, anal intercourse, and cunnilingus—when one partner is 12 or younger and the other is at least 12 and four or more years older than the victim.<sup>24</sup>

22. Louise Hanson, *Second Comprehensive Study of Missing Children*, NCJ 179085, JUVENILE JUSTICE BULLETIN at 1 (April 2000). Available at [www.ncjrs.org](http://www.ncjrs.org).

23. G.S. 14-27.2.

24. G.S. 14-27.4(a).

- Vaginal intercourse between a 13-, 14-, or 15-year-old and a person more than four years older is statutory rape<sup>25</sup> unless they are “lawfully married.” The penalties are greater if the older partner is six or more years older.<sup>26</sup>
- Intercourse “by force and against the will” of one partner of any age is second-degree rape.<sup>27</sup> The force need not be physical; inducing fear can be sufficient.<sup>28</sup>
- Regardless of age, incest between a grandparent and grandchild, a parent and a child or stepchild, or a brother and a sister is a felony,<sup>29</sup> as is intercourse between an adult and a minor residing in a home where the adult has the position of parent.<sup>30</sup>

As noted earlier, DSS investigates only abuse, neglect, and dependency as civil matters. In order for DSS to be involved, a child’s condition must result from the action or inaction of a parent, guardian, custodian, or caretaker. However, most people do not understand DSS’s limited responsibility and are likely to report any mistreatment of children, by anyone, to DSS. If DSS receives reports of possible crimes in which someone other than a caretaker may have physically harmed a minor, the DSS director<sup>31</sup> must pass the information on to law enforcement within 48 hours.<sup>32</sup>

No court has ruled on whether the DSS duty to contact law enforcement

25. State statute uses “statutory rape” to designate intercourse between 13-, 14-, and 15-year-olds and significantly older partners, and that is its meaning here. Many in law enforcement, however, use the term for any rape or sexual offense to which the victim’s consent is not a defense.

26. G.S. 14-27.7A.

27. G.S. 14-27.3.

28. *State v. Martin*, 126 N.C. App. 426, 485 S.E.2d 352 (1997).

29. G.S. 14-178.

30. G.S. 14-27.7. As noted, this is also child abuse.

31. A director may assign staff members to act as his or her representative, G.S. 108A-14(b).

32. G.S. 7B-307(a).

applies to statutory rape. A director might reasonably conclude that it does, since sexual activity frequently causes minors physical harm (unintended pregnancy—often with higher risks than for adult women—and sexually transmitted diseases including HIV infection). In addition, a director cannot know, especially within the required 48 hours, whether a minor’s sexual activity is statutory rape alone or if it results from greater coercion. State DSS officials have told county DSS directors that any report of statutory rape that a county DSS receives should be passed on to law enforcement.<sup>33</sup> Some health departments routinely report statutory rape to DSS and at least one DSS (Rowan County) requires caseworkers to report to Child Protective Services (CPS) any sign of abuse or neglect involving a pregnant or parenting minor. CPS then screens for abuse or neglect “by the parent, caretaker or any other party” and informs law enforcement and the district attorney in cases of suspected abuse.<sup>34</sup>

Some prosecutors and law enforcement agencies in North Carolina were initially reluctant to enforce the statutory rape law, which became effective December 1, 1995,<sup>35</sup> but that is changing even in instances where the perpetrator is still a teen himself.<sup>36</sup> There were 1210 statutory rape charges brought in this state in 2001.<sup>37</sup> The federal welfare reform act encourages prosecution of statutory rape and requires states to educate law enforcement and other agencies about it.<sup>38</sup>

33. Letter from Pheon E. Beal, Director, Division of Social Services, NC DHHS, to Ed Koontz, April 24, 2002, and Letter from Barry Miller, Chief, Child Support Enforcement, and Chuck Harris, Chief, Children’s Services Division, NC DHHS, to County Directors for Social Services, July 1, 1999.

34. Cortney L. Hill, *Minors with Babies Get New DSS Protections*, SALISBURY POST, Mar. 27, 2002.

35. *No Convictions under Tougher Statutory Rape Law*, RALEIGH NEWS & OBSERVER, Nov. 26, 1997, at 3A. See, for example, *11-year-old Chatham Girl Missing*, RALEIGH NEWS & OBSERVER, Dec. 24, 1998, at 6B.

36. *Statutory Rape Charge Filed against 19-Year-Old*, RALEIGH NEWS & OBSERVER, Nov. 1, 2001, at 3B.

37. Telephone conversation with Patrick Tamer, Statistician, North Carolina Administrative Office of the Courts (Apr. 29, 2002).

38. 42 U.S.C. § 602(a)(1)(A)(vi); however, few states seem to have implemented

## DOMESTIC VIOLENCE

Pregnant or parenting adolescents are at substantial risk of domestic violence. Women in the United States report partner assaults in alarming numbers,<sup>39</sup> and far more violence is thought to occur than is reported.<sup>40</sup> Moreover, the risk of domestic violence is greater to adolescent<sup>41</sup> or pregnant<sup>42</sup> women than to women in general. If a pregnant woman is abused, there is also a possibility of harm to her pregnancy<sup>43</sup> and to infants and young chil-

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the directive. See JODIE LEVIN-EPSTEIN, STATE TANF PLANS: OUT-OF-WEDLOCK AND STATUTORY RAPE PROVISIONS. Center for Law and Social Policy: Washington, D.C. 1997, at 4–6. Available at [www.clasp.org](http://www.clasp.org).

39. For example, 54 percent of women seen in one emergency room said they had been threatened or injured by an intimate partner sometime during their lives. Twenty-four percent said their current partner had injured them. Abbott, et al., “Domestic Violence Against Women: Incidence and Prevalence in a Department Population,” 273 JAMA 1765–1767 (June 14, 1995).

Men also suffer domestic violence, but researchers conclude, based on frequency, severity, and fear of injury, that “intimate partner violence should be considered first and foremost a crime against women.” Patricia Tjaden and Nancy Thoennes, EXTENT, NATURE, AND CONSEQUENCES OF INTIMATE PARTNER VIOLENCE. NCJ 181867, U.S. Dep’t of Justice: Washington, D.C. (July 2000) at 55.

In North Carolina 34,902 women and 2,113 men called a crisis center in a year to report abuse, Report of the North Carolina Council for Women’s Domestic Violence Program, 07/01/1999–06/30/2000.

40. VIOLENCE, Position Paper of THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, 2000, at 1. Available at [www.aafp.org](http://www.aafp.org).

41. Constance M. Weimann et al., *Pregnant Adolescents: Experiences and Behaviors Associated with Physical Assault by an Intimate Partner*, 4 MATERNAL AND CHILD HEALTH J. 93–101(2000); and Barbara Parker et al., *Physical and Emotional Abuse In Pregnancy: A Comparison of Adult and Teenage Women*, 42 NURSING RESEARCH 173–77 (1993).

42. Twenty-six percent of pregnant teens report physical abuse from partners, and 40 to 60 percent, depending on the study, say the abuse began or increased with pregnancy. Nancy Worchester, *A More Hidden Crime: Adolescent Battered Women*, THE NETWORK NEWS, NATIONAL WOMEN’S HEALTH NETWORK, July/Aug. 1993 at 4.

43. MARCH OF DIMES BIRTH DEFECTS FOUNDATION, FACT SHEET: DOMESTIC VIOLENCE & TEENAGE PREGNANCY (1996).

dren. About half of the men who abuse partners also abuse children living in the home.<sup>44</sup>

A North Carolina statute defines domestic violence, for purposes of seeking a civil protective order, as a (specified) wrongful act against a person—or a minor child living with or in the custody of the person—by someone with whom the person currently has or has had a personal relationship.<sup>45</sup> Notice that, under the definition, partners need not live together. This is important in the case of adolescents, who are very often not married to or living with their partners. Domestic violence may include dating behavior and acts between non-cohabiting partners. What is necessary is that the two parties have a personal relationship. The relationship can be between current or former spouses; persons of the opposite sex who are living together or have lived together in the past; parents and children or grandparents and grandchildren;<sup>46</sup> persons who have a child in common; current or former members of the same household; or members of the opposite sex who currently have or formerly had a dating relationship.<sup>47</sup> (If a parent, grandparent, or other caretaker is violent toward their minor child or grandchild, the violence may be child abuse as well as domestic violence. In such cases, every adult who reasonably suspects that domestic violence has occurred must report it and DSS must investigate it.)

An adolescent who suffers domestic violence may want a civil protective order.<sup>48</sup> By issuing the order a judge can act in various ways to protect her. Besides directing the abuser to stop the abuse and leave her alone in future, a judge can regulate the couple's housing, child custody and support, and personal property; can require the abuser to pay legal costs and attorneys'

44. AMERICAN PSYCHOLOGICAL ASSOCIATION, *VIOLENCE AND THE FAMILY: REPORT OF THE APA PRESIDENTIAL TASK FORCE ON VIOLENCE AND THE FAMILY*. Washington, D.C. (1996) at 80 (hereafter APA REPORT).

45. G.S. 50B-1.

46. Or a similar relationship, "acting in loco parentis to a minor child." A child of any age may be the victim, but a child must be 16 or older to be considered the abuser. G.S. 50B-1(b).

47. *Id.*

48. G.S. 50B-2 through -4.2.

fees; and can even require the abuser to accept treatment.<sup>49</sup> Violating a civil protection order is a crime.<sup>50</sup>

Evidence and opinion are divided on whether orders are helpful. They seem to be effective in some cases,<sup>51</sup> and it is important to point out all options to a victim, to explain that an order offers limited protection, and to let her choose how to proceed.

A person can seek a protective order by going to the office of the clerk of superior court in a county courthouse and requesting the forms.<sup>52</sup> (The forms, available in English and in Spanish, are also available on the Internet.<sup>53</sup>) A minor must bring a friend or relative who is at least 18 to serve as her guardian ad litem (GAL).<sup>54</sup> If a minor cannot pay the court costs, she may file as an indigent.<sup>55</sup> She does not have to have a lawyer,<sup>56</sup> although having one may be to her advantage.<sup>57</sup> If the person seeking the order has no

49. G.S. 50B-3.

50. G.S. 50B-4.1.

51. In one study, six months after obtaining one, 65 percent of victims had had no further problem. ABA Domestic Violence statistics, available at [www.abanet](http://www.abanet), citing *CPOs: The Benefits and Limitations for Victims of Domestic Violence*, NATIONAL CENTER FOR STATE COURTS RESEARCH REPORT, 1997.

52. G.S. 50B-2(a) and (d).

53. First, enter <http://www.nccourts.org>. Under the page heading, The North Carolina Court System, click Judicial Forms. Next, enter AOC-CV-303 in the first box and click Search.

54. G.S. 1A-1, Rule 17(b). If the defendant (the alleged abuser) is a minor, a guardian ad litem (GAL) must also be appointed for him. The form for the appointment of a GAL in domestic violence actions is AOC-CV-318.

There are several kinds of GALs. All are appointed to represent a minor's best interests in a particular case. The AOC Guardian Ad Litem Program provides GALs for abuse, neglect or dependency proceedings. GALs for other proceedings are appointed under Rule 17 or other statutes.

55. G.S. 1-110.

56. G.S. 50B-2(a). JOAN BRANNON, *DOMESTIC VIOLENCE IN NORTH CAROLINA, unpublished manuscript*, Institute of Government (October 2000). No one bringing a civil lawsuit in North Carolina is entitled to a court-appointed attorney. See G.S. 7A-451 for cases in which the state provides counsel. A Legal Services attorney might assist the adolescent in some counties.

57. Orloff, Leslye E. et al. *With No Place to Turn: Improving Legal Advocacy for*

lawyer, the GAL files the necessary forms. After the alleged abuser is notified, the minor will be granted an emergency hearing. Emergency hearings typically occur within ten days of filing, but the GAL may request that an *ex parte* order be granted immediately, before the alleged abuser is notified.<sup>58</sup>

Law enforcement officers can help, too. A domestic violence victim “may request the assistance of a local law enforcement agency . . . [which] shall respond as soon as practicable.”<sup>59</sup> An officer may take steps to protect the person and tell her where to find shelter, medical care, counseling, and other services. If she asks and “if feasible,” the officer may take her to appropriate facilities for care and to her home to remove needed items.<sup>60</sup> If an officer declines to help the young woman retrieve personal belongings, she can seek that relief as part of a protective order.<sup>61</sup>

A violent act against a partner is often a crime as well as a civil injury, and the victim may seek help in criminal court, too. Criminal acts that can also be domestic violence include assault, battery, rape, and other sexual offenses.<sup>62</sup> Other acts, such as stalking, communicating threats, or destruction of property, might also qualify.

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*Battered Immigrant Women*, 29 FAMILY LAW QUARTERLY 2, 313–29, at 319 (Summer 1995).

58. G.S. 50B-2(b).

59. G.S. 50B-5(a).

60. *Id.*

62. BRANNON, MAGISTRATE’S ROLE IN DOMESTIC VIOLENCE PROTECTIVE ORDERS. Institute of Government (January 2001), 120.

62. “(1) Attempting to cause bodily injury, or intentionally causing bodily injury;  
or

(2) Placing the aggrieved party or a member of the aggrieved party’s family or household in fear of imminent serious bodily injury or continued harassment, as defined in G.S. 14-277.3, that rises to such a level as to inflict substantial emotional distress; or

(3) Committing any act defined in G.S. 14-27.2 through G.S. 14-27.7.”

(These criminal statutes describe first- and second-degree rape; first- and second-degree sexual offense; and intercourse and sexual offenses with certain victims [children in a home where the defendant “has assumed the position of a parent” or students where the defendant is a school staff member.]) G.S. 50B-1.



Besides explaining available legal remedies to a young woman, DSS can refer her to private agencies. A domestic violence hotline is an important resource for many victims and one that adolescents are especially likely to use. Professionals should be aware that victims can use the services of a domestic violence program whether or not they plan to leave a partner. It is also important to note that seeking help is often a first or an interim step to leaving.<sup>63</sup> The national domestic violence hotline (1-800-799-SAFE [7233]) can refer callers to local programs or shelters. During normal business hours the North Carolina Coalition Against Domestic Violence also refers callers to local programs.<sup>64</sup>

Most local programs in North Carolina offer 24-hour hotlines, court advocacy, support groups, and shelter for victims. Programs differ, however, and DSS staff will want to know what services are offered locally. Most shelters accept minors on an emergency basis and work with them to normalize their legal status.

## **EDUCATING PROFESSIONALS ABOUT REPORTING**

As noted, pregnant and parenting minors may be dependent, abused, or neglected, or victims of sexual assault or domestic violence. In our state all adults have a legal duty to report to DSS any reasonable suspicion of abuse or neglect as well as a minor's dependency.<sup>65</sup> Members of the health and education professions are in a good position to see such problems, but they often fail to ask about maltreatment.<sup>66</sup> Those that do may not understand the law or know who is mistreating the adolescent; or they may fear liabil-

63. "Many women do return to the abuser many times during the process of ending the abuse." APA REPORT, at 66.

64. Unless otherwise attributed, the information in this paragraph is from Marie French, training specialist, North Carolina Coalition Against Domestic Violence, Durham, N.C. (Dec.12, 2000). The Coalition can be reached at 919-956-9124.

65. G.S. 7B-301.

66. See note 7.

ity for breaching confidentiality or simply feel that they ought to keep the information in confidence. DSS staff can help these adults recognize who needs assistance, what must be reported, what could be reported, and how to report it. DSS educational efforts are more likely to succeed if staff knows the issues that affect reporting by health care providers and school professionals.

The earliest child abuse reporting laws in the United States often applied only to physicians and medical guidelines support North Carolina's legal requirement to report suspected maltreatment. The American Medical Association (AMA), for example, recommends that every adolescent patient "be asked annually about a history of emotional, physical, and sexual abuse."<sup>67</sup> The American Academy of Pediatrics (AAP) urges providers to "be sensitive to the possibility of sexual abuse or incest in the young or developmentally delayed pregnant adolescent."<sup>68</sup> The annual contract between a local health department and the State of North Carolina requires health department staff to try to help minors resist coercive sexual activities.<sup>69</sup>

In talking with health providers, DSS staff should remember that providers—like most people—often misunderstand the terminology of child protection laws. For example, most physicians treating a pregnant 15-year old with a 25-year old partner will think of the patient as "abused," rather than as dependent or a crime victim—and they will be confused when told that a report to DSS is not required (because DSS investigates only the behavior of parents or certain other caretakers), unless they suspect

67. AMERICAN MEDICAL ASSOCIATION, *Guidelines for Adolescent Preventive Services: Recommendations for Physicians and Other Health Professionals*, recommendation 21.

68. *Counseling the Adolescent about Pregnancy Options*, 101 PEDIATRICS 938–40 (May 1998) and at [www.aap.org](http://www.aap.org).

69. "All minors will be: (1) offered counseling on how to resist coercive attempts to engage in sexual activities; (2) provided counseling in cases where the minor requests it; and (3) provided counseling and other appropriate services where there is physical evidence or evidence by history that such counseling is indicated." DIVISION OF WOMEN'S AND CHILDREN'S HEALTH, NORTH CAROLINA DEP'T OF HEALTH AND HUMAN SERVICES, SUBSECTION 5D, SECTION D: QUALITY ASSURANCE DELIVERABLES, FAMILY PLANNING ADDENDUM TO THE CONSOLIDATED CONTRACT (n.d.).

inadequate care or inappropriate supervision or other neglectful conduct on the part of the minor's parent or caretaker. *Reporting Child Abuse and Neglect in North Carolina* by Janet Mason is a very useful source for all professionals involved with child maltreatment.<sup>70</sup> DSS should recommend the book to health agencies and practitioners involved with adolescents.

Once they understand definitions, most providers understand their duties: that, if they form a reasonable suspicion that a caretaker is abusing or neglecting a young patient or that she is dependent, they must report their suspicions to DSS in the county where the minor "resides or is found."<sup>71</sup> If DSS opens an investigation, providers must cooperate with it. A DSS director or representative has the right to see any information the director thinks may be relevant to an investigation.<sup>72</sup> A provider who reports and cooperates with DSS is protected from liability so long as he or she acts in good faith—and good faith is presumed.<sup>73</sup> Providers should be told that DSS does not identify reporters.<sup>74</sup> They should also know that DSS will report the outcome of its inquiry to them and let them know if DSS gave the information to law enforcement.<sup>75</sup>

Providers whose minor patient might suffer immediate harm can do more than report. They can ask DSS or law enforcement to take temporary custody of the patient.<sup>76</sup> A DSS worker or law enforcement officer may take temporary custody "if there are reasonable grounds to believe that a juvenile [a minor] is abused, neglected, or dependent and that the juvenile would be injured or could not be taken into custody if it were first necessary to obtain a court order."<sup>77</sup>

70. Institute of Government, The University of North Carolina at Chapel Hill (1996).

71. G.S. 7B-301.

72. G.S. 7B-302(e) and 7B-303.

73. G.S. 7B-309.

74. G.S. 7B-302(a).

75. G.S. 7B-302(f).

76. G.S. 7B-500(a).

77. G.S. 7B-308 lets a physician or health facility administrator seek a court order to hold a minor for up to 12 hours. However, it is less useful than 7B-500(a) since, as

Frequently, a provider does not know *who* may be mistreating a young patient or what the patient's relationship is to the person. When the minor's partner is not a caretaker and her parents do not approve of her sexual activity, the relationship may be a crime—sexual assault—but the health provider is not required to inform DSS or law enforcement. Health providers in North Carolina must report only a few possible crimes to law enforcement,<sup>78</sup> and sexual assault (including statutory rape) is not among them.

Many health providers are reluctant to report patient information to other agencies unless they are legally required to do so. Some wonder whether the crime will be prosecuted. Indeed, some prosecutors share the still common views that young girls, like adult women, must take full responsibility for their sexual behavior, that sex between minors and older people is not a serious problem, that convictions are unlikely, or that the legal penalty for statutory rape is too severe,<sup>79</sup> although these perceptions are changing. Providers also may hesitate to report—indeed, or even raise the subject of sexual assault with the patient—because they fear it may drive her away from medical care. Providers also know that they could be liable for violating patient confidentiality if they report patient information when not legally required to do so.<sup>80</sup> Regardless, without risking liability, a provider can tell a young patient that an older partner is acting unlawfully and encourage her to end the relationship or to tell her parents about it. If

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a practical matter, a physician can more easily contact DSS or law enforcement than obtain a court order. Moreover, 7B-308 lets a physician or administrator petition only when abuse is suspected.

78. Physicians and health facilities are required to report illness or injury resulting from firearms, knives or poison or “grave bodily harm or grave illness if it appears . . . that the wound, injury or illness resulted from a criminal act of violence.” G.S. 90-21.20.

79. *No Convictions under Tougher Statutory Rape Law*, RALEIGH NEWS & OBSERVER, Nov. 26, 1997, at 3A.

80. As noted earlier, providers are protected from liability when making required reports, G.S. 7B-309, and the doctor–patient privilege does not shield them from the requirement. G.S. 7B-310.

a minor seeks health care alone and a treating physician thinks that notifying the patient's parents "is essential to the life or health of the minor," the physician must notify them.<sup>81</sup>

School personnel are also well situated to see signs of mistreatment and they often report to DSS. Much of the information above regarding health providers is also relevant to them. However, DSS staff should be aware that the laws affecting the two groups as reporters differ somewhat.

The legal obligation to report abuse, neglect, and dependency, which binds all adults, has been included in the elementary and secondary education statutes of North Carolina,<sup>82</sup> and the state School Boards Association has a model policy explaining to school personnel the need to report and cooperate with investigations.<sup>83</sup> Moreover, the state Court of Appeals has applied the state statute that confers immunity for good faith reporting so as to protect a school principal from liability.<sup>84</sup> These facts may make school staff more aware of their reporting duty than other adults.

Other factors can make the duty to report unclear for school employees. Frequently, there is a school board policy requiring an employee to report any suspicion of child maltreatment to a school official—the principal perhaps or the superintendent. Such a policy can be useful, but only if employees understand—as the School Boards Association's policy makes clear—that their legal duty is to report a reasonable suspicion of abuse, neglect, or dependency to DSS and reporting to another school employee does not fulfill that duty.

Like other professionals, school personnel sometimes balance confidentiality against what they see as a higher need to help students or keep their trust. When should a teacher, for example, report harm deliberately inflicted on a student, and to whom? State law requires principals to report to law en-

81. G.S. 90-21.4.

82. G.S. 115C-400.

83. NCSBA, Policy 4240, CHILD ABUSE—REPORTS AND INVESTIGATIONS, POLICIES TO LEAD THE SCHOOLS. Raleigh, N.C.

84. *Davis v. Durham City Schools*, 91 N.C. App. 520, 372 S.E.2d 318 (1988), applying former G.S. 7A-550 (now, G.S. 7B-309).

forcement certain crimes committed on school property and the statute assumes that school personnel will inform the principal of these acts.<sup>85</sup> Unless committed by a caretaker, harmful behavior is not child abuse and need not be reported to DSS. Most likely, if a teacher learned that someone other than a caretaker was harming a student, the teacher would talk with an administrator and then someone would notify the child's parent.

School employees sometimes mistake the scope of their legal duty of confidentiality. School counselors and psychologists have state statutory "privileges" protecting student confidences to some degree,<sup>86</sup> but the privileges do not excuse these individuals from reporting suspected abuse, neglect, or dependency to DSS or testifying about it.<sup>87</sup> Certainly, both groups' ethics codes stress confidentiality but they also require members to breach it at times. Under the psychologists' code, "Information is revealed only with the informed consent of the child, or the child's parent or legal guardian, except in those situations in which failure to release information would result in clear danger to the child or others."<sup>88</sup> Counselors are to reveal student confidences when necessary "to prevent clear and imminent danger to the counselee or others or when legal requirements demand. . . ."<sup>89</sup>

A federal statute forbids schools from disclosing most information about students to anyone other than parents or other school personnel with a need

85. The crimes that must be reported are assault resulting in serious personal injury, sexual assault, sexual offense, rape, kidnapping, indecent liberties with a minor, various weapons offenses, and unlawful possession of a controlled substance, G.S. 115C-288(g).

86. The counselors' privilege is found in G.S. 8-53.4. The psychologists' privilege is similar, but is not "grounds for excluding evidence . . . of an illness of or injuries to a child. . . ." G.S. 8-53.3. Each provision states that a judge may waive the privilege when "in his opinion disclosure is necessary to a proper administration of justice."

87. G.S. 7B-310.

88. National Association of School Psychologists, *Principles for Professional Ethics*, PROFESSIONAL CONDUCT MANUAL FOR SCHOOL PSYCHOLOGY, effective January 1, 2001, Principle 9, at 19. Available at [www.nasponline.org](http://www.nasponline.org).

89. AMERICAN SCHOOL COUNSELOR ASSOCIATION, ETHICAL STANDARDS FOR SCHOOL COUNSELORS (*revised* June 25, 1998), Standard A.2b, available at [www.schoolcounselor.org](http://www.schoolcounselor.org).

to know.<sup>90</sup> However, the statute might not apply if the report is not part of the student's records. It is also possible that reporting a crime or abuse, neglect, or dependency would fall under the statute's emergency exception for health and safety information.<sup>91</sup>

90. Federal Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232(g). FERPA regulations are found at 34 C.F.R. Part 99.

91. 20 U.S.C.A. § 1232g(b)(1)(l) and (h) and 34 C.F.R. 99.36.

## Health Care

HEALTH CARE, among the most pressing needs of pregnant adolescents, is made more difficult because these adolescents are paradoxical patients. On the one hand, their medical condition (pregnancy) is adult in nature and their right to deal with it must be respected. On the other hand, as the AAP reminds health practitioners, the girl or young woman is still a pediatric patient<sup>1</sup> and entitled to broad attention and concern,<sup>2</sup> particularly if she becomes a mother.<sup>3</sup>

Some pregnant minors do not understand the basic facts of sexual activity or pregnancy, and those who counsel them may be able to help them reject sexual activity by telling them directly that they do not have to allow it.<sup>4</sup> While young women usually do well physically as obstetric or abortion patients, they are likely to have other needs that health providers should address. Counseling, referring, and supporting pregnant adolescents, especially the youngest,<sup>5</sup> is a difficult task for providers but it is likely to be of great benefit to their patients and the children their patients may bear.

DSS may be called on to arrange for health care for a pregnant or parenting minor and her children or supervise foster parents in doing so; to counsel an adolescent about health issues and decisions; or to consent to care. To carry out these responsibilities, DSS staff will find it valuable to

1. *Age Limits of Pediatrics*, 81 PEDIATRICS 736 (May 1988) and at [www.aap.org](http://www.aap.org).

2. *Adolescent Pregnancy—Current Trends and Issues*: 1998, 103 PEDIATRICS 516–20 (Feb. 1999) and at [www.aap.org](http://www.aap.org).

3. *Care of Adolescent Parents and Their Children*, 107 PEDIATRICS 429–34 (Feb. 2001) and at [www.aap.org](http://www.aap.org).

4. MUSICK, YOUNG, POOR, AND PREGNANT 85.

5. “[I]t is really the early adolescents who need the most help and counseling [from health providers], but . . . they are the least likely to report for follow-up appointments.” Sherry Lynn Marcus Hatcher, *The Adolescent Experience of Pregnancy and Abortion: A Developmental Analysis*, 2 J. YOUTH & ADOLESCENCE 53, 72 (1973).



know the law on health care for minors—particularly who consents to a minor’s treatment and what kinds of treatment are appropriate and lawful.

## **CONSENT TO TREATMENT FOR MINORS AND THEIR CHILDREN**

### **General Rule That Parental Consent Is Required.**

In North Carolina, minors are “subject to the supervision and control of” their parents.<sup>6</sup> As part of supervision, parents must make sure that their children receive the necessary medical care. DSS might file a petition for neglect if parents fail to fulfill their duty.<sup>7</sup> Because parents are responsible for medical care, they usually have the legal right to control the care—arranging for it, consenting to it, and paying for it. Another reason why parents are legally charged with consenting to health care for minors is that minors cannot enter into binding contracts.

The law in some states considers older minors capable of making their own medical decisions, but North Carolina law generally does not. Still, in recent decades, the General Assembly has made exceptions to the traditional rule that parents control the medical treatment of minors. The legislature has identified several situations in which a minor may consent for herself, an adult other than the girl’s parent may consent for her, or a physician may treat her without consent.

These exceptions are described below. More than one exception may apply to a particular minor, but any applicable exception allows a provider to treat a minor without parental consent.

### **Consent from Another Adult**

In some cases an adult who is not a minor’s parent may legally consent to her care. The most common situations in which this is true are the following:

6. G. S. 7B-3400 .

7. G.S. 7B-101(15).

### **Guardians**

North Carolina law provides two types of guardianship for minors. One takes effect only when a parent is ill or dead or when the minor has been abandoned, and therefore is used rarely.<sup>8</sup> With the other, a juvenile court appoints a guardian because no parent appears in a juvenile hearing or because it would be in the child's best interests to have a guardian.<sup>9</sup> A guardian can consent to a minor's medical care as fully as a parent can.<sup>10</sup> However, to become a guardian, a person must be so designated by a court. Therefore, health-care providers will ask an adult consenting for a minor's care to show his or her court appointment as guardian as proof of legal authority to consent before any treatment.

### **Custodians**

For a minor in DSS custody, the director may consent to some types of treatment, namely, "routine or emergency medical or surgical care or treatment."<sup>11</sup> Sometimes a DSS director will delegate to foster parents the authority to consent to routine care. Unless a court has terminated parents' rights, a custodian cannot consent to elective care. It remains the parent's prerogative, unless the court orders otherwise or the minor is consenting to her own care for certain conditions. (The terms *routine*, *emergency*, and *elective* care are not, to my knowledge, defined in North Carolina statute or regulation.)

If a minor is confined to a youth development center,<sup>12</sup> legal custody is not transferred to the facility, but "remains with the parent, guardian, custodian, agency, or institution in which it was vested."<sup>13</sup>

8. G.S., Article 6, Ch. 35A.

9. G.S. 7B-600.

10. G.S. 35A-1241(a)(3); 7B-600; 7B-906(d); and 7B-2001.

11. G.S. 7B-903(a)(2)c; 7B-2503(1)c; and 7B-2506(1)c.

12. "A secure residential facility authorized to provide long-term treatment, education, and rehabilitative services for delinquent juveniles committed by the court to the Department" of Juvenile Justice and Delinquency Prevention. G.S. 7B-1501(29).

13. G.S. 7B-2513(g).

### ***People Acting as if They Were Parents***

The law allows health providers to accept consent for a minor from someone acting as her parent. (The legal term is a person standing *in loco parentis*.) Being *in loco parentis* means taking on informally the rights and duties of a parent, especially the burden of support.<sup>14</sup> Unfortunately, it is quite difficult to be confident that a person wanting to consent actually is *in loco parentis*. It is difficult to know who is supporting a child and to judge whether a particular adult *intends* to act as a parent—or, if so, how fully and for how long. Thus, many providers hesitate to accept consent from an individual on the assumption that she or he is *in loco parentis*.

### ***People Acting for an Absent Parent***

North Carolina law lets a parent transfer the power to consent to treatment for a child to someone else when “the parent is unavailable for a period of time by reason of travel or otherwise.”<sup>15</sup> To do so, the parent must have sole or joint custody of the child and transfer his or her authority in writing. No parent, however, may authorize another person to agree to the withholding or withdrawal of life-sustaining procedures for a child.

### **Adult Consent Not Needed in Emergencies and Other Situations**

At his or her discretion, a physician may treat<sup>16</sup> a minor whose parents are unavailable if

1. despite reasonable efforts the physician cannot reach the proper adult during the time the minor needs treatment; or

14. State v. Pittard, 45 N.C. App. 701, 263 S.E.2d 809 (1980).

15. G.S. 32A-28 through -34.

16. “Treatment” does not include surgery. It is defined as “any medical procedure or treatment, including X rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures employed by or ordered by a physician licensed to practice medicine in the State of North Carolina that is used, employed, or ordered to be used or employed commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in the community where said physician administers treatment to said minor.” G.S. 90-21.2.

2. delaying treatment, in order to seek consent, would endanger the life or seriously worsen the minor's physical condition; or
3. the minor's identity is unknown.<sup>17</sup>

When a parent is available but refuses consent, a physician also has alternatives in some circumstances. If a parent refuses to consent to treatment, a physician may ask a judge to order it.<sup>18</sup> If taking time to ask for a court order would endanger the life of the minor or seriously worsen his or her physical condition, the physician may provide nonsurgical treatment over a parent's objection and without a court order. In such a case, another North Carolina–licensed physician must agree—before treatment—that it is needed to prevent immediate harm to the minor.<sup>19</sup>

The statute that allows physicians to treat without consent does not say whether they can do so simply to relieve pain. However, that is a reasonable inference. The statute refers to the “time when the minor needs treatment.” This phrasing could cover a period of pain or suffering, even if the problem was not expected to result in immediate harm, a threat to life, or worsening of the minor's physical condition. The AAP guidelines suggest that physicians assume an implied parental consent to treatment when a child is suffering or in pain.<sup>20</sup>

If a physician wants to perform surgery on a minor in the circumstances listed above, he or she must get a second opinion, if it is feasible to do so.<sup>21</sup> The second opinion is not required in a “rural community” (not defined) or if it is impossible to reach another physician in time.

It should be noted that a physician's decision to treat a minor in an emergency would not justify the treatment of nonemergency conditions at the same time.

17. G.S. 90-21.1.

18. G.S. 7B-3600.

19. G.S. 90-21.1.

20. AMERICAN ACADEMY OF PEDIATRICS, *Consent for Medical Services for Children and Adolescents*, 92 PEDIATRICS 290–91 (Aug. 1993) and at [www.aap.org](http://www.aap.org).

21. G.S. 90-21.3.

Emergency abortion on a minor is treated separately under the law.<sup>22</sup> A physician may perform an abortion without a parent’s consent when in his or her “best medical judgment . . . based on the facts of the case . . . a medical emergency exists that so complicates the pregnancy as to require an emergency abortion.” A physician may perform an emergency abortion over a parent’s objection also if the delay in getting a court order would endanger the minor’s life or seriously worsen her physical condition. In that instance, though—where a parent has refused to give consent—the physician must get a second opinion, from another North Carolina–licensed physician, that an abortion is needed to prevent immediate harm to the minor.<sup>23</sup>

### **Consent from the Minor Only**

In some cases an adult’s consent is not needed to provide a minor with medical services. In North Carolina, as in many other states, a minor may seek care on her own in certain circumstances, namely, when she wants treatment for one of a few specified conditions, when she is consenting to care for her child, or when she is emancipated.

#### ***Minors Seeking Care for Certain Conditions***

Minors can approach providers independently for contraception, treatment for sexually transmitted diseases (STDs), and perinatal care (although not for abortion).<sup>24</sup> They can consent to services for the *prevention, diagnosis, and treatment* of these and other conditions specified by statute, if the provider is a North Carolina–licensed physician<sup>25</sup> or is working under such a physician’s direction and supervision or standing orders.<sup>26</sup>

22. G.S. 90-21.9.

23. G.S. 90-21.9, telling the physician to follow the directions of G.S. 90-21.1(4).

24. G.S. 90-21.5. The other conditions with respect to which minors may consent to treatment are any reportable communicable disease, abuse of controlled substances or alcohol, and emotional disturbance. The statute cited does not cover abortion, sterilization, or nonemergency hospitalization for mental health care. G.S. 90-21.6 through -21.10, described later, require a parent’s or other adult’s consent to abortion or a judicial waiver of the requirement.

25. G.S. 90-21.5(a).

26. Opinion of Attorney General to Ed McCleary, Staff Attorney, Mental

Moreover, the law instructs the physician to keep the minor's confidence, except in unusual circumstances. A physician *must* notify a parent about a minor's condition if the physician thinks notification may be essential to the minor's life or health; the physician *may* talk with parents if they contact him or her.<sup>27</sup>

In weighing whether or not to notify a parent, providers consider the minor's mental and physical health—hints that she may be thinking of suicide, for example, or her refusal to seek treatment for a serious health condition. One county health director, for example, notified a parent when a minor who was a family planning patient took no action for months after receiving a troubling PAP test result. His decision seems reasonable.

Although, according to the statute allowing minors to consent, “[a]ny minor may give effective consent,” a provider cannot take the word *any* literally. In order to give valid consent, a minor, like anyone else, must understand her condition, the alternatives for treating it, and the risks and benefits of treatment or nontreatment. That is, she may be able to provide “informed consent.”

There is no specific age at which adolescents become capable of understanding these matters, and selecting an age arbitrarily seems especially problematic when the health issue is pregnancy. Legal commentators, psychologists, and judges are divided, for example, on whether girls under fifteen should be able to consent to abortion or childbirth. A national commission on consent to treatment recognized that “there is an age, below about 14 years old, at which the traditional presumption of incompetence remains sensible.” Still, the commission advised against a generally applied rule for age of consent, thinking it “more reasonable to ask—of any person at any age—‘is *this* person capable of making *this* decision?’”<sup>28</sup>

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Health Study Commission, Raleigh, N.C., 47 N.C.A.G. 83 (1977), and Opinion of Attorney General to Margie Rose, M.P.H., Branch Head, Family Planning Branch, Division of Health Services, Raleigh, N.C., 47 N.C.A.G. 80 (1977).

27. G.S. 90-21.4(b).

28. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS at 122 n.5 (1983).

Anyone working with adolescents struggles with whether—and at what point—adolescents are capable of making decisions that, although perhaps not fully mature, are good enough. Health providers’ techniques for judging, some of which are described below, may be useful to DSS as well. The commission on consent to treatment defined *decisional capacity* in health matters as having “sufficient ability to understand a situation and to make a choice in the light of that understanding.”<sup>29</sup> Another definition is the ability to understand the situation, weigh the risks and benefits of the choices, compare choices, incorporate her own values in the final decision, and make a decision that is not overly affected by the opinions of others.<sup>30</sup>

One North Carolina specialist in adolescent medicine uses practical tasks to help her judge a patient’s capacity—for example, whether the patient demonstrates responsibility for her own health by keeping appointments that have been described to her as important. In addition, this provider usually asks a pregnant adolescent to describe what she thinks her life will be like in one year and in five years if she makes one decision or another, for childbirth or abortion.<sup>31</sup> Simply talking with a patient about her situation and plans helps this provider form an opinion about the patient’s competence to make medical decisions.

If providers think that a minor patient is able to consent, they must next gauge whether the minor’s consent is voluntary. Are the pregnant girl’s decisions unduly influenced by peers or adults—family, partner, or advisers, including her health providers? People who have studied adolescents making medical decisions disagree on whether most of them act autonomously.<sup>32</sup> Several staff members in North Carolina institutions (hospitals,

29. *Id.* at 123.

30. BRUCE AMBUEL & JULIAN RAPPAPORT, *Developmental Trends in Adolescents’ Psychological and Legal Competence to Consent to Abortion*, 16 L. & HUM. BEHAV. 129, 132 (1992).

31. Interview with Carol A. Ford, Assistant Professor of Pediatrics and Internal Medicine and Director, UNC Adolescent Medicine Program, Chapel Hill, N.C. (Mar. 3, 1999).

32. “[M]inors younger than 14 or 15 years are unlikely to assert themselves well against authority figures, such as physicians or parents. . . . Also, there are significant

clinics, and adoption agencies) have told the author that they often fear that the decision made by a young pregnant adolescent—whether to give birth, have an abortion, or keep her child—was not truly her own. Naturally, adolescents—especially the youngest—will be influenced by their parents. However, if providers suspect that a minor’s consent is coerced, they should, after talking with her alone, tell her that she has a right to decide. If the coercion could be construed as abuse or neglect, they should ask DSS to intervene on her behalf.<sup>33</sup> Treatment should be postponed until the issue is resolved and the minor’s consent seems to be freely given.

The scope of consent is another important issue under the minor’s consent statute. When a minor is treated for one of the specified conditions—an STD, for example—providers may not also treat clearly unrelated conditions, such as asthma or a sprained ankle. Providers sometimes find it hard to classify a condition as related or not; however, there are no set guidelines to follow at this point.

### ***A Minor Consenting to Her Child’s Treatment***

When there is no law directly on point concerning a practical matter that has to be settled, lawyers must look to other legal principles for guidance. As explained above, a parent is responsible for a child’s basic needs, including medical care. Thus, in the author’s opinion, a minor parent must be able to consent to her child’s treatment because no one else has the responsibility or the authority to do so.

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social class differences that may modify willingness to express preference.” Sanford L. Leikin, *Minors’ Assent or Dissent to Medical Treatment*, 102 J. PEDIATRICS 169, 173 (Feb. 1983). But Leikin’s views contrast with those of David G. Scherer: “Children [ages 9 and 10] were significantly more likely to defer to parents than either adolescents [14 or 15] or young adults [ages 21 to 25]. Adolescents were more likely to defer to parents than young adults, although this finding only approximated statistical significance.” David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 L. & HUM. BEHAV. 431, 431 (1991).

33. FAY A. ROZOVSKY, *Children’s Refusal of Treatment*, in CONSENT TO TREATMENT: A PRACTICAL GUIDE § 5.18, at 358–59 (2d ed. 1990).



Here is the reasoning. State statute allows an emancipated minor to consent for her child's treatment,<sup>34</sup> but very few minor parents are emancipated because only marriage or a court order—not parenting—is evidence of emancipation. (See section on emancipation.) Unless a minor parent who is not emancipated may also consent to her child's treatment, many infants and small children could not be treated. The minor's parents or her partner's parents might seem logical parties to give consent, but their potential support obligation for a grandchild confers no legal right to make decisions.

As explained earlier, if a minor (or any other) parent cannot carry out a parent's duties, a court can appoint a guardian for her child or place the child in the custody of another person or of DSS.<sup>35</sup> The guardian or custodian can consent to any appropriate health care. But, unless a court orders otherwise, DSS as custodian may consent only to routine and emergency medical or surgical care, with the parent retaining the right to consent to elective care.

Unless a minor's child has a guardian or custodian, the minor retains the rights and duties of parenthood. Thus, the result is that minor parents can consent to their *children's* treatment even though it is generally believed that an unemancipated minor cannot consent to *her own* treatment outside of the conditions listed in G.S. 90-21.5, discussed above.

## TREATMENT OF PREGNANT MINORS

### Taking the History

Girls who become pregnant at an early age often have been leading more difficult lives than older teens or adults.<sup>36</sup> Prudent providers take careful pa-

34. G.S. 90-21.5(b).

35. G.S. 7B-903(a).

36. JUDITH MUSICK, YOUNG, POOR, AND PREGNANT: THE PSYCHOLOGY OF TEENAGE MOTHERHOOD, especially 127–29 (1993). Also, interview with Carol A. Ford, Assistant Professor of Pediatrics and Internal Medicine and Director, UNC Adolescent Medicine Program, Chapel Hill, N.C. (Mar. 3, 1999).

tient histories in such cases for legal and medical reasons—to resolve questions about consent to treatment or patient discharge, for instance, and to understand risk factors, the patient’s ability to comply with treatment, and the need for patient and family education.

A patient’s sexual history can yield important clues about neglect, abuse, and assault, which are known to be associated with early adolescent pregnancy.<sup>37</sup> The AAP recommends that pediatricians “be prepared to obtain a developmentally appropriate sexual history on all adolescent patients.”<sup>38</sup>

Despite such recommendations, certain data—age at first intercourse, number and age of partners, screening for STDs, and patient concerns about intercourse or pregnancy—often are missing in the records of pregnant adolescents. In one set the author reviewed, age at first intercourse was recorded for only 31 of 50 girls. The possible value of the missing information can be inferred from what was recorded: Two of the thirty-one said they were raped at age seven. A third stated that she began intercourse “voluntarily” (the provider’s word) at age ten. Two more began intercourse at age eleven.

Attending to a young patient’s personal history and social context is appropriate recognition that she is still in part a pediatric patient, that sexual activity at a young age usually is related to maltreatment,<sup>39</sup> and that pregnancy in early adolescence can be either a cause or effect of psychic distress. Compiling a psychosocial history alerts providers to matters that a pregnant adolescent may want help with, and this in turn improves the chances of good outcomes for her and her child.<sup>40</sup>

37. M. Jocelyn Elders, *Adolescent Pregnancy and Sexual Abuse*, 280 JAMA 648–49 (Aug. 19, 1998); Harold P. Gershon et al., *The Prevalence of Coercive Sexual Experience among Teenage Mothers*, 4 J. INTERP’L VIOLENCE 204–19 (June 1989).

38. Recommendation 2 in *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS 516–20 and at [www.aap.org](http://www.aap.org).

39. “Some 74% of women who had intercourse before age 14 and 60% of those who had sex before age 15 report having had sex involuntarily.” ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA’S TEENAGERS* 22 (1994).

40. Personal communication to Anne Dellinger from Carol A. Ford, Assistant Professor of Internal Medicine and Pediatrics and Director, UNC Adolescent Medicine Program, Chapel Hill, N.C. (Dec. 30, 1999).

### **Pregnancy Options Counseling**

Before providers ask for consent to treatment, medical<sup>41</sup> and legal<sup>42</sup> standards require them to explain to the patient her medical condition, the treatments available for it, and the likely results of treatment or nontreatment.<sup>43</sup> North Carolina law on obtaining an informed consent to treatment is found both in statute and in court decisions.

Under the consent statute, a provider counsels a patient (and avoids liability) by acting like his or her fellow practitioners,<sup>44</sup> that is, by explaining enough to give a reasonable person a “general understanding of the . . . treatments and of the usual and most frequent risks.”<sup>45</sup> An alternative test for liability is whether a reasonable person would have consented if advised under the first test.<sup>46</sup>

North Carolina courts occasionally hear allegations that patients were not fully informed. Although no court has yet to rule directly on liability for not explaining the options for a normal pregnancy,<sup>47</sup> a decision about unwanted conception may be relevant.<sup>48</sup> Allegedly a woman’s IUD was removed during surgery, and she was not told, although her doctor knew that

41. For example, Standard RI.1.2.1 of the JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS’ COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS (2000).

42. G.S. 90-21.13.

43. For a full discussion, see FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* (2d ed. 1990 & Cum. Supp. 1999).

44. Specifically, “in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities.” G.S. 90-21.13.

45. *Id.*

46. *Id.*

47. The state supreme court refused to recognize claims by a child born with a genetic defect and his parents. Although conceding that the mother would likely have aborted but for the providers’ inadequate counseling, the court told the child that “even life with genetic defects cannot be an injury in the legal sense.” The court deferred to the General Assembly on the parents’ claim. *Azzolino v. Dingfelder*, 315 N.C. 103, 337 S.E.2d 528 (1985).

48. *Jackson v. Bumgardner*, 318 N.C. 172, 347 S.E.2d 743 (1986).

she did not want more children. After bearing a healthy child the woman sued for malpractice, and the state supreme court upheld her right to sue. The justices wrote, “There are many reasons . . . to avoid pregnancy, some of which are matters of personal inclination and some of which are related to health.”<sup>49</sup> When a patient conceives because of a provider’s mistake, “it is the fact of the pregnancy *as a medical condition* that gives rise to compensable damages and completes the elements for a claim of negligence.”<sup>50</sup> In other words, the court viewed pregnancy as a medical condition and as a condition that some patients want medical help to avoid. The case, like the informed consent statute, suggests that a provider’s failure to counsel a patient about pregnancy options is malpractice.

Other considerations besides state law apply to some providers. Most family planning programs in local health departments and elsewhere in North Carolina receive federal funds. Providers who work in these federally funded (Title X) family planning programs are bound by federal regulations<sup>51</sup> and program guidelines.<sup>52</sup> Whether Title X clinics are to counsel patients about abortion and provide referrals for it<sup>53</sup> has inspired public controversy and official action for years, involving Congress, the federal courts, and several presidents. Since 1993, when the abortion counseling “gag rule” was suspended,<sup>54</sup> any health provider paid with Title X funds or participating in a Title X program, has again been required to counsel patients on the full range of pregnancy options, including abortion counseling and referral.<sup>55</sup>

49. *Id.* at 177, 347 S.E.2d at 746.

50. *Id.* at 181, 347 S.E.2d at 748 (emphasis in opinion).

51. 42 U.S.C.A. § 300a authorizes the Secretary of the U.S. Department of Health and Human Services to make grants to states for family planning services. The states, in turn, fund local agencies to provide services. Regulations for the operation of these programs are found at 42 C.F.R. § 59.1.

52. BUREAU OF COMMUNITY HEALTH SERVICES, U.S. DEP’T OF HEALTH AND HUMAN SERVICES, PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES (n.d.).

53. 42 C.F.R. § 59.8.

54. Memoranda of President, 58 Fed. Reg. 7,453 (Jan. 22, 1993).

55. Standards of Compliance for Abortion-Related Services in Family Planning Service Projects, 58 Fed. Reg. 7,462 (Feb. 5, 1993), and U.S. DEP’T OF HEALTH AND

If any provider is unwilling to explain options or treat the minor, he or she should refer her. If the girl has been a patient of the provider, referral may be necessary to avoid a claim of abandonment. The AAP, the American College of Obstetrics and Gynecology (ACOG),<sup>56</sup> and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)<sup>57</sup> also advise referral. AAP's position is that "Pediatricians and other health professionals should not allow their personal beliefs and values to interfere with optimal patient health care. The physician needs to respect the adolescent's personal decision and her legal right to continue or terminate her pregnancy and not impose barriers to health services from another provider."<sup>58</sup>

For adolescent patients, it is extremely important to explain options as soon as pregnancy is diagnosed. Typically these young women lack sufficient information about pregnancy, the law, and health systems. They come for care near the deadline for obtaining an abortion and past the time when prenatal care should have begun. In one group of fifty-eight teens, for example, 74 percent realized they were pregnant only after "someone else suggested the possibility, and half of them did not detect it until the second trimester."<sup>59</sup>

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HUMAN SERVICES, PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES § 8.6 (n.d.).

56. ACOG EDUCATIONAL BULLETIN at 3.

57. For women of all ages, AWHONN "supports and promotes a . . . right to accurate and complete information and access to reproductive health services." AWHONN POSITION STATEMENT: HEALTH CARE DECISION MAKING FOR REPRODUCTIVE CARE (*revised & reaffirmed under new title* Sept. 1999); *see also*, AWHONN POSITION STATEMENT: NURSES' RIGHTS AND RESPONSIBILITIES RELATED TO ABORTION AND STERILIZATION (1999); both available at <http://www.awhonn.org>.

58. *Counseling the Adolescent About Pregnancy Options*, 101 PEDIATRICS 938–40 (May 1998), at 938 and at [www.aap.org](http://www.aap.org). *See also*, *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746–51 (May 1996) and at [www.aap.org](http://www.aap.org).

59. Kari Sandven & Michael D. Resnick, *Informal Adoption among Black Adolescent Mothers*, 60 AM. J. ORTHOPSYCHIATRY 210, 217 (1990).

A health-care provider should counsel a pregnant adolescent in private even if someone else is with her, and her desire for confidentiality must almost always be respected. (For the exceptions under North Carolina law, see the “Minors Seeking Care for Certain Conditions” section, above.) Medical and nursing association policy statements advise providers to meet separately with a minor patient to counsel her, to seek the most sensitive information, and to learn how and whether she wants a parent to be involved in her medical care.<sup>60</sup> The AAP policy is typical. It recommends that the diagnosis of pregnancy be delivered to a minor patient alone and that she then be urged, particularly if she is a younger adolescent, to involve her parents and partner.

Ninety percent of pregnant girls under fifteen report that one parent knows about the pregnancy; 43 percent report that both parents know.<sup>61</sup> Unless an adult tells them, however, many of these young patients will not realize the extent to which they are entitled to make health care decisions.<sup>62</sup> Also, while most patients would benefit from parent involvement, the AAP realizes that, for some, their parent or partner is not a supportive figure. In those instances, the Academy simply advises the provider to take “appropriate action.”<sup>63</sup>

60. ACOG, *Confidentiality in Adolescent Health Care*, ACOG EDUCATIONAL BULLETIN No. 249 (Aug. 1998); AWHONN POSITION STATEMENT: CONFIDENTIALITY IN ADOLESCENT HEALTH CARE (*reaffirmed* 1995); AMERICAN MEDICAL ASSOCIATION, GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES: RECOMMENDATIONS FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS (n.d.).

61. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA'S TEENAGERS* 49 (1994).

62. A pregnant girl may consent to prenatal care if competent. In the case of abortion *she* must consent, but a parent or other specified adult also must consent or a judge must waive the adult consent requirement. On the subject of minors' competence, see Lois A. Weithorn, *Involving Children in Decisions Affecting Their Own Welfare: Guidelines for Professionals*, in CHILDREN'S COMPETENCE TO CONSENT at 252 (Gary B. Melton et al. eds., 1983).

63. AMERICAN ACADEMY OF PEDIATRICS, *Counseling the Adolescent about Pregnancy Options*, in 101 PEDIATRICS 938–40 (May 1998) and at [www.aap.org](http://www.aap.org).

## Abortion

In North Carolina, written consent from the minor is required for abortion. In addition, either an adult from one of several categories must consent in writing or a court must waive the adult consent requirement.<sup>64</sup> As has been noted, most minors obtaining an abortion have parental (or a guardian's or grandparent's) consent. In 2000, only 288<sup>65</sup> of the 1,761 minors who obtained an abortion in North Carolina<sup>66</sup> did not have parental consent. For adolescents who will not or cannot obtain adult consent, the court process described in this section is an alternative means of gaining permission for abortion.

Many young women do not know how long into a pregnancy abortion is legally, practically, or medically available; where or how to obtain one; or that, if they choose an abortion, they will need an eligible adult's consent or must ask a judge to waive that requirement.

Abortion is legal for any woman in North Carolina until the fetus is viable<sup>67</sup> or through the end of the second trimester (the twenty-fourth week of gestation), whichever comes first. An abortion is legal at any point in pregnancy if "necessary to preserve the life or health of the mother."<sup>68</sup>

64. G.S. 90-21.7.

65. ADMINISTRATIVE OFFICE OF THE COURTS, Raleigh, N.C.

66. STATE CTR. FOR HEALTH STATISTICS, NORTH CAROLINA DEP'T OF HEALTH & HUMAN SERVICES, NORTH CAROLINA REPORTED PREGNANCIES [2000]. Available only at <http://hermes.sches.ehnr.state.nc.us/SCHS>.

67. In *Roe v. Wade*, 410 U.S. 113 (1973), the U.S. Supreme Court established an unfettered right to choose abortion through the first trimester of pregnancy. Under *Roe*, in the second trimester a state may regulate to protect maternal health and, after viability, a state may forbid abortion except where a woman's life or health may be at stake. Subsequent U.S. Supreme Court decisions have retreated from *Roe* by allowing states to impose restrictions that the Court does not find unduly burdensome to the exercise of a right to abortion.

*Roe* invalidated G.S. 14-45.1, which permitted abortion only through twenty weeks of gestation. Although the General Assembly has not enacted a new statute, the author assumes that the legislature wishes to prohibit abortion after viability except, as required by *Roe*, to preserve a woman's life or health.

68. *Roe v. Wade*, 410 U.S. 113, 164 (1973).

The state of North Carolina licenses clinics<sup>69</sup> and ambulatory surgical facilities<sup>70</sup> to offer abortions only through twenty weeks of gestation. Not all licensed facilities offer abortion for that length of time, however.<sup>71</sup> In North Carolina, after twenty weeks of gestation, an abortion must be performed in a hospital.<sup>72</sup>

The requirements for a minor to obtain an abortion are described below.

### ***With a Parent's or Another Adult's Permission***

Unless a judge waives the requirement, a health provider performing an abortion on a minor must have written consent from the minor and from one of the following adults: a custodial parent, a legal guardian or custodian, a parent with whom the girl is living, or a grandparent with whom she has lived for six months immediately before the abortion.<sup>73</sup> Although the statute just cited would seem to let DSS consent to abortion for a minor in its custody, under another statute a DSS director generally may consent only to “needed routine or emergency . . . care or treatment.”<sup>74</sup> For this reason, perhaps, DSS directors often require a minor in custody who wants an abortion to seek a judicial waiver (described in the next section).

69. 10 NCAC 3E.0101(1).

70. 10 NCAC 3Q.0204.

71. For example, the Statesville, North Carolina, telephone book for 2001–2002 listed under “Abortion Services” one clinic advertising abortions through twenty weeks; one, through sixteen weeks; and a third, through fifteen weeks. In addition to different time limits set by facilities, physicians serving a single clinic sometimes have different numbers of weeks through which each is willing to perform abortions. Occasionally, too, a provider declines to perform an abortion on a young woman because of the problems presented by her small or immature uterus.

72. In 2000, North Carolina hospitals performed 125 abortions after twenty weeks—less than one half of one percent of the 26,944 abortions performed in the state that year. Information from Roy Clark, State Center for Health Statistics, N.C. Dep’t of Health and Human Services, Raleigh, N.C. (May 7, 2002).

73. G.S. 90-21.7(a).

74. G.S. 7B-903.



### ***With Court Waiver of the Adult Consent Requirement***

If a minor wants an abortion but no eligible adult is available to consent, or will consent, or if the minor does not want to ask the adult, she may ask a judge to allow her to decide.<sup>75</sup> (The official name of such a request is a “Petition for Waiver of Parental Consent for Minor’s Abortion,” which court staff usually call a *waiver petition* or *judicial waiver*.) The judge must grant the request if he or she finds any one of the following to be true:

1. the minor is mature and well-informed enough to make the decision;
2. making the decision herself would be in her best interest; or
3. she is a victim of rape—which would include statutory rape—or felonious incest.<sup>76</sup>

If a minor wants a waiver, she goes to the clerk of superior court’s office in a county courthouse for information and assistance.<sup>77</sup> The minor need not be a North Carolina resident to submit a waiver petition here,<sup>78</sup> and if she is a resident of the state, she does not have to file her request in the county where she lives. Any minor may ask for a judicial waiver in any county in the state.<sup>79</sup>

DSS employees, health-care providers, and other knowledgeable adults can help a minor who wants a waiver by explaining the court procedure. Providers can also help by giving her a certification of pregnancy and the estimated gestational age of the fetus to take to court. Although neither the statute nor the court forms on waiver mention these items, some judges ask for this information. Having it to present to a judge might save the minor a delay that would make it impossible for her to obtain an abortion.

75. G.S. 90-21.7.

76. The court must notify DSS if the pregnancy is the result of incest (G.S. 90-21.8.) or abuse or neglect (G.S. 7B-301).

77. G.S. 90-21.8.

78. G.S. 90-21.8(a).

79. The petition may be filed “in the district court where the minor resides or where she is physically present.” G.S. 90-21.7(b).

State law requires that a court employee help a young woman prepare her request if she wants help. The court employee will give the young woman forms entitled “Instructions for Minor Petitioners.”<sup>80</sup> She is entitled to have, without charge, the assistance of a lawyer or someone else,<sup>81</sup> or she may proceed on her own.<sup>82</sup> If she wants a lawyer, the court will find and appoint one to represent her. Court costs and fees are waived for this procedure, so it costs the minor nothing. The minor’s identity and the record of the hearing are kept confidential, except that the court must notify DSS if the pregnancy results from incest<sup>83</sup> or abuse, neglect, or dependency.<sup>84</sup> The DSS investigation or its consequences could cause parents to learn of the minor’s abortion. Otherwise the minor’s parents are not notified. Forms used for the waiver process are available at [www.nccourts.org](http://www.nccourts.org).<sup>85</sup>

After a waiver petition has been filed, a judge has seven days to decide whether to grant it. Some judges talk with the minor on the same day the petition is filed and reach a decision at the conclusion of the hearing.<sup>86</sup> If the judge grants the request, she or he issues an order. The clerk of court then gives the minor a certificate stating that she does not need an adult’s consent, which the girl can present to an abortion provider. If the minor’s request is denied, she has twenty-four hours to appeal. On appeal, she will be required to present her case anew, to a different judge. Or, since the statute does not limit the minor to a single petition, she could instead begin the process again by filing another petition in a different county or before a different judge.

80. G.S. 90-21.8(b). *See also* JACK COZORT, Rule 1C, RULES OF RECORDKEEPING: JUDICIAL WAIVER OF PARENTAL CONSENT (JW) PROCEEDINGS (Oct. 1, 1995) (hereafter, *Rules of Recordkeeping*).

81. The guardian ad litem, that is, guardian for purposes of the court proceeding, could be someone suggested by the minor or identified by the clerk of court.

82. G.S. 90-21.8(c). *See also* Rule 1B, *Rules of Recordkeeping*.

83. G.S. 90-21.8(f).

84. G.S. 7B-301.

85. After clicking Judicial Forms at this site, enter the word *abortion* in the search space marked *Title*.

86. Interview with a North Carolina assistant clerk of court (Apr. 7, 1999).

### ***Payment for Abortion***

Many minors likely find it hard to pay for an abortion. Health Choice does not cover abortion and Medicaid very rarely covers the procedure.<sup>87</sup> The state abortion fund, which in the past paid for many procedures, no longer functions.<sup>88</sup> However, some private health insurance policies cover a dependent's abortion, and clinics and hospitals sometimes reduce or waive charges—or spread out payments—for those who are unable to pay.

### **Childbirth**

Although many adolescents choose to end their pregnancies, a majority of them in recent years are giving birth.<sup>89</sup> The law governing the perinatal period is straightforward. As part of the state permission to minors to consent to treatment for pregnancy,<sup>90</sup> an adolescent can consent for prenatal care, labor and delivery, and postnatal care.

One issue is whether the hospital stay following delivery should be longer for minor mothers. Although most do well physically, the medical risks of childbirth for them (especially the youngest) and their infants are substan-

87. Abortions that qualify for Medicaid reimbursement are those where the pregnancy is the result of rape or incest, or is life-endangering. A North Carolina-licensed physician must fill out and sign a statement to that effect. In 2001, Medicaid paid for seven abortions in North Carolina, according to Beth Osborne, N.C. Dep't of Health and Human Services, Division of Medical Assistance, Raleigh, N.C. (May 10, 2002).

88. Since 1995, the fund has consisted of \$50,000 available under the same conditions as Medicaid, but the applicant must not be eligible for Medicaid despite her poverty status. 1995 N.C. Sess. Laws ch. 324, sec. 23.27; ch. 507, sec. 23.8A; 1999 N.C. Sess. Laws ch. 237, sec. 11.29. According to Beth Osborne, N.C. Dep't of Health and Human Services, Division of Medical Assistance, Raleigh, N.C., the fund has not paid for an abortion in five years. Telephone conversation with Anne Dellinger (May 10, 2002).

89. In 2000, North Carolina reported 551 pregnancies in girls under age fifteen; 335 of the pregnancies resulted in live births. 5,415 of the 7,227 girls pregnant under age 18 gave birth. STATE CTR. FOR HEALTH STATISTICS, NORTH CAROLINA DEP'T OF HEALTH AND HUMAN SERVICES, NORTH CAROLINA REPORTED PREGNANCIES (2000).

90. G.S. 90-21.5.

tially greater than for adult women.<sup>91</sup> In addition, these adolescents are disproportionately poor,<sup>92</sup> usually first-time mothers, and less prepared than older women for parenthood—facts that make a very brief postpartum stay a strain on their personal resources. A short hospital stay for high-risk mothers is viewed as a problem for their infants, according to the AAP, which includes among the reasons not to discharge a woman who has just given birth a “lack of social support, particularly for single, first-time mothers.” The AAP lists being a teen mother as a separate reason. For new mothers who present these or other risk factors, the AAP recommends that discharge be delayed until these circumstances “are resolved or a plan to safeguard the infant is in place.”<sup>93</sup> A 1999 policy statement advises pediatricians to “recommend that adolescent mothers not receive early postpartum discharge so that clinicians can ensure that the mother is capable of caring for her child and has resources available for assistance.”<sup>94</sup>

North Carolina law requires private insurers to cover a forty-eight-hour stay for any mother after a normal vaginal delivery.<sup>95</sup> If a mother and her

91. AAP COMMITTEE ON ADOLESCENCE, *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS 516–20 (Feb. 1999) and at [www.aap.org](http://www.aap.org), citing L. J. Piccinino & W. D. Mosher, *Trends in Contraception Use in the US: 1982–1995*, 46 FAM. PLAN. PERSP. 4–10 (1998), and A. J. Satin et al., *Maternal Youth and Pregnancy Outcomes: Middle School versus High School Age Groups Compared with Women Beyond the Teen Years*, 171 AM. J. OBSTETRICS & GYNECOLOGY 184–87 (1994).

92. “Poverty is correlated significantly with adolescent pregnancy in the United States. Although 38% of adolescents live in poor or low-income families, ~83% of adolescents who give birth and 61% who have abortions are from poor or low-income families.” *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS at 516–20 and at [www.aap.org](http://www.aap.org).

93. *Hospital Stay for Healthy Term Newborns*, 96 PEDIATRICS 788–90 (October 1995, reaffirmed Oct. 1999) and at [www.aap.org](http://www.aap.org).

94. Recommendation 6 in AAP COMMITTEE ON ADOLESCENT PREGNANCY, *Adolescent Pregnancy—Current Trends and Issues: 1998*, 103 PEDIATRICS at 516–20 and at [www.aap.org](http://www.aap.org).

95. G.S. 58-3-169(b).

physician agree on earlier discharge, the insurer must cover “timely postdelivery care.”<sup>96</sup> Medicaid has similar postpartum coverage (1.9 days) but allows a longer stay if medically necessary. If a minor’s parents’ insurance does not cover her,<sup>97</sup> she very likely is eligible for Medicaid because only the minor’s income is considered in determining childbirth coverage under Medicaid. As a last resort for pregnant women, a federal statute requires hospitals to treat anyone, regardless of ability to pay, who comes to the hospital in active labor.<sup>98</sup>

A minor who gives birth and keeps the child faces medical and financial challenges that must be met while she also learns to function as a parent and begins work or resumes schoolwork. Previous pregnancies or other children may add to the difficulties. For example, in one group of 186 pregnant North Carolina girls under age fifteen, nine were second pregnancies. At least four girls had a child at home already. For help with these challenges adolescent mothers are often referred to North Carolina’s Child Services Coordination program.<sup>99</sup> This voluntary program, available in every county and open to all families, provides home visits by a nurse or social worker trained to identify services available for the child for the first three years of a child’s life. Visits are made at least quarterly and more frequently if needed.

Staying in school is crucial to the economic well being of adolescents and their children.<sup>100</sup> In North Carolina, school districts’ and individual schools’

96. G.S. 58-3-169(d).

97. Many insurance policies sold in the state exclude dependents’ coverage for labor and delivery. Telephone conversation with Kim Shepherd, Life and Health Section, N.C. Dep’t of Insurance, Raleigh, N.C. (June 9, 1999).

98. Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, *renamed* in 1989 Examination and Treatment for Emergency Medical Conditions and Labor Act.

99. The state Department of Health and Human Services, Division of Public Health, Women’s and Children’s Health, Children and Youth Branch, operates the program.

100. For one of numerous studies reaching this conclusion, see J. Brooks-Gunn & Frank F. Furstenberg, Jr., *Continuity and Change in the Context of Poverty: Adoles-*

policies vary greatly in how well they facilitate a new mother's return to school and her gaining credit for the semester or year in which she gives birth. One district grants students an excused absence for up to thirty days before and thirty days after delivery.<sup>101</sup> Another requires a doctor's letter before excusing absences even for the physical necessities of the postpartum period. Given these differences in both policy and practice, if an absence of more than a few days is advisable—for bonding, establishing breast-feeding, securing child care, or other reasons—a written statement of need and request for additional time from the girl's physician may help convince school officials to extend the period of working at home for credit.

### **Contraception**<sup>102</sup>

Even after pregnancy, some girls do not fully understand reproduction and reproductive health. In that respect, they are typical teens. A 1999 survey of over one thousand high school students showed widespread ignorance. Most girls did not know about emergency contraception.<sup>103</sup> Of those who were sexually active, 39 percent did not know that they could obtain birth control pills without a parent's permission and 47 percent did not know that an STD increases the chance of contracting HIV during sex. The high school students were quite aware that they lacked information. Roughly half of those surveyed—more or less, depending on the item—

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*cent Mothers and Their Children*, in *THE MALLEABILITY OF CHILDREN* at 171–88 (J. Gallagher & C. Ramey, eds. 1989).

101. The “Homebound Instruction” policy of the Alamance–Burlington School System allows for such an absence. Telephone conversation with Jerry Ferguson, Director of Student Support Services (Mar. 13, 2000). Moreover, under the system's “High School Attendance Policy Procedures,” for “[a]bsences resulting from . . . life-altering circumstances of the student, the principal has the authority to exempt the student from the provisions of the individual class attendance policy.”

102. This section was written by Arlene M. Davis, co-director of the Adolescent Pregnancy Project.

103. Also called “morning after” contraception, these methods are used after unprotected intercourse to prevent pregnancy and involve either a regimen of contraceptive pills or insertion of an intrauterine device (IUD).

wanted information on contraception, STDs, HIV, handling the pressure to have sex, and dealing with rape or sexual assault.<sup>104</sup>

Minors as a group are at high risk for unintended pregnancies, and as many as one-quarter of adolescent girls who conceive have had one or more prior clinic visits resulting in a negative pregnancy test result.<sup>105</sup> Although sexually active teens are using contraception more often and more effectively,<sup>106</sup> the youngest are the least likely to do so.<sup>107</sup> Moreover, contraception fails more often among women who are young, unmarried, low-income, African American, or Hispanic.<sup>108</sup>

National health organizations advise confidential counseling of adolescent patients about responsible sexual behavior, including abstinence, and offering them the means to protect themselves against an unplanned pregnancy beginning at age eleven.<sup>109</sup> The AAP recommends that pediatricians encourage and support abstinence but also inform teens about contraceptive options.<sup>110</sup> North Carolina law allows minors independent access to con-

104. KAISER FAMILY FOUNDATION, KAISER FAMILY FOUNDATION NATIONAL SURVEY OF SECONDARY SCHOOL STUDENTS ABOUT SEXUAL HEALTH ISSUES AND SERVICES: THE FACTS AND MORE (<http://www.kff.org>).

105. Such visits can be an opportunity to counsel sexually active teens. See Luella Klein & Felicia Stewart, *Preconception Care*, in ROBERT A. HATCHER ET AL., *CONTRACEPTIVE TECHNOLOGY* at 624–25 (17th revised ed. 1998), citing L. S. ZABIN ET AL., *Adolescents with Negative Pregnancy Tests*, 275 JAMA 113–17 (1996).

106. THE ANNIE E. CASEY FOUNDATION, *WHEN TEENS HAVE SEX: ISSUES AND TRENDS* 8–9 (1998).

107. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA'S TEENAGERS* 33 (1994).

108. Markus J. Steiner, *Contraceptive Effectiveness: What Should the Counseling Message Be?* 282 JAMA 1405 (Oct. 20, 1999).

109. AMERICAN MEDICAL ASSOCIATION (AMA), *GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES (GAPS): RECOMMENDATIONS FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS 1995–99* (hereafter, *GAPS Recommendations*) at [www.ama-assn.org](http://www.ama-assn.org). For American Academy of Pediatrics (AAP) recommendations, see *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746–51 (May 1996); *Counseling the Adolescent about Pregnancy Options*, 101 PEDIATRICS 938–40 (May 1998); and AAP Committee on Adolescence, *Contraception and Adolescents*, 104 PEDIATRICS 1161–66 (Nov. 1999). All are available at [www.aap.org](http://www.aap.org).

110. *Contraception and Adolescents*, 104 PEDIATRICS 1161–66 (Nov. 1999) and at [www.aap.org](http://www.aap.org).

trapeption.<sup>111</sup> Local health departments offer family planning services to minors and, as a condition of state or federal funding, counsel minors “about the importance of discussing birth control needs with parent(s).”<sup>112</sup> It is especially important for adolescents who have been pregnant to understand contraception and have access to it.

### **Sterilization**

It is rare that a minor asks to be sterilized and that a physician is willing to consider it.<sup>113</sup> State law allows married minors to consent to sterilization—after all, they are emancipated. An unmarried minor, though, may be sterilized only if

- she gives written consent;
- her parent or guardian files a request with a juvenile court;
- the court finds that the surgery would be in her best interest; and
- the court issues an order authorizing a physician to perform the operation.<sup>114</sup>

Federal funds cannot be used to pay for the procedure.<sup>115</sup>

Separate provisions of state law (Article 7, Ch. 35) cover sterilization of someone who is mentally ill or mentally retarded. The individual’s parent or guardian, the director of the institution where the individual lives, or the DSS director of the county in which he or she resides may ask a district court judge to order the operation.

111. G.S. 90-21.5.

112. DIVISION OF WOMEN’S AND CHILDREN’S HEALTH, NORTH CAROLINA DEP’T OF HEALTH AND HUMAN SERVICES, SUBSECTION 6C, SECTION D: QUALITY ASSURANCE DELIVERABLES, FAMILY PLANNING ADDENDUM TO THE CONSOLIDATED CONTRACT (n.d.).

113. In two of 186 records reviewed for this project, the patients requested sterilization. One young woman had had four children, the other woman five, before the age of eighteen.

114. G.S. 90-272.

115. Family planning [42 C.F.R. § 50.203(a)] and Medicaid (42 C.F.R. § 441.253) funds cannot be used to sterilize anyone under twenty-one.



### **Sexually Transmitted Diseases, Including HIV<sup>116</sup>**

STDs<sup>117</sup> pose serious health risks for teens in the United States,<sup>118</sup> particularly in our state. In 2000, among ten- to fourteen-year-old girls, North Carolina recorded 3 cases of syphilis, 179 cases of gonorrhea, and 470 cases of chlamydia.<sup>119</sup> Treatment for an STD was noted in many of the records of early adolescent pregnancies the author reviewed. About 20 percent (35 of 186) of the patients had STDs diagnosed during their pregnancy; for another 11 patients, an STD was identified during preparation for an abortion or during labor. These diseases disproportionately affect African-American and Latino youth.<sup>120</sup>

The AMA recommends talking to adolescent patients annually about STDs and making latex condoms available.<sup>121</sup> The AAP emphasizes the danger of HIV transmission.<sup>122</sup> While the Academy thinks it advisable to give

116. This section was written by Arlene M. Davis, co-director of the Adolescent Pregnancy Project.

117. STDs are also referred to as STIs (sexually transmitted infections). STIs and common infections of the genital tract are collectively referred to as reproductive tract infections (RTIs). These RTIs have serious health consequences: tubal occlusion, pregnancy loss and neonatal morbidity, genital cancers, and enhanced HIV transmission. As used here, STDs mean HIV, syphilis, gonorrhea, chlamydia, and the pelvic inflammatory disease that can follow from either of the last two diseases. Also included are trichomoniasis, herpes genitalis (HSV), and human papillomavirus (HPV). Hepatitis B also may be transmitted through sexual activity. Willard Cates, Jr., *Reproductive Tract Infections*, in ROBERT A. HATCHER ET AL., *CONTRACEPTIVE TECHNOLOGY* at 187–88 (17th revised ed. 1998).

118. Ralph J. DiClemente, *Preventing Sexually Transmitted Infections among Adolescents, A Clash of Ideology and Science*, 279 *JAMA* 1574 (May 20, 1998).

119. Information from Roy Clark, State Ctr. for Health Statistics, North Carolina Dep't of Health and Human Services, Raleigh, N.C. (May 1, 2002).

120. Rochelle N. Shain et al., *A Randomized Controlled Trial of Behavioral Intervention to Prevent Sexually Transmitted Disease among Minority Women*, 340 *NEW ENG. J. MED.* at 93 (Jan. 14, 1999). See also John B. Jemmott III et al., *Abstinence and Safer Sex: HIV Risk-Reduction Interventions for African American Adolescents*, 279 *JAMA* 1529 (May 20, 1998); Philip S. Rosenberg et al., *Trends I HIV Incidence among Young Adults in the United States*, 279 *JAMA* 1896–99 (June 17, 1998).

121. Recommendation 9 in *GAPS Recommendations*, *supra* note 110.

122. AAP COMMITTEES ON PEDIATRIC AIDS AND ON ADOLESCENCE, *Adolescents*

general advice on HIV to all teens, it recommends more specific counseling for teens in the following high-risk categories: drug abusers, homosexual or bisexual teens, teens with a history of STDs (particularly herpes or syphilis), teens with multiple partners, and teens whose partners engage in high-risk behaviors.<sup>123</sup> Under North Carolina law, a patient must specifically consent to be tested for HIV before a physician may order the test,<sup>124</sup> and the patient must be “counseled appropriately” when informed of the result.<sup>125</sup>

Pregnant teens also need STD testing and counseling. As with birth control and pregnancy, North Carolina law lets minors ask for medical care for the prevention, diagnosis, and treatment of “reportable” communicable diseases.<sup>126</sup> This category includes all STDs. The state Commission for Health Services decides which diseases are to be reported,<sup>127</sup> and physicians, diagnostic laboratories, school principals, and child-care operators must inform the local health director of each case they encounter.<sup>128</sup> If a reportable disease is diagnosed, state law requires the attending physician to teach the patient how to prevent its transmission.<sup>129</sup> Providers (and everyone else) must keep information and medical records about reportable disease cases confidential.<sup>130</sup>

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*and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention*, 107 PEDIATRICS 188–90 (Jan. 2001) and at [www.aap.org](http://www.aap.org).

123. *Id.*

124. G.S. 130A-148(h). Although it is not required, written consent would be advisable for liability protection.

125. G.S. 130A-148(g).

126. G.S. 90-21.5(a).

127. G.S. 130A-134.

128. Physicians must report if they have “reason to suspect” a case in someone “about whom the physician has been consulted professionally,” G.S. 130A-135. Principals and childcare operators must report a suspected case in any person within the school or facility. G.S. 130A-136.

129. G.S. 130A-144 requires the Commission for Health Services to prescribe control measures, which it does in the state’s administrative code: 15A NCAC 19A.0204—Control Measures—Sexually Transmitted Diseases (1991, *amended* 1993) & 15A NCAC 19A.0202—Control Measures—HIV (1988, *temporary amendment, recodified, or amended* 1989, 1990, 1991, 1992, 1994, 1995).

130. G.S. 130A-143.

# Living Arrangements

## WITH PARENTS

MOST UNMARRIED MINORS WHO ARE PREGNANT or have a child probably continue to live in their parents' home. As a matter of law, parents' duty to care for and supervise an adolescent is unchanged by her pregnancy or parenting. Her parents must support her until she is eighteen or emancipated.<sup>1</sup> Although parents can arrange for a minor child to live elsewhere, they remain responsible. If (as sometimes happens) a child becomes pregnant and they order her to leave without arranging suitable care, DSS could file a petition for neglect.<sup>2</sup>

Likewise, under state law the adolescent and the father of her child are legally responsible for their child's care and supervision. Unlike most states, in North Carolina a minor's parents and her partner's parents may have a duty to support the minor's child, too.<sup>3</sup> Unless "circumstances otherwise warrant," if both parents are minors, the four grandparents share liability for supporting, or helping to support, the grandchild. If one parent is a minor and the other an adult, the adult is expected to support the child. However, if he does not, the four grandparents are responsible for what he owes. The law recognizes that some grandparents cannot support a grandchild at all and that some can contribute more than others. The court decides how much each pays. If needed, grandparents' support obligations continue until the minor parent or parents reach eighteen or are emancipated. Grandparents' duty to support would not require them to keep the grandchild in their home.

Besides their concern for a daughter and their legal duty to support her, some parents of an unmarried pregnant or parenting minor have another

1. G.S. 50-13.4. See also G.S. 14-322(d), G.S. 49-7, and G.S. 110-129(2).

2. G.S. 7B-101(15).

3. G.S. 50-13.4(b), upheld in *Whitman v. Kiger*, 353 N.C. 360, 543 S.E.2d 476 (2001).

reason to encourage her to remain at home. Work First, North Carolina’s version of the federal Temporary Assistance to Needy Families (TANF) program, usually<sup>4</sup> requires an unmarried pregnant girl or custodial minor parent (in most cases this is the mother) as a condition of receiving cash assistance, to live with a parent, legal guardian, or other adult relative if doing so is safe and appropriate. While receiving TANF she must also work toward completing high school or the equivalent.<sup>5</sup> While living in a parent’s home (or equivalent) an adolescent mother does not begin using up the five-year lifetime limit on assistance.<sup>6</sup> Emancipated minors are likely to be exempt from the living-at-home rule, though emancipation by itself does not automatically exempt them.

## **IN THE CARE OF OTHERS**

As noted, TANF recognizes that a minor parent who needs public assistance may not be able to live with a parent, guardian, or relative. If DSS determines that such a minor’s current living arrangement is not appropriate, the agency must provide or help the minor locate an appropriate adult-supervised supportive living arrangement.<sup>7</sup> Sometimes—especially if abuse or

4. A unmarried minor parent who satisfies any of these conditions is exempt: (1) no parent, guardian or appropriate adult relative with whom the minor could live is alive or, if alive, their whereabouts are unknown; (2) no parent, guardian or appropriate adult relative will allow the minor to live in their home; (3) the state agency determines that the minor or her child has been subjected to serious physical or emotional harm, sexual abuse or exploitation in the parent’s or guardian’s home; (4) there is substantial evidence that imminent or serious harm to the minor or her child could occur if they lived with the parent or guardian; or (5) the state agency finds it in the best interests of the minor’s child to exempt them. 42 U.S.C. § 608(a)(5)(B)(ii) (2001 Supp.).

5. TANF can be used only for a minor parent who has completed or is working toward completing a high school education or state-approved “alternative educational or training program.” 42 U.S.C. § 608(a)(4).

6. 42 U.S.C. § 608(a)(7)(B)(2001 Supp.).

7. PRWORA, 42 U.S.C. § 608(a)(5)(B)(i) and (ii)(2001 Supp.). The possible arrangements include a maternity home or “second-chance home.”

neglect is the reason the minor cannot live with her parent—DSS will do this through child protective services and, if necessary, juvenile court. A “second-chance home” that federal law finds an acceptable alternative to living with a parent must require a minor parent “to learn parenting skills, including child development, family budgeting, health and nutrition, and other skills to promote their long-term economic independence and the well being of their children.”<sup>8</sup>

One national social work advocacy organization reports that DSS workers are sometimes unaware of this provision, and mistakenly believe that only minor parents living with a parent can qualify for TANF.<sup>9</sup> North Carolina’s Work First program correctly informs DSS workers that a minor who cannot live with a parent or adult relative may still qualify for TANF,<sup>10</sup> although the state apparently has not instructed local DSS agencies to provide or find an appropriate adult-supervised home for such a minor.

### **DSS Intervention**

The Child Protective Services staff of DSS responds to reports that a child has been abused or neglected, or is dependent.<sup>11</sup> If they substantiate the report DSS will work with the family to remedy the situation. Sometimes the parents, with DSS approval, will place a child with a relative while case management services are being provided. If the parents do not cooperate or if for any reason the risk to the child is too high, the director may initiate court involvement by filing a petition alleging one of those conditions.<sup>12</sup> A hearing will be held (and the child may be removed from the home under a nonsecure custody order pending it) to determine whether the allegations are true and, if so, how the child should be cared for.<sup>13</sup> A court has the authority,

8. 42 U.S.C. § 608(a)(5)(B)(iii)(2001 Supp.).

9. CENTER FOR LAW AND SOCIAL POLICY, REAUTHORIZATION ISSUES: THE MINOR PARENT LIVING ARRANGEMENT PROVISION, Washington, D.C. Available at [www.clasp.org](http://www.clasp.org).

10. WORK FIRST MANUAL, Section 107-I, “What Are the Minor Parent Rules?” at <http://info.dhhs.state.nc.us/olm/manuals/dss>.

11. G.S. art. 3, ch. 7B.

12. G.S. art. 4, ch. 7B.

13. G.S. art. 5, ch. 7B.

with or without giving legal custody to DSS, to ask DSS to supervise a child at home,<sup>14</sup> but it rarely does so. The court may also grant custody to DSS, but allow the child to remain in the home. Most often, when a child is adjudicated abused, neglected, or dependent, custody is awarded to DSS and the child comes into foster care.

DSS must consider carefully before recommending a child's removal. A federal law, the Adoption and Safe Families Act (ASFA),<sup>15</sup> requires states to make reasonable efforts to keep families together.<sup>16</sup> Federal law does not describe the efforts necessary, but says that the child's health and safety are the paramount concerns in deciding where she lives.<sup>17</sup> North Carolina offers guidance on the meaning of "reasonable efforts." Under state law, DSS must make "diligent use of preventive or reunification services" to keep a child at home if that is safe and if the efforts are likely to create a permanent home in a reasonable amount of time.<sup>18</sup> A court order placing or continuing placement of a child in DSS custody must contain findings that DSS made reasonable efforts to prevent removal.<sup>19</sup> Thus, DSS works to preserve families by providing services and putting families in touch with community resources,<sup>20</sup> but state law, like federal law, recognizes that keeping a minor at home is not appropriate in every case.<sup>21</sup>

14. "If possible, the initial approach [to possible abuse, neglect or dependency] should involve working with the juvenile and the juvenile's family in their own home. . . ." NC Division of Social Services, CHILDREN'S SERVICES MANUAL, Chapter IV: Section 1201, IV. "Children in DSS Custody Who Remain in the Home," based on G.S. 7B-900 and G.S. 7B-903(2)a.

15. 42 U.S.C. § 670 et seq. (2001 Supp.)

16. 42 U.S.C. § 671(a)(15)(2001 Supp.).

17. *Id.*

18. G.S. 7B-101(18).

19. G.S. 7B-507.

20. "The court should arrange for appropriate community-level services to be provided to the juvenile and the juvenile's family in order to strengthen the home situation." CHILDREN'S SERVICES MANUAL, Ch. IV, Section 1201: Child Placement Services, "Community-based Support for Families," based on G.S. 7B-900.

21. Reasonable efforts need not be made or may stop if clearly futile or inconsistent with the child's health, safety or need for a safe permanent home within a reasonable time; if the parent has severely harmed the child; parental rights to a sibling

This same federal law also strongly influences DSS's custody and supervision of children. As a condition of federal funding for foster care<sup>22</sup> and adoption services, ASFA first directs state courts and DSS to try, before and after removing a child for abuse, neglect, or dependency, to keep families together. However, if the family cannot be preserved, DSS must move quickly to find the child a safe, permanent home elsewhere. Unless an exception applies, DSS must petition to terminate parental rights for every child who has been in foster care for 12 of the past 22 months,<sup>23</sup> been abandoned, or whose parents have committed specified crimes. The exceptions, one of which will very often apply, are:

1. if DSS's permanent plan for a child is placement in the legal custody of a relative or other suitable person or under guardianship;
2. if DSS has a compelling reason why termination would not be in the child's best interest; or
3. if DSS has failed to make "reasonable efforts" toward family reunification.<sup>24</sup>

ASFA requirements are reflected in North Carolina's law<sup>25</sup> and in state DSS directives.

Since placement with relatives can often be an appropriate permanent plan for a child, DSS must very quickly try to identify relatives with whom the child could be placed.<sup>26</sup> DSS has a legal obligation to search for missing

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have been terminated involuntarily; or the parent is guilty of various crimes against the child or his or her other children, G.S. 7B-507(b).

22. The federal government bears more than half of the expense of North Carolina's foster care system. NC DSS Admin. Letter #.C.S. 3-00, "New Federal Guidance Relating to ASFA and IV-E Eligibility," available at <http://info.dhhs.state.nc.us/olm/manuals/dss>.

23. G.S. 7B-907(d).

24. 42 U.S.C. § 675(5)(E)(2001 Supp.).

25. G.S. 7B-907(d).

26. 42 U.S.C. § 671(a)(19)(2001 Supp.); G.S. 7B-505 and -506(h)(2).

parents<sup>27</sup> and look for relatives or others in a family’s network to take an adolescent, perhaps with her child, into their home. A person need not be biologically related to the minor or her parents to qualify as family. NC DSS’s Children’s Services manual advises, “Kinship relationships are self-defined. Many families value non-relatives as kin, such as godparents, friends and neighbors with whom they have a family-like relationship. Workers can help families identify who they consider to be part of their kinship network.”<sup>28</sup> Caseworkers are to encourage kinship care by helping the relative obtain resources.<sup>29</sup> State statute requires that a child be placed with any in-state relative “willing and able to provide proper care and supervision in a safe home,” unless the placement would be contrary to the minor’s interests.<sup>30</sup> Giving custody to relatives often has advantages for a child. For a pregnant or parenting minor it may have the added advantage of making it easier to live with and retain custody of her child.

### **Foster Care**

If no one in a family network can take a child, DSS may place the minor with a non-related foster family or in a facility.<sup>31</sup> Federal law encourages

27. CHILDREN’S SERVICES MANUAL, Ch. IV, Section 1201-IV, “Kinship Support for Families,” based on G.S. 7B-506(h)(1).

28. *Id.*

29. “Potential caregivers shall be informed of available agency resources, such as child-only Work First grants, subsidized guardianship assistance, medical coverage, day care and food stamps. When needed, families shall also be informed of any available community resources for free or low-cost clothing or furniture, minor home repairs, or other such incidental needs that may unnecessarily prohibit their being approved to provide care for children. If the kinship caregiver wishes to be licensed as a foster parent, the agency is required to determine whether or not the family meets state licensing requirements, thus enabling them to receive foster care assistance payments, Medicaid and other benefits,” (citations omitted) CHILDREN’S SERVICES MANUAL, Ch. IV, Section 1201-V, “Choosing the Best Placement Resource.”

30. G.S. 7B-505(h)(2) and 7B-903(a)(2)c. “Safe home” is defined in law as one in which a child is not at substantial risk of being abused or neglected, G.S. 7B-101(19).

31. G.S. 7B-505; 7B-903(a)(2)c; 108A-14(a)(12) and CHILDREN’S SERVICES MANUAL, Ch. IV, Section 1201-VI “Out of Home Placement Services: Maintaining One Single, Stable Foster Care Placement.”



placing children in the most family-like, least restrictive setting close to their parents.<sup>32</sup> Foster care is intended to be temporary, but very often it is not for older children. Many young people spend years leading up to their eighteenth birthday in that status. Still, federal law requires DSS to continue to seek a permanent home for older minors<sup>33</sup> and North Carolina state policy is the same. North Carolina's Children's Services Manual states that "Agency efforts to locate permanent families for teens should continue as long as the agency is involved."<sup>34</sup> The Manual goes on to note that successful adoption recruitment strategies for older minors differ from those used for young children and that a teen may already have formed a "family" not biologically related to him, one of whose members can offer a good home.<sup>35</sup> For an 18-year-old who has not found a home but still needs and wants significant support, DSS can supply it until age twenty-one. (See description of LINKS program in section on "Foster Children Entering Adulthood.")

### **Juvenile Court Custody or Guardianship**

ASFA requires states to find or at least try to find a permanent home within a year for every child in foster care. Otherwise, DSS must offer compelling reasons why the effort is not in a child's best interest.<sup>36</sup> Granting juvenile court custody or guardianship to an appropriate caregiver, usually a relative, is now frequently that case plan. Obtaining custody of a child under Chapter 50 of the North Carolina General Statutes or guardianship of a child under Chapter 35 can be difficult and expensive. However, the juvenile

32. If a placement does not meet the guidelines, the case plan must show why the placement is in the child's best interest, 42 U.S.C. § 675(5)(A)(2001 Supp.).

33. The minor's placement must be reviewed regularly and her case plan must show "progress . . . toward alleviating or mitigating the causes necessitating placement in foster care, and . . . project a likely date by which the child may be returned to and safely maintained in the home or placed for adoption or legal guardianship." 42 U.S.C. § 675(5)(B)(2001 Supp.).

34. Ch.IV, Section 1201-VIII, "Permanency Planning Process: Transitional Living Plans."

35. CHILDREN'S SERVICES MANUAL, Ch. IV, Section 1201-VIII, "Development of Permanent Planning Resources."

36. 42 U.S.C. § Sec. 675(1)(E) and (5)(C)(2001 Supp.).

code, Chapter 7B, provides both custody and guardianship as dispositional alternatives for the court when a child has been adjudicated abused, neglected, or dependent.

The court can grant juvenile court custody at any time after it has sufficient information to determine that the caregiver will adequately and appropriately provide for the adolescent, her child, or both. DSS must carefully consider, with the caregiver, whether the caregiver can meet the adolescent's and her child's needs once custody—and the services that come with it—are no longer with DSS. Although juvenile court custody can be changed from DSS to someone else soon after a juvenile court becomes involved, the juvenile court judge must still review the case until the child has lived with the relative for at least a year. Then the court may waive further scheduled reviews, but must hear any review requested by a party to the case.<sup>37</sup> Termination of parental rights is not required before an award of juvenile court custody, so the parents' child support obligation continues and can assist the relative or other person awarded custody with the cost of the child's care. Since the parents do not lose their rights, they may also petition the court to return custody to them if they can show that their circumstances have changed.<sup>38</sup>

Under ASFA, guardianship is “a judicially created relationship between child and caretaker which is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker of the following parental rights . . . protection, education, care, and control of the person, custody of the person, and decision making.”<sup>39</sup> North Carolina's definition is similar. A juvenile court may appoint a guardian of the person, who operates under court supervision and reports to the court. The guardian has “care, custody and control of the juvenile or may arrange a suitable placement . . . and . . . represent the juvenile in legal actions. . . .” The guardian may consent in the place of the parent to the minor's marriage, enlistment in the armed services,

37. G.S. 7B-906(b).

38. In re Williamson, 77 N.C. App. 53, 334 S.E.2d 428 (1985).

39. 42 U.S.C. § 675(7)(2001 Supp.).

or school enrollment.<sup>40</sup> (The guardian of the person should not be confused with a guardian ad litem.)<sup>41</sup>

As these definitions show, guardians have broad control over minors. Moreover, guardianship cannot be removed without a showing that the guardian is unfit, unwilling, has neglected her duties, or the relationship with the juvenile is such that guardianship is no longer in the child's best interest.<sup>42</sup> Thus, a juvenile court guardian is afforded more protection against loss of that status than a juvenile court custodian. Although the legal authority of guardianship helps a concerned adult care for a minor, it also imposes serious obligations (although not the duty to support, which still rests with the parents) as it relieves DSS of them. While this may often be appropriate, in some cases, as with juvenile court custody, there is the danger of depriving relatives of resources needed to care for a minor—resources only available to a child in DSS custody.

Finally, when a relative or other appropriate caregiver is willing to accept juvenile court custody or guardianship of a pregnant or parenting adolescent, the option of adopting that child should also be discussed. Adoption must be preceded by termination of parental rights or a relinquishment by the parents. (The parents can sign a designated relinquishment that only authorizes DSS to place the child with the person named in the relinquishment.) “Special needs” foster children, who make up almost all of the state's foster care population, are eligible for and entitled to adoption assistance. This assistance includes monthly payments equal to foster care payments (presently \$415 for children 13–18 years old), yearly vendor payments for medical and other therapeutic services, and the services of an adoption worker to provide post-adoption services aimed at strengthening and supporting the adoption.

40. G.S. 7B-600.

41. G.S. 7B-601.

42. G.S. 7B-600(b).

## ALONE OR WITH A PARTNER

Unless a minor is married or otherwise emancipated, the law requires that she live under the supervision of parents, guardians, or authorized custodians. If she does not, the law describes her as “undisciplined”—that is, someone who is “regularly disobedient,” “beyond disciplinary control,” “regularly found in places where it is unlawful for a juvenile to be,” or has run away for more than 24 hours. For someone under 16, the definition of “undisciplined” also includes being absent from school without permission.<sup>43</sup>

According to a federal official, pregnant girls are over-represented among homeless and runaway youth. They may run away because they are pregnant or become pregnant while living on the street.<sup>44</sup> Shelter staff in our state, however, reports seeing very few pregnant or parenting teens.<sup>45</sup> Policies and available programs for these adolescents vary among North Carolina’s ten youth shelters, which are located in Winston-Salem, Greensboro, Belmont, Pembroke, Sylva, Sanford, Raleigh, Charlotte, Wilmington, and Asheville. Typically, though, if a facility has an open bed, a girl can stay for a few days to a few weeks. Parents are notified of a minor’s presence at a shelter within 24 to 72 hours after her arrival and must agree to her admission.<sup>46</sup> Shelter staff can help a young woman with pregnancy and parenting

43. G.S. 7B-1501(27).

44. Telephone conversation with Julie Bosland, Special Assistant to the Commissioner, Administration on Children, Youth and Families, U.S. Dep’t of Health and Human Services, February 2, 2000.

45. Telephone conversation with Michael Rieder, Exec. Director, Haven House, Raleigh, N.C., March 5, 2001. (Rieder points out that staff might easily miss a teen’s pregnancy in dealing with other problems.) Telephone conversation with Tami Graven, Case Management Supervisor, The Relatives, Inc., Charlotte, N.C., March 5, 2001. Telephone conversation with Elizabeth Chambers, Exec. Director, Mountain Youth Resources, Sylva, N.C., March 6, 2001.

46. Regulations under the federal Runaway and Homeless Youth Act (42 U.S.C. § 5701 et seq.) encourage notifying parents within the shorter period and require it within the longer one, 45 C.F.R. 1351.18(e). State licensing requires notice and parental consent within 72 hours, 10 N.C.A.C. 41T.0202(b)(1).

issues while she is there on an emergency basis or during longer programs for which she might qualify.

Arrangements for children who seek shelter often involve DSS. Shelter staff may call DSS in a number of circumstances: to report possible maltreatment; when a parent cannot be located; if a client refuses to name a parent; or if the time for which a shelter will keep someone has expired and there is nowhere for her to go. Even if a shelter discharges clients to return home, it may refer them to DSS for services.

If DSS takes custody of runaway parents, they—or other minors raising children (see next section)—may be candidates for the LINKS program described in the “Employment” section. For possible legal consequences when a minor has a sexual relationship with a considerably older unmarried partner, see the section above on “Sexual Assault.” For information on when minors may marry, see the section on “Marriage” below.

## **WITH HER CHILD**

Nearly all minors who give birth plan to raise the child. Many care for their children while living with their own parents or other relatives or, less often, with a partner. However, if a minor is in DSS custody, her opportunity to parent is likely to be more complicated. State statutes governing placement of abused, neglected, or dependent children encourage keeping families together<sup>47</sup> but do not seem to anticipate *two* children in a single case—mother and child—perhaps with conflicting needs. In such a case, it is no help to judges to be told by statute to rule in favor of the best interests of “the child.” DSS personnel report that questions arise that are difficult legally and emotionally. These include

47. For example, unless contrary to the child’s best interest, “the court should arrange for appropriate community-level services to be provided to the juvenile and the juvenile’s family in order to strengthen the home situation,” G.S. 7B-900, and if a child is removed, the court must address the issue of “appropriate visitation” between parent and child, G.S. 7B-905.

1. If a young mother in DSS custody wants to parent and is capable of it, must DSS place her and the child together?
2. Who should have custody of a minor mother's child when child and mother are in DSS custody—the mother or DSS? and
3. If a mother is in custody, what are *her* mother's rights with respect to the baby?

The answer to the first question may be yes, particularly if DSS has custody of the younger child. To qualify for federal help with foster care and adoption expenses, every state must agree to make “reasonable efforts to preserve and reunify families.”<sup>48</sup> Thus, North Carolina provides that to justify DSS custody a court must find that it is not in the child's best interest to be with a parent.<sup>49</sup> Placing a child and parent separately would seem to violate this requirement. DSS must try to keep a child with a parent unless a parent has subjected a child to “abandonment, torture, chronic abuse . . . sexual abuse” or similar aggravated circumstances or committed serious crimes against others.<sup>50</sup> Moreover, the federal government clearly expects some minor parents in foster care to have their children with them since it is willing to compensate states for the additional expense of the younger child—whether or not DSS has custody of the younger child.<sup>51</sup>

Besides being legally indicated and reimbursable by the federal government, keeping a parent and child together is usually the humane decision.

48. 42 U.S.C. § 671(a)(15)(B)(2001 Supp.).

49. The statute refers to the child's “own home.” For a child whose parent is in DSS custody this would mean in the same foster care placement as the parent. G.S. 7B-507.

50. 42 U.S.C. § 671(a)(15)(D)(2001 Supp.).

51. “In cases where (i) a child placed in a foster family home or child-care institution is the parent of a son or daughter who is in the same home or institution, and (ii) payments . . . are being made under this part with respect to such child, the foster care maintenance payments made with respect to such child . . . shall also include such amounts as may be necessary to cover the cost of the items . . . with respect to such son or daughter.” 42 U.S.C. § 675(4)(B)(2001 Supp.). *See also* 45 C.F.R. 1356.21(j).

One teen who spent years in North Carolina foster care with her children said, with great regret, “I can tell you this. Foster parents don’t want someone with a child.”<sup>52</sup> Asked what might make another young mother’s experience easier, she had these suggestions:

- Tell her that DSS does not have to take legal custody of her child.
- Urge foster parents to treat the adolescent *as a parent*, giving her as much responsibility as possible for the child’s care.
- Encourage foster parents and DSS caseworkers to talk honestly to an adolescent about her options as a parent, adults’ opinions of her parenting skills, and similar matters that will help her regain custody when she leaves foster care.
- Do not separate mother and child (as this mother and children were for several months).
- Be sure foster parents understand how the younger child’s allotment may be used. (When one of her children broke something, a foster parent used money from the child’s allotment to replace the item.)

As for the second question, some DSS attorneys and staff in North Carolina report that their agency always asks the court for custody of both children, on the theory that the younger child is dependent because her custodial parent is. Foster parents may be more comfortable caring for mother and child if DSS has custody of both and the availability of some resources may depend on who has custody. For these or other reasons, DSS custody of the younger child may be justified, but it does add a significant complication for the mother. When leaving foster care herself, she must leave the child behind until DSS is satisfied that she can provide an acceptable level of care.

A few states’ laws address some of these points. Michigan, for example, provides in its administrative code that a minor parent in foster care

52. Interview with 19-year-old mother of three, formerly a foster child, Durham, N.C., January 15, 2001.

and her child must live together under the supervision of an appropriate adult (not the child's other parent). The adult acts as parent to the minor parent while she cares for her child.<sup>53</sup> The minor parent executes a voluntary placement agreement with respect to her child that does not have the usual six-month limit.<sup>54</sup>

North Carolina law apparently does not answer the first two questions definitely and practice within the state varies. However, most DSS agencies place mother and child together in foster care if the young parent wants it, seems to be a fit parent, and if DSS can find an appropriate home that will accept both children. This would seem to be the practice most consistent with the state and federal law described above.

The third question appears more straightforward. A grandparent's rights to visit, for example, will depend on custody. If the minor mother retains custody of her child, she will decide. If DSS is the younger child's custodian, DSS will decide.

53. "Adult parents should act as the caretakers of their minor children and provide maintenance, physical care and guidance, even after a minor child has become a parent. When living with a parent, stepparent, or legal guardian is not possible, the minor parent and child should live in another adult-supervised living arrangement." PEM 201, State of Michigan Program Eligibility Manual—Family Independence Agency, available at [www.mfia.state.mi.us/olmweb/ex/per/201.pdf](http://www.mfia.state.mi.us/olmweb/ex/per/201.pdf).

54. This arrangement is for minor parents receiving assistance, but every local office has a Minor Parent Coordinator and the state "Agency offers services to minor parents whether eligible for assistance benefits or not." CFF-722-1, State of Michigan Children's Foster Care Manual—Family Independence Agency, available at [www.mfia.state.mi.us/olmweb/ex/pem/201.pdf](http://www.mfia.state.mi.us/olmweb/ex/pem/201.pdf).



# The Adolescent's Future

ONCE A PREGNANT ADOLESCENT'S IMMEDIATE NEEDS ARE MET DSS may be able to help her move toward an independent future. Her most important decision will be whether to raise a child. The following section reviews aspects of the law on that issue and on emancipation, marriage, education, and employment. It ends with a description of services that federal funding has recently made available for current and former foster children until they are 21 years old.

## **EMANCIPATION**

An emancipated person is one who may conduct business as an adult, is no longer entitled to parental support, and is legally free of parental control.<sup>1</sup> Simply becoming eighteen is the usual means of emancipation. Those under eighteen may be emancipated by several means. Marriage is one.<sup>2</sup> Another, open only to sixteen- and seventeen-year-olds who have lived in the state for six months before filing, is to petition a court for an order of emancipation. Lastly, a minor enrolled in the armed services is no longer "subject to the supervision and control" of parents.<sup>3</sup> Becoming a parent does not emancipate a minor in North Carolina.

In the court proceeding the minor must persuade the judge by a preponderance of the evidence that emancipation would be in her best interests.<sup>4</sup> The process assumes, though it is not always true, that the minor's parents object to emancipation. They must be given notice of the hearing and, like

1. G.S. 7B-3507.

2. G.S. 7B-3402. Some adolescents who are emancipated by marriage divorce while still under the age of 18. Although the law does not address their status, it is the author's opinion that such a minor remains emancipated.

3. G.S. 7B-3402.

4. 7B-3503.

the minor, may present evidence and cross-examine witnesses.<sup>5</sup> The judge considers these factors:

- Do her parents need her earnings?
- Can she function as an adult?
- Does she need to contract as an adult or to marry?
- Is she employed and does she have stable living arrangements?
- Is there family discord and, if so, is parent/child reconciliation unlikely?
- Is she rejecting family supervision or support? and
- How good are the parental supervision and support?<sup>6</sup>

Weighing these points the judge may grant the petition if all parties have had a chance to be heard; the minor offered a plan for adequately providing for her own needs and expenses; she is knowingly seeking emancipation and understands its legal effects; and emancipation is in her best interests.<sup>7</sup>

## **MARRIAGE**

In North Carolina people can marry at age eighteen—or earlier if emancipated through the court procedure. Otherwise, sixteen- and seventeen-year-olds need consent to marry from an appropriate adult—that is, a person having legal custody of them or serving as their guardian.<sup>8</sup> A fourteen- or fifteen-year-old girl may marry only if she (1) is pregnant or has a child by the person she agrees to marry, and (2) a district court judge authorizes the marriage. Likewise, a fourteen- or fifteen-year old boy may marry a woman he has impregnated or who is the mother of his child if he agrees to be mar-

5. *Id.*

6. G.S. 7B-3504.

7. G.S. 7B-3505.

8. G.S. 51-2(a1).

ried and a judge authorizes it.<sup>9</sup> The form and instructions for an underage person to initiate the judicial process are available at [www.nccourts.org/Forms/FormSearch.asp](http://www.nccourts.org/Forms/FormSearch.asp).<sup>10</sup>

To authorize marriage for a fourteen- or fifteen-year-old, a judge must make two findings: that the young person can fulfill the responsibilities of marriage and that marriage would be in her or his best interest. Before ruling on “best interest,” the judge must listen to the underage person’s parents, custodian, guardian, and GAL, but does not have to follow their opinions. (Presumably, a DSS director, as custodian of a minor in foster care, would express an opinion as to the minor’s best interests.)<sup>11</sup> The GAL, in the case of underage marriage, is an attorney whom the judge asks to investigate and advise the judge on the minor’s best interest and to assess, among other things, “the emotional development, maturity, intellect, and understanding” of the youth.<sup>12</sup> The minor is not entitled to appointed counsel, however. The law states that the fact that a girl or woman is pregnant or has given birth is not enough to show that it is in the underage person’s best interest to marry.<sup>13</sup>

North Carolina strongly favors marriage and the legitimacy of children, and many pregnant and parenting teens do marry. Indeed, in 2000, at least 15 pregnant girls 14 or younger were married.<sup>14</sup> However, DSS directors asked to consent or express opinions to a judge about teen marriages have difficult decisions.<sup>15</sup> While each case must be considered on its own merits,

9. G.S. 51-2.1(a).

10. AOC-CV-120, Complaint for Judicial Authorization for Underage Person to Marry, and AOC-CV-1201, Instructions for Underage Person Seeking Court Authorization to Marry.

11. The statute directs a judge to consider “The opinion of any person, agency, or institution having legal custody or serving as a guardian of the underage party as to whether the marriage serves the interest of the underage party,” G.S. 51-2.1(a)(2).

12. G.S. 51-2.1(d).

13. G.S. 51-2.1(a).

14. STATE CTR FOR HEALTH STATISTICS, REPORTED PREGNANCIES 2000, available only at <http://hermes.sches.ehnr.state.nc.us/SCHS>.

15. According to one source, the policy “subordinates other interests, such as

young women married before age eighteen are nearly twice as likely to end the marriage as are women married at twenty-five or older.<sup>16</sup> Marriage can have other adverse legal consequences. For example, it arguably relieves a young person of the legal obligation to attend school until age 16.<sup>17</sup> It can obscure sexual assault, since spouses cannot be forced to testify against each other even about events that took place before they married. It also deprives a minor of important rights including the right to child support, the protection of juvenile courts and departments of social services,<sup>18</sup> and the chance to apply for special immigrant juvenile status.<sup>19</sup> The latter lets an undocumented minor who is dependent on a state court remain in the United States lawfully and eventually become a citizen.

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those of the parents and guardians of the underage applicant [for a marriage license] and the long-term welfare of both the child and its mother.” William A. Campbell, *North Carolina Marriage Laws: Some Questions*, 63 POPULAR GOV'T 50, 53 (Winter 1998). Another legal writer points out that the Uniform Marriage and Divorce Act, which North Carolina has not adopted, allows no one younger than sixteen to consent to marriage and “expressly rejects pregnancy as an automatic exception to an age requirement” because “marriages entered into under these circumstances are even more vulnerable than other youthful marriages.” Suzanne Reynolds, 1 LEE'S NORTH CAROLINA FAMILY PRACTICE § 2.8 at 98 (5th ed. 1993). A third source concludes that “[a]dolescent child bearers may not be able to combine school attendance and marriage successfully.” Diane Scott-Jones, *Educational Levels of Adolescent Childbearers at First and Second Births*, 99 AM. J. EDUC. 461, 477 (Aug. 1991).

16. Matthew D. Bramlett and William D. Mosher, *First Marriage Dissolution, Divorce and Remarriage: United States*, ADVANCE DATA 323 (May 31, 2001), Centers for Disease Control and Prevention, National Center for Health Statistics. Available at <http://www.cdc.gov/nchs/>.

17. G.S. 115C-378 requires “Every parent, guardian or other person having care or control” of a child between seven and sixteen years old to send the child to school. However, parents have no legal responsibilities for married children. As a result, some attorneys think the compulsory attendance statute is ineffective as to married fourteen- or fifteen-year-olds. Others note that these emancipated teens have “care or control” of themselves and thus *they* should be bound by the statute. Such an interpretation would be consistent with the legislative intent that minors attend school at least until age sixteen.

18. G.S. 7B-101(14).

19. 8 U.S.C. § 1101(a)(27)(J).

## SURRENDERING A NEWBORN

Under certain circumstances DSS employees have a legal duty to accept a newborn from a parent—or from an adult to whom a parent has given a child. With particular concern for the children of young parents<sup>20</sup> the General Assembly allows any parent to avoid criminal liability when surrendering custody of an infant fewer than seven days old. If a parent offers a child and “does not express an intent to return,” DSS workers, health-care providers, emergency medical service workers, and law enforcement officers who are on duty or at their workplace *must*, and other adults *may*, accept a child.<sup>21</sup> An adult who takes a newborn must guard the infant’s health and well being and immediately contact DSS or law enforcement. He or she may ask the parent’s identity and medical history, but must tell parents they are not required to answer. An adult acting in good faith who accepts an infant is safe from civil or criminal liability for ordinary negligence.<sup>22</sup>

For a parent, surrendering a newborn in compliance with this statute prevents prosecution for abandonment<sup>23</sup> or the milder forms of (misdemeanor) child abuse.<sup>24</sup> However, abandonment of this nature for 60 consecutive days immediately before the filing of a petition to terminate parental rights gives a court grounds for termination.<sup>25</sup>

DSS has numerous duties under the legislation besides the obligation of DSS staff who are on duty or at the agency to accept an infant. When DSS receives a report of an abandoned child, it must “(1) initiate an investigation immediately, (2) take appropriate steps to assume custody of the child, and (3) take appropriate steps to obtain a court order allowing the agency to

20. Section 6, Session Law 2001-291.

21. G.S. 7B-500(b) and (d).

22. The immunity does not extend to “gross negligence, wanton conduct, or intentional wrongdoing.” G.S. 7B-500(e).

23. G.S. 14-322.3.

24. G.S. 14-318.2. For a parent convicted of felony child abuse under G.S. 14-318.4, abandonment in compliance with this statute may be considered a mitigating factor in sentencing.

25. G.S. 7B-1111(a)(7).

keep custody pending a court hearing. The social services director also must ask law enforcement officials to investigate, using the North Carolina Center for Missing Persons and other national and state resources to determine whether the juvenile is a missing child.”<sup>26</sup>

The first reported event under the statute involved paramedics, a hospital social worker, and law enforcement. The mother, who gave birth in the woods in January, “reluctantly” supplied a medical history but little else. The report credits the social worker with convincing police to take no action against the mother by showing them a copy of the law.<sup>27</sup>

## ADOPTION

As DSS staff knows, very few adolescents place a child for adoption, although minors have the same legal ability in this regard as adults.<sup>28</sup> Estimates of unmarried adolescent mothers in the United States who complete an adoption vary from two to five percent.<sup>29</sup> However, a much larger number of young mothers consider adoption—12 percent in one study, although 89 percent predicted a negative reaction from partner, friends, or family members.<sup>30</sup> DSS is well placed to help teens explore adoption since DSS both places children and does home studies for other adoptions. In addition, girls and families may contact DSS for services when a minor is pregnant, or be-

26. Cheryl Howell and Janet Mason, Chapter 3, *Children and Families*, NORTH CAROLINA LEGISLATION 2001 (2002) at 6–7.

27. Trish Wilson, *Infant, Mother Safe with New Law*, RALEIGH NEWS & OBSERVER, Jan. 26, 2002, at 1A.

28. G.S. 48-3-605(b).

29. One source reports five percent: JUDITH MUSICK, YOUNG, POOR, AND PREGNANT: THE PSYCHOLOGY OF TEENAGE MOTHERHOOD 18 (1993); another, three percent: Rickie Solinger, *Introduction*, in THE ABORTION WARS (1998); and, according to the American Academy of Pediatrics, two to four percent: *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746751 (May 1996) and at [www.aap.org](http://www.aap.org).

30. Kari Sandven & Michael D. Resnick, *Informal Adoption among Black Adolescent Mothers*, 60 AM. J. ORTHOPSYCHIATRY 210, 217.

cause a young mother was in DSS custody or had a caseworker when she became pregnant or gave birth.

Below are questions that young women commonly have about adoption. The brief answers, based on North Carolina law, may be useful to professionals who are talking with them.

### **1. Do my parents have to agree to my baby's adoption?**

No. Whatever your age, you, rather than your parents, can decide to let the baby be adopted.<sup>31</sup> By the same token, if your parents want the baby to be adopted and you do not, you do not have to agree.

### **2. Does the baby's father have to agree to adoption?**

The baby's father does have legal rights, including the right to object to adoption, and his rights do not depend on his being an adult. He could stop an adoption if you and he married, if he took legal responsibility for the baby in any of a number of ways, supported you or the baby, or was ordered by a court to support the baby.<sup>32</sup> He can lose the right to object to adoption, though, by not taking responsibility in the ways mentioned<sup>33</sup> or not responding to notice from those hoping to adopt that an adoption is scheduled to take place. Another way for an unmarried father to lose his parental rights is to sign a notarized statement denying that he is the father or indicating that he does not have a legal interest in the baby.<sup>34</sup>

### **3. If I agree to adoption, could the baby's father or his family end up with the baby?**

A father can always try to get custody, whether or not you are trying to have the baby adopted. But you can prevent the father or his family from gaining custody of the child from you *as a result of* the adoption process. If you

31. G.S. 48-3-605(b).

32. G.S. 48-3-601(2).

33. See the discussion of *In re Byrd*, 354 N.C. 188, 552 S.E.2d 142 (2001) in the section on Termination of Parental Rights.

34. G.S. 48-3-603(a)(5).

choose the person who adopts the baby,<sup>35</sup> you and that person can agree, in writing, that if the father tries to claim the baby before the adoption, you will take the baby back.<sup>36</sup> If an agency handles the adoption, you can agree to give up the baby only on the condition that a particular family that has been described to you adopts the child. (The legal term for setting a condition about who will adopt is *designated relinquishment*.) Be sure that the relinquishment form you sign says that if the adoption does not work out you want to be notified so that you can take the baby back.<sup>37</sup>

#### **4. Can I talk to an adoption agency or a person who wants to adopt my baby and then decide against adoption? What about changing my mind?**

Certainly, you can explore placing your child for adoption and decide not to. You have any amount of time you want before deciding, and you have a brief time after agreeing to adoption to change your mind. A mother cannot agree to her baby's adoption until the baby is born, though the baby's father can.<sup>38</sup> Once you sign a consent to adoption, you usually have seven days to change your mind.<sup>39</sup>

#### **5. Can I choose the family that will adopt my baby?**

Yes. You might choose someone you know, who (unless he or she is a close relative) would have to be investigated before being approved as an adoptive parent. Or you could let an adoption agency or DSS find a family. If you do

35. This kind of adoption, if arranged by a baby's parent, is called *direct adoption* (see G.S. 48-3-202) or, if an agency is involved, a *designated agency adoption* (see G.S. 48-3-703(a)(5)(b)).

36. G.S. 48-3-609(a)(2). Both you and the baby's father might then seek custody. Having previously consented to adoption will not prevent a mother from being awarded custody. G.S. 50-13.2(d).

37. If the agency can locate you (it must make diligent efforts), you would have 10 days after notification to decide to take the baby back or let the agency place him or her with someone else. G.S. 48-3-704.

38. G.S. 48-3-604(a) and (b).

39. G.S. 48-3-608 and -706. In a few circumstances the periods could be shorter or longer. For example, if you consent a second time to give the baby to a particular person or agency, you cannot change your mind.



not want to name a particular person, you can still say what kind of person or family you would like.<sup>40</sup> Most agencies would let you choose from descriptions or pictures or from meeting a couple already approved for adoption. Whatever way an adoptive parent is selected, though, a court must find that person suitable before it will approve an adoption.<sup>41</sup>

**6. If I don't choose someone I know or a family described to me, will I ever know anything about the parents?**

Most agencies (including social services departments) will tell you about the adopting family and may show you pictures or let you and the adoptive parents speak by phone or meet. If knowing about the family is important to you, ask adoption agencies, before you choose one, how much information they would give you. You might learn the most from the “home study” done on a possible adoptive family for your child, which you are entitled to see.<sup>42</sup> Agencies are required by law to answer your questions about their process and to place your child with the couple you choose if the agency agrees to let you select one.<sup>43</sup>

**7. Will I have to pay to have my baby adopted?**

No. There are no charges.

**8. Can the adoptive parents give me money?**

They can pay your ordinary living expenses during pregnancy and for six weeks afterward. They can also pay counseling, medical, and legal fees.<sup>44</sup> You can accept this money and still change your mind about letting the baby be adopted. The money is not payment for the baby.<sup>45</sup>

40. G.S. 48-3-201 through 48-3-203.

41. G.S. 48-2-603.

42. G.S. 48-3-307(c). The study is called a preplacement assessment.

43. G.S. 48-3-203(d)(1).

44. G.S. 48-10-103.

45. It is a crime to give or to take money for a baby. G.S. 48-10-102.

### 9. Can I visit or hear about my baby as he or she grows up?

You will have no legal right to do so, not even if you choose the adoptive parents. If they promise that you will be able to contact the child, they might keep the promise, but they are not legally obliged to do so.<sup>46</sup>

### 10. Can the baby find me when he or she is grown?

You and the adoptive parents can agree to let the agency release information that would identify you to one another. (The agreement has to be in writing, acknowledged under oath, and made before the adoption.)<sup>47</sup> Even without the agreement, if your grown child wants to find you, and you want to be found, the answer is probably yes. North Carolina has not created a system for adult children and birth parents to contact one another but, if someone asks for information about an adoption, a court will consider releasing it.<sup>48</sup> There are registries in the United States that match inquiries from birth parents and children.

### 11. Why should I think about adoption if a relative or friend will keep the baby?

Actually, more than half of all adoptions are by relatives. Letting a friend or relative adopt, rather than just keeping your baby, would help that person care for the baby. As an adoptive parent, your relative or friend could much more easily act for and gather resources for the baby—get the baby medical care, enter him or her in school, and apply for health insurance or other benefits, for example. Still, you must understand that *after adoption, the person becomes the baby's parent for all legal purposes.*

### 12. Are there places I could go for a while, have the baby, and then return home? If so, how can I find one?

Yes. They are called maternity homes, and there are several in North Car-

46. G.S. 48-3-610.

47. G.S. 48-9-109(b).

48. G.S. 48-9-105.

olina. One way to locate a maternity home is to ask DSS or an adoption agency for information about them. These sources can also tell you about state funding that might be available to pay for a maternity home stay.

## **RAISING A CHILD**

The law sets no minimum age for parenthood, but all parents have a legal duty to give a child the necessities of life (food, clothing, shelter, health care, and education) and to keep a child from harm. Failure to carry out these duties can result in civil and criminal penalties<sup>49</sup> and cause authorities to take custody of a child or even terminate a person’s parental rights.<sup>50</sup>

A minor raising a child is usually a single parent. She and her family may look to DSS for information on a number of legal issues including parents’ rights, establishment of paternity, legitimation of the child, and child support. They are also likely to need resources that DSS determines eligibility for or administers, such as Medicaid or the Children’s Health Insurance Program, WIC, cash assistance, and adolescent parenting programs. State and federal law on these topics are discussed below.

### **Parents’ Rights and Duties**

The father of a fetus does not have the legal right to determine whether a woman completes a pregnancy. However, if a child is born, the father can establish rights equal to those of the mother. For example, North Carolina law on child custody and visitation instructs judges that “Between the mother and the father . . . no presumption shall apply as to who will better promote the interest and welfare of the child.”<sup>51</sup> Similarly, once paternity is established for a child whose parents have not married, the law provides

49. G.S. Article 39, ch. 14, Protection of Minors, contains criminal statutes. The state court of appeals finds the same duty in civil law. *Coleman v. Cooper*, 89 N.C. App. 188, 366 S.E.2d 2, *discretionary review denied*, 322 N.C. 834, 371 S.E.2d 275 (1988).

50. G.S. ch. 7B, especially Articles 3, 5, and 11.

51. G.S. 50-13.2(a).

that their “rights, duties, and obligations . . . regarding support and custody of the child, shall be the same.”<sup>52</sup> For a father’s rights regarding adoption, see question 2 in the section above and the discussion of *In re Byrd* in “Termination of Parental Rights” below.

### **Paternity and Legitimacy**<sup>53</sup>

If a woman is not married to the father of her child, she may want legal recognition of his fatherhood (paternity). An important reason to formalize the relationship is that it is the first step toward securing his financial support for the child. Even if a young father cannot provide support now, establishing paternity helps insure that he will in future. Most unmarried fathers in North Carolina acknowledge paternity as part of hospital procedure at the time of the child’s birth.<sup>54</sup> Fifty-two percent of unmarried fathers acknowledge paternity at the hospital. Paternity is established later for 57 percent of the remaining newborns. Fathers acknowledge a child in other ways too. According to the state supreme court, acknowledgment of paternity means “recognition of a parental relation, either by written agreement, verbal declarations or statements, by the life, acts, and conduct of the parties, or any other satisfactory evidence that the relation was recognized and admitted.”<sup>55</sup> If necessary, a mother can ask a court to establish paternity by filing a civil action any time until the child is eighteen.<sup>56</sup>

52. G.S. 49-15. The Court of Appeals has held that a father must either legitimate his child or establish paternity under G.S. 49-14 if he is to overcome the presumption that gives custody to the mother of an illegitimate child if the mother is fit. Acknowledging paternity under G.S. 110-132, for child support purposes, is not sufficient, *Rosero v. Blake*, No. COA01-483 (May 21, 2002). The North Carolina Supreme Court will review this case.

53. G.S. Article 2, ch. 49, see Sections 16.31 through 16.34; Suzanne Reynolds and Jacquelyn Kane Connors, *Lee’s North Carolina Family Law*. 5th Ed., Vol. 3 (2000).

54. Telephone conversation with Barry Burger, Assistant Chief of Program Operations, Child Support Enforcement, Division of Social Services, North Carolina Dept of Health and Human Services, Raleigh, N.C. (Mar. 23, 2000).

55. *In re Byrd*, 354 N.C. 188, 552 S.E.2d 142 (2001).

56. Not only the mother, but the father, the child, the personal representative of the mother or child, or the DSS director if the child or mother “is likely to become a public charge” may bring an action to establish paternity, G.S. 49-16.

An unmarried mother might also want her partner to legitimate their child. Legitimacy is “the status of a person who is born within a lawful marriage or who acquires that status by later action of the parents.”<sup>57</sup> Legitimacy confers benefits, especially with respect to inheritance.<sup>58</sup> North Carolina specifies two means of legitimation: for the mother and father (or a man who reasonably believes he is the father) to marry,<sup>59</sup> or for the father to petition the superior court to make his child legitimate.<sup>60</sup>

After marrying, parents may ask for a new birth certificate for the child showing the father’s name and, if they like, changing the child’s last name.<sup>61</sup> If a court orders legitimation the state registrar issues a new certificate.

### **Child Support**

Congress helps the states enforce child support orders and the Welfare Reform Act of 1996<sup>62</sup> significantly increased the federal role and the efficiency of collection.<sup>63</sup> State law, influenced by federal law, explains how to establish paternity; find noncustodial parents; deduct child support from wages; and require a parent and his employer to extend health insurance to a child. A federal formula largely determines how support money from a noncustodial parent is distributed.<sup>64</sup> Federal law insures the following: that states cooper-

57. BRYAN A. GARNER (ed.), *BLACK’S LAW DICTIONARY*. (7th Ed.), West Publishing Company, 1999.

58. G.S. 49-11.

59. G.S. 49-12.

60. G.S. 49-10 (assuming the mother is unmarried).

61. G.S. 49-13.

62. 42 U.S.C. § 654. The regulations are at 45 CFR 303.4 through 303.11.

63. Nationally, collections increased from \$12 billion in fiscal 1996 to \$18 billion in fiscal 2000. U.S. Department of Health and Human Services, *HHS Role in Child Support Enforcement*, HHS FACT SHEET, March 16, 2001, formerly at [www.hhs.gov/news](http://www.hhs.gov/news).

64. A family that has never used public assistance receives the full amount of child support collected. If a family is receiving public assistance at the time of the collection, the state must reimburse the federal government for its share of the collection. Then, at the state’s option, either the entire remainder may go to the family or what is left after the state claims its share. Other provisions govern distribution of collections for families formerly using public assistance, 42 U.S.C. § 657(a).

ate with one another and that the United States cooperate with other countries to collect judgments; a court may order a parent to seek gainful employment, participate in work activities, or perform public service; that passports for parents who owe child support may be denied; that states may suspend professional or drivers' licenses and inform credit bureaus of child support owed. In addition to enforcing special (federal) requirements for those who receive public assistance, states are required to help parents who ask for Title IV-D service to locate the other parent, establish paternity, or enforce a child support order or agreement for a minimal fee.

Descriptions of these processes are spread throughout North Carolina's General Statutes with many located in Article 9 of Chapter 110. For more information, see also the manual of the state's child support enforcement program and the *North Carolina Child Support Enforcement Handbook*, which answers questions for parents or others responsible for a child and for employers. The publications are available at [www.dhhs.state.nc.us/dss](http://www.dhhs.state.nc.us/dss).

Both parents must support a *dependent child*, a term that generally refers to a person under eighteen.<sup>65</sup> However, if the person has not finished high school, support usually continues (unless conditions are not met<sup>66</sup> or a court orders otherwise) until graduation or age 20. Grandparents can also be liable for child support. Congress encourages, but does not require, states to enforce child support orders against the parents of a minor who is a non-custodial parent.<sup>67</sup> North Carolina goes further, requiring both sets of grandparents to support a child if one or both parents are unemancipated minors and together they do not provide full support for their child.<sup>68</sup> If another person or an official of an agency, organization, or institution stands *in loco parentis* to the minor parent, that party too can become responsible for support.

65. "[A]ny person under the age of 18 who is not otherwise emancipated, married or a member of the armed forces of the United States, or any person over the age of 18 for whom a court orders that support payments continue. . . ." G.S. 110-129(2).

66. Support can be stopped if the child does not attend school regularly or fails to make satisfactory academic progress toward graduation. G.S. 50-13.4(c).

67. 42 U.S.C. § 666(a)(18).

68. G.S. 50-13.4(b).

North Carolina has “uniform, statewide presumptive guidelines for the computation of child support obligations of each parent.”<sup>69</sup> When the guidelines are inappropriate for a particular case, any party may ask the court to set them aside and look at individual circumstances. If departing from the guidelines, the court must consider “the reasonable needs of the child for health, education and maintenance” as well as the “estates, earnings, conditions, accustomed standard of living of the child and the parties, the child care and homemaker contributions of each party, and other facts of the particular case.”<sup>70</sup> A man can be ordered to reimburse a woman for pregnancy and childbirth expenses, and a custodial parent can be awarded the costs of seeking child support.<sup>71</sup>

Suppose the parent owing child support is a minor. Can he be made to pay? Yes. Under state law acknowledgment of paternity and agreement to support a child are binding on minors as well as adults.<sup>72</sup> As noted, before ordering support a court must find that the parent has the means and ability to provide it, but this requirement does not prevent an action against a minor parent. Some older teens have left school to work and others could be ordered to look for work or get job training.<sup>73</sup> If a minor noncustodial parent is in school and has “no resources or means to supply support,” the state *Child Support Enforcement Manual* indicates that paternity should be established,<sup>74</sup> even though “the process of establishing a support obli-

69. G.S. 50-13.4(c1).

70. G.S. 50-13.4(c).

71. G.S. 110-132(b).

72. G.S. 110-132(a). G.S. 50-13.4, Action for support of minor child, also discusses the support obligations of minor parents.

73. Telephone conversation with Barry Burger, Assistant Chief of Program Operations, Child Support Enforcement, Division of Social Services, North Carolina Dep’t of Health and Human Services, Raleigh, N.C. (Oct. 2, 2001).

74. If the putative father is an unemancipated minor, state DHHS officials suggest (as policy rather than law) that DSS child support enforcement agents not discuss paternity with him except in the presence of certain adults or after he has waived their presence in writing, CHILD SUPPORT ENFORCEMENT PROGRAM BASICS: Paternity Establishment Policy, Minor Parents. Available at [www.dhhs.state.nc.us/dss](http://www.dhhs.state.nc.us/dss).

gation must be delayed until verification of income and resources can be obtained.”<sup>75</sup>

Once a man acknowledges paternity, either he agrees to support the child, or the mother (or a child support enforcement agent on her behalf) must initiate a support action. If she receives TANF she must cooperate in identifying and locating her child's father. (A parent who reasonably fears violence if she cooperates may apply to be excused from the requirement.) Those who work with teen parents say they are often unaware of these TANF conditions and recommend that DSS explain them fully to a teen parent before she applies.<sup>76</sup>

Most actions for support are civil. However, nonsupporting parents can also be charged with crimes<sup>77</sup> and TANF recipients who do not cooperate with enforcement can be charged with contempt of court.

### **Parenting Programs**

The 32 Adolescent Parenting Programs (APP) in North Carolina, many of which are located in local DSSs, are a major resource for adolescents raising a child. The programs accept girls and boys 17 years of age or younger who are pregnant with their first child or already the parent of one child. Participants are encouraged to delay a second pregnancy, finish secondary education, and strengthen parenting skills. Several DSS employees interviewed for this guide named APP as the best service DSS offers young mothers and fathers. While details of the programs differ, each monitors prenatal care and the minor's child's emotional and physical health, helps a teen reach other services, and connects her or him to peers and to the community. Funding opportunities for new APP programs are available annually.

75. North Carolina Department of Health and Human Services, *CHILD SUPPORT ENFORCEMENT PROGRAM BASICS: Enforcement: General Enforcement Policies: Enforcement Actions for Minor Non-custodial Parents*. Available at [www.dhhs.state.nc.us/dss](http://www.dhhs.state.nc.us/dss).

76. Interview with Sharon Holmes, Director, Adolescent Parenting Program, Orange County DSS (Sept. 26, 2000).

77. G.S. 49-2; 14-322 & -322.1.



To receive information on how to apply, contact the state director, Sydney Atkinson, at (919) 715-8432.

## **TERMINATION OF PARENTAL RIGHTS**

Termination of parental rights may be a concern for a pregnant or parenting adolescent in several ways: her parents' rights with respect to her, or her or her partner's rights with respect to their child. As noted earlier, a minor's pregnancy or parenting does not change her parents' rights and duties to her. They must continue to provide for her (and possibly her child), just as they continue to control and supervise her in most respects.

A parent who is a minor has the same rights and duties as an adult parent, and the consequence of not meeting those obligations can be the same. Parental rights are terminated when a court finds both that there is a ground for it<sup>78</sup> and that it would be in the child's best interest.<sup>79</sup> State law on termination recognizes that a parent may be a child herself. While holding the minor parent responsible for her child a statute protects the parent to some degree. It provides that a "court shall have jurisdiction to terminate the parental rights of any parent irrespective of the age of the parent. The parent has the right to counsel and to appointed [free] counsel in cases of indigence unless the parent waives the right. . . . In addition . . . a guardian ad litem shall be appointed . . . to represent a parent . . . [w]here the parent is under the age of 18 years."<sup>80</sup>

A recent decision of the state court of appeals requires trial courts to recognize the difficulties facing minor parents before terminating their parental rights.<sup>81</sup> The appeals court reversed a termination because the court below made "no finding that [the minor] was emancipated and able to 'establish'

78. G.S. 7B-1111.

79. G.S. 7B-1110.

80. G.S. 7B-1101.

81. *In re Matherly*, No. COA01-580, 562 S.E. 2d15 (Mar. 19, 2002).

her own residency when . . . only sixteen years old.” The ground for termination was willfully leaving a child in foster care for more than 12 months without reasonable progress toward correcting the conditions that led to placement. The appeals court stated that, “The trial court must make specific findings of fact showing that a minor parent’s age-related limitations as to willfulness have been adequately considered. . . . Likewise, the juvenile court is under a duty to make findings as to whether a minor parent’s inevitable move into adulthood is likely to cure what would otherwise form the basis” [for termination].

The statutory grounds for termination<sup>82</sup> are as follows:

- abusing or neglecting one’s child;<sup>83</sup>
- willfully leaving a child in foster care or placement for more than 12 months without reasonable progress toward correcting what led to placement;
- failure to pay, for six months before the petition to terminate, reasonable support for a child in placement although physically and financially able to do so;
- failure to pay, for a year before the petition is filed, child support owed to a custodial parent under a custody decree or the parents’ agreement;
- in the case of a child of unmarried parents, a father’s failure to do one of the following before a petition to terminate his rights is filed: acknowledge paternity, legitimate the child by marriage or the filing of a petition, or provide substantial financial support or consistent care to the child and its mother;
- being unable to care for and supervise the child along with a reasonable probability that the incapacity will continue for the foreseeable future;

82. G.S. 7B-1111.

83. Abuse and neglect are defined in G.S. 7B-101. An indigent parent of any age has a right to appointed counsel in abuse, neglect, or dependency proceedings. G.S. 7B-602.

- willfully abandoning a child for six consecutive months, or voluntarily abandoning a newborn for at least 60 days, immediately before a petition or motion is filed;
- committing or assisting the commission of specified violent crimes against the child, another child of the parent, or child living in the same home; or
- in the case of a parent whose parental rights with respect to another child have been ended, being unable or unwilling to establish a safe home.

Another statute, which cites grounds for determining that an unmarried father's consent to his child's adoption is not required, has the effect of terminating the father's rights.<sup>84</sup> Applying the statute, the state supreme court refused to let a 17-year-old father object to his daughter's adoption because he did not do each of the following by the day after her birth: acknowledge paternity; try to visit or communicate with the mother or child during or after the pregnancy; and make reasonable and consistent support payments.<sup>85</sup> The court's majority conceded that he had met the first two requirements and had attempted, both on his own and through his mother, to meet the third. The justices even commented that the boy "demonstrated remarkable resolve and a commendable sense of responsibility and concern for a seventeen-year-old father,"<sup>86</sup> but they declined to reverse the adoption. The dissenting justices found the result unjust, objecting to, among other points, the majority's failure to consider biological parents' constitutional rights. DSS employees who have occasion to discuss parental rights with an unmarried father or father-to-be should be familiar with this decision—*In re Byrd*, 354 N.C. 188, 552 S.E.2d 142 (2001)—and suggest that the client and his lawyer consult it.

Minors of either sex who want to be parents often need information and other help, which DSS may be able to offer. For example, they should know

84. G.S. 48-3-601.

85. *In re Byrd*, 354 N.C. 188, 552 S.E.2d 142 (2001).

86. *Id.* at 354 N.C. 198, 552 S.E.2d 149.

that North Carolina law provides that “no parental rights shall be terminated for the sole reason that the parents are unable to care for the juvenile on account of their poverty.”<sup>87</sup> In another example, DSS staff report that minor parents sometimes have difficulty understanding the permanence and irreversibility of losing parental rights.<sup>88</sup> These individuals advise fellow DSS professionals working with young parents to emphasize the point.

## EDUCATION

The economic well being of parents and children is closely tied to the parents' educational achievement. Congress recognized this in requiring custodial parents receiving TANF (Work First) benefits to complete high school or the equivalent.<sup>89</sup> Many young mothers face hurdles as students: they are more likely than others to have been in academic difficulty before becoming pregnant<sup>90</sup> and parenting itself creates academic difficulties—above all, the need for child care—even for those who had been doing well.<sup>91</sup>

State and federal law guarantee pregnant students certain education rights. Pregnant students appear to have more protection than parenting ones, although the latter need more support to remain in school. For example, as explained more fully below, federal regulations that protect *pregnant* students in a number of ways merely require schools to treat *parents* (male

87. G.S. 7B-1111(a)(2).

88. Telephone conversation with Jan Dillard, Foster Care Placement Supervisor, Durham County DSS, Durham, N.C. (Oct. 31, 2000).

89. States may sanction adults who receive cash assistance or food stamps if they fail to ensure that their minor dependent children attend school, 42 U.S.C. § 604(i)(2001 Supp.). A teen head of household who attends school or “education directly related to employment” satisfies the TANF work requirement, 42 U.S.C. § 607(c)(2)(B)(2001 Supp.). States may use TANF funds for post-secondary academic or vocational training, 42 U.S.C. § 604(h)(2001 Supp.).

90. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA'S TEENAGERS* 63 (1994); MUSICK 53–54; Stamm, Monica J., “A Skeleton in the Closet: Single-Sex Schools for Pregnant Girls,” 98 *Colum. L.R.* 1203, 1222 (1998).

91. JANICE EARLE, *KEEPING PREGNANT AND PARENTING TEENS IN SCHOOL* (1990).

and female) alike. However, it is not necessarily true that parenting, by itself, has no legal protection against discrimination from school officials. Female students, who are the large majority of young custodial parents, might succeed with a sex discrimination claim brought under Title IX itself, and a minor parent of either sex might have a viable claim under the United States constitution.

The state constitution guarantees a right to education<sup>92</sup> and promises “equal opportunities for all students” in the public schools.<sup>93</sup> By statute, any child between the ages of seven and sixteen must attend school.<sup>94</sup> Indeed, North Carolina recognizes that pregnant students may have special educational needs,<sup>95</sup> although it does not treat them like others with special needs.<sup>96</sup> The most significant difference is that a pregnant student is not entitled to an individualized education program (IEP),<sup>97</sup> a basic educational and legal asset for students with special needs. Through the IEP parents and teachers agree on goals and monitor a student’s progress.

State statute directs the state Board of Education to set minimum standards for the education of pregnant students<sup>98</sup> and charges the Department of Public Instruction (DPI) with monitoring the effectiveness of educational programs for them.<sup>99</sup> However, the state Board of Education has not adopted standards, which would apply statewide. Instead, it directs each

92. Article I, Section 15.

93. Article IX, Section 2.

94. G.S. 115C-378. A parent may be prosecuted for failing to send a child. In addition, failure to send a child to school falls within the definition of neglect, *In re McMillan*, 30 N.C.App. 235, 226 S.E.2d 693 (1976); *In re Devone*, 86 N.C.App. 57, 356 S.E.2d 389 (1987).

95. G.S. 115C-108, Definition of special education and related services.

96. Federal special education law does not recognize pregnancy as a disability and therefore federal funding for pregnant students with educational needs is not available. It has been suggested that lack of federal funding largely accounts for the state’s disparate treatment, Susan M. Presti and Blanche Gimps, “Pregnant Teenagers: Their Education Is Suffering,” *NC INSIGHT*. Vol. 4, No. 3 (Sept. 1981), 2–9.

97. G.S. 115C-113(f).

98. G.S. 115C-110(d)(2).

99. G.S. 115C-110(k).

local board of education to adopt written standards.<sup>100</sup> Fewer than half—51 of 112 school districts—have done so.<sup>101</sup>

Title IX, the federal statute mentioned earlier, protects pregnant students' right to be in school and forbids discrimination based on gender.<sup>102</sup> Regulations under the statute from the U.S. Department of Education, Office for Civil Rights, address pregnancy, marriage, and parenting.<sup>103</sup> Recipients of federal assistance (which all public schools receive) “may not apply any rule concerning a student’s actual or potential parental, family, or marital status which treats students differently on the basis of sex.”<sup>104</sup> For example, a school could not discipline young mothers but not fathers. Similarly, unless all students under a doctor’s care need a certificate to re-enter school, it could not be required of girls who have given birth.

Expelling pregnant and parenting female students was common before the regulations were issued in 1974.<sup>105</sup> Now schools must observe these rules with respect to pregnancy and related conditions.<sup>106</sup>

- no discrimination or exclusion from school, or any program, class, or extracurricular activity including sports;
- a health service or coverage offered to other students with temporary disabilities must be offered to these students;

100. 16 N.C.A.C. 6H.0107(d)(6).

101. ACLU-NC, *Pregnant Student Data Chart Analysis February–March 2002*, unpublished, copy in author’s files.

102. “No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance. . . .” 20 U.S.C. § 1681.

103. 34 C.F.R. 106.40. Marital or parental status.

104. 34 C.F.R. 106.40(a).

105. Kate Hevner Mueller and Florence C. Myers, *Married Girls and Unmarried Mothers in the High Schools*, 28 J. OF THE NAT’L ASS’N OF WOMEN DEANS AND COUNSELORS 3, NATIONAL EDUCATION ASSOCIATION (Spring 1965). See also Ordway v. Hargraves, 323 F.Supp. 1155 (D.Mass 1971)(despite school committee rule expelling pregnant girls, judge orders plaintiff’s re-admission).

106. Related conditions include childbirth, false pregnancy, and termination of pregnancy or recovery from any of these conditions, 34 C.F.R. 106.40(b)(1).

- a doctor's certification that a girl is physically and emotionally able to participate in activities can be required only if required of all students under a doctor's care[?];
- enrollment in a program especially for pregnant students must be completely voluntary;
- any such program must be comparable in quality and academic offerings to the regular program;
- excused absences for pregnancy and related conditions must be granted for the length of time the student's doctor finds medically necessary; and
- after a medically necessary absence a student must be restored to the academic and extracurricular status she held when the leave began.

Despite the legal provisions described above, pregnant and parenting adolescents may encounter difficulties in school. Many school personnel make good, and at times extraordinary, efforts for these students but, sadly, some may not. Social workers, physicians with teen patients, and school and health department nurses have described numerous incidents to the author including the following:

- A fellow student makes threatening calls to a pregnant student and pushes her at school. When the girl's parents, who have tapes of the calls, contact the school they are told that the school can only offer homebound instruction.
- A pregnant student's doctor orders bed rest. The principal says there is no teacher available for homebound instruction.
- Pregnant students could receive optimal care at a hospital teen clinic in an adjoining county. Because the school requires them to make up time missed for appointments, most refuse the opportunity because it would frequently extend the school day to five p.m.

- A girl who gave birth in early August asks to return September 1. Another with a Thanksgiving due date, who plans to breastfeed, asks to return after Christmas. Both requests are denied under a policy that no student receives semester credit if more than 10 days are missed.
- A girl whose mother, on discovering the pregnancy, ordered her to leave home tries to join the other parent in North Carolina. He sometimes lets her stay in his house but won't miss work to enroll her in school. The school will not accept her without his registering her, nor let him come to sign the forms before or after his work day.

School can be problematic for pregnant adolescents and more so for young parents, but their leaving school before finishing high school is a far more serious concern to DSS professionals and other adults. Nationally, forty-three percent of girls who drop out do so because of pregnancy, parenthood, or marriage.<sup>107</sup> Minor fathers also leave school at greater than normal rates, although their dropout rate does not approach that for girls.<sup>108</sup>

The number of North Carolina students who leave school because they are pregnant or parenting is not known, although there is no reason to think the rate is lower here. DPI collects schools "self-reported" data on dropouts and checks it for discrepancy but does not audit it.<sup>109</sup> DPI requires schools to assign a single reason for each drop out. Pregnancy (though not parenting) is among the choices, but it is the reason reported for only 1.16 percent

107. U.S. DEP'T OF EDUCATION, OFFICE OF CIVIL RIGHTS, *TEENAGE PREGNANCY AND PARENTHOOD ISSUES UNDER TITLE IX OF THE EDUCATION AMENDMENTS OF 1972* 3 (1991). This source also reports "Almost half of the unmarried teens who have a child before age 18 will never complete high school."

108. *The AAUW Report: How Schools Shortchange Girls*. AAUW Educational Foundation/National Education Association: 1992, 40 (citation omitted).

109. Instructional and Accountability Services, DPI, *Report to the Joint Legislative Education Oversight Committee on the Dropout Data Report 2000–2001*. Raleigh, North Carolina, March 2002, at 1 (hereafter *Dropout Data Report*).



of dropouts.<sup>110</sup> Without a doubt, the actual percentage is far higher. The principal problem with the datum is that at least nine of the sixteen possible reasons might describe a pregnant or parenting student who leaves school.<sup>111</sup>

Some who leave school would continue their education if they could transfer with little interruption to community college, which allows greater flexibility for scheduling work and childcare.<sup>112</sup> Schools must refer students dropping out to appropriate services including a community college,<sup>113</sup> and there is a legal rule allowing them to transfer.<sup>114</sup> The rule provides two means for a 16- or 17-year-old to enter community college to finish high school work. A student may transfer immediately if her school determines that community college is the best educational option for her and the college permits her to enroll. Otherwise, she must stay out of school for six months after which she has a right to enroll in a community college. She need only submit an application that “is supported by a notarized petition of [her] parent, legal guardian, or other person or agency having legal custody and control.”<sup>115</sup>

School employees and others who work with teens are familiar with the second means, but many are unaware of the possibility of immediate trans-

110. *Id.* at 27.

111. In 2000–2001, the reasons were total attendance, moved-school status unknown, academic problems, enrollment in a community college, choice of work over school, failure to return after a long-term suspension, discipline problems, pregnancy, incarcerated in adult facility, unstable home environment, runaway, need to care for children, health problems, marriage, suspected substance abuse, or employment necessary. *Id.*

112. Several North Carolinians who work closely with pregnant and parenting adolescents expressed this view to the author. For example, interview with G. Earl Marett, Director of Johnston County Department of Social Services, October 17, 2000.

113. G.S. 115C-47(32).

114. 23 N.C.A.C. 2C.0305, Education Services for Minors.

115. The petition “shall certify the student’s residence, date of birth, date of leaving school, and the petitioner’s legal relationship to the student.” 23 N.C.A.C. 2C.0305(b).

fer. However, some 16- and 17-year-olds use it each year. That is, they enter community college less than six months after leaving high school.<sup>116</sup> A third possibility is available for a few students. The General Assembly is experimenting with allowing intellectually gifted children under 16 “with the maturity to justify admission” to enroll in community college.<sup>117</sup> DSS staff should tell adolescents and their families about these possibilities. DSS could also help by encouraging and advocating for the adolescent as she tries to secure the approvals needed to move from school to community college.

The Guilford County schools in cooperation with two colleges let students enroll in college to complete high school and begin college work. Two hundred students participated in spring 2002. Another county is considering a similar program.<sup>118</sup>

## EMPLOYMENT

While teen mothers are often eager to work,<sup>119</sup> the current thrust of U.S. law and policy is that schooling should take precedence over work for minors. To qualify for several kinds of federal–state assistance, a pregnant or parenting minor must attend school, and a teen head-of-household is counted as meeting work requirements for receiving assistance as long as she is in school.<sup>120</sup> But the same programs require work of most custodial parents who are not in school<sup>121</sup> and of the noncustodial parent of a minor's child.

116. 51 students in the 2000–2001 school year. Information provided by Sean Hall, Applications Programmer, Division of Administration, N.C. Community Colleges System, Raleigh, N.C. (Dec. 11, 2001).

117. G.S. 115D-1.1 (expires Sept. 1, 2004).

118. Stephaan Harris, *Orange Studying “Middle” Colleges*, RALEIGH NEWS & OBSERVER (Jan. 26, 2002) at 1B.

119. JUDITH MUSICK, YOUNG, POOR, AND PREGNANT: THE PSYCHOLOGY OF TEENAGE MOTHERHOOD 197 (1993).

120. PRWORA, 42 U.S.C. § 607(c)(2)(C) (2001 Supp.).

121. North Carolina Department of Health and Human Services, Division of

More than half a million mothers under age 20 work in the United States. The large majority are unmarried and, of that group, nearly 52 percent work or are actively looking for work.<sup>122</sup> Although no count is available of North Carolina's employed minor parents, certainly many have jobs.

North Carolina's youth employment statute<sup>123</sup> and regulations<sup>124</sup> penalize almost anyone who hires a minor without a work permit. These laws incorporate the child labor provisions of the federal Fair Labor Standards Act<sup>125</sup> and its regulations,<sup>126</sup> and contain other provisions as well. Under state law it is usually local DSS directors who issue work permits to minors living or planning to work in the county.<sup>127</sup>

In general, these are the legal conditions for youth employment: no one under 13 may work. Fourteen- and fifteen-year-olds may work only in certain occupations and outside school hours. 16- and 17-year-olds may work somewhat longer hours with written permission from a parent and a school official. However, their jobs may not be hazardous or harmful to their health or well-being. At this time, the state Department of Labor takes the position that even emancipated minors must obtain work permits, but if a minor is married the Department lets the minor's spouse—instead of parent

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Social Services, *North Carolina Temporary Assistance for Needy Families State Plan, FFY 2002–2003*. Raleigh, 2001, at 22. The custodial parent of a child fewer than 12 months old is exempt (if she has not used this exemption before), as is a parent who cannot find care for a child under 6 years old.

122. There are 514,000 16- to 19-year old mothers; 395,000 unmarried, 119,000 married. 205,000 of the unmarried group are in the labor force, defined as employed or seeking employment. 39 percent of the unmarried group is employed. Telephone conversation with Karen Kosarovich, U.S. Bureau of Labor Statistics, June 11, 2001.

123. G.S. 95-25.5.

124. 13 N.C.A.C. 12.0401 through 12.0406; 0501; .0701 and .0702.

125. 29 U.S.C. § 212.

126. 29 C.F.R. 570.117, et seq.

127. DSS directors and the Commissioner of Labor share responsibility. Subject to the Labor department's approval, a director may delegate responsibility, G.S. 95-25.5(a). Some DSS directors have delegated responsibility, usually to local school officials or, less often, to public libraries' staff. Telephone conversation with Shannon Council, Youth Employment Specialist, N.C. Dep't of Labor, Raleigh, N.C. (June 8, 2001).

or guardian—sign the permit.<sup>128</sup> Anyone advising a particular minor or her family on her ability to work should consult a lawyer or the Youth Employment Section of the North Carolina Department of Labor.

## **FOSTER CHILDREN ENTERING ADULTHOOD**

In 1999 Congress enacted the John Chafee-Foster Care Independence Act. Its funding, which the states allocate to counties, eases current or former foster children's transition to adulthood.<sup>129</sup> The act requires DSS to offer a number of services to youth who become 18 while in foster care as well as to those who have left foster care but are not yet 21. Pregnant and parenting adolescents would seem particularly likely to benefit from such assistance.

In North Carolina the transitional program is called LINKS. It replaces and broadens the Independent Living program. Children between 13 and 21 years of age who are or were in foster care after age 13 are eligible. The child must be a U.S. citizen or qualified alien, may possess no more than \$10,000, and must actively participate in planning his or her transition to independence.<sup>130</sup> DSS may use LINKS funding to help a participant get a

128. N.C. DEP'T OF LABOR, A GUIDE TO YOUTH EMPLOYMENT LAWS AND REGULATIONS FOR ISSUING YOUTH EMPLOYMENT CERTIFICATES. Telephone conversation with Barbara Jackson, attorney for the N.C. Dep't of Labor (June 15, 2001).

129. 42 U.S.C. § Sec. 677(2001 Supp.). The state provides 20 percent of LINKS funding. The Chafee Act's chief sponsor, Senator Jay Rockefeller, emphasized that it does not substitute for the permanency planning required by ASFA, which he also sponsored. "Rockefeller Applauds Passage of Bill to Assist Teens in Foster Care," Press Release, Washington, D.C., November 19, 1999. State officials made the same point to DSS directors applying for LINKS funding, NC Div'n of Social Services, "Re: Application for LINKS (formerly Independent Living) Program Funds," August 18, 2000, at 2.

130. CHILDREN'S SERVICES MANUAL, Ch. IV, Section 1201-VIII "Eligibility for LINKS Services," and telephone conversation with Joan S. McAllister, N.C. LINKS Coordinator, N.C. Dep't of Health and Human Services, Raleigh, N.C. (May 17, 2001).

high school diploma, higher education, or vocational training; explore careers; get a job; develop “daily living skills;” learn how to budget and manage money; and avoid smoking, pregnancy, and substance abuse, and get “personal and emotional support.” For eighteen to twenty-one-year-olds, states may seek federal reimbursement for direct financial support, housing, and counseling, assistance with employment, education, health insurance, and whatever else might help to close the gap between adolescence and adulthood.<sup>131</sup> Typically DSS in North Carolina helps eligible youth with transitional housing, higher education, services needed after leaving the program, or with specific needs of particularly high-risk teens and then seeks reimbursement from the state.<sup>132</sup> Each agency is required to search for individuals under 21 years of age who have left care “to assess their current status and need for further services.”<sup>133</sup> Data that DSS must keep to evaluate the program include participants’ nonmarital childbearing.<sup>134</sup>

131. 42 U.S.C. § Sec. 677(a)(2001 Supp.). The act provides housing assistance only for those who were in foster care on their eighteenth birthday.

132. Information from Joan S. McAllister, North Carolina LINKS Coordinator, N.C. Dep’t of Health and Human Services, Raleigh, N.C. (May 1, 2002).

133. N.C. Div’n of Social Services, “Re: Application for LINKS (formerly Independent Living) Program Funds,” August 18, 2000, at 6.

134. 42 U.S.C. § 677(f)(1)(A)(2001 Supp.).

# Major DSS Responsibilities

PREGNANT OR PARENTING ADOLESCENTS might contact DSS for protection, information about resources, or for help in securing services from DSS or other agencies. Sometimes DSS will be responsible for both minor parents and their children, which creates the possibility of a conflict of interest. DSS's relationships with minor clients, like all other clients, are governed by confidentiality rules.

## **PROTECTION**

Since pregnancy or parenting does not relieve a minor's parents of responsibility for her, DSS protection might consist of returning her to her parents; requiring them to support her elsewhere; investigating abuse or neglect reports and passing on to law enforcement any report of crime. If a minor is in DSS's care, DSS must provide a suitable living environment, guidance, health care, education, and training for adulthood leading to financial independence.

## **INFORMATION**

The minor's pregnancy or parenting requires DSS to make additional efforts. Young women in DSS custody must be counseled about pregnancy options—childbirth or abortion, parenting or placement for adoption—and then must be assisted in carrying out their decisions. Many other teens will come to DSS because the programs that DSS administers or determines eligibility for may be important resources: WIC, Work First, Medicaid, food stamps, child-care assistance, youth employment and adolescent parenting programs, among others. If a minor is not eligible for governmental programs—because of immigration status, for example—DSS staff's knowledge of community resources may be essential to her ability to locate private assistance.

## **ADVOCACY**

North Carolina's 32 adolescent parenting programs, many of which are located within a DSS, are good examples of DSS's role as advocate for this group of clients. Program staff in the APP counties, as well as caseworkers in every DSS, help girls balance staying in school, working, and pregnancy or parenting. Tasks as essential as enrolling in school, a GED program, or community college, or applying for special immigration status require adult intervention. Of only slightly less importance is helping the teen negotiate such matters as school reentry, academic credit, and schedule changes. (For the difficulties teens can encounter in continuing education, see Wendy C. Wolf, "Using Title IX To Protect the Rights of Pregnant and Parenting Teens," *PPFY Newsletter*, March 2000, available at [www.wested.org/ppfy](http://www.wested.org/ppfy).)

## **IMPARTIALITY**

As the primary resource for families in difficulty, DSS may find that some clients' interests conflict with others'.<sup>1</sup> For example, a very young mother may be ambivalent and unskilled as a parent, but may not want to relinquish her child. In some counties, to acknowledge and reduce conflicts of interest, judges customarily appoint different guardians ad litem for a minor mother in custody and for her child. The second guardian is not drawn from the same GAL program as the mother's GAL.<sup>2</sup>

1. See, for example, 10 NCAC 41L.0103(b), allowing a DSS director to ask another county to investigate a child protective service matter when he or she believes the department has a conflict of interests.

2. Telephone conversation with Lynne G. Schifftan, Guilford County attorney (Sept. 27, 2000).

## CONFIDENTIALITY

What legal rights to confidentiality do DSS clients in North Carolina have?<sup>3</sup> Both federal and state statutes and regulations require confidentiality in certain DSS programs.<sup>4</sup> The federal government assures clients of confidentiality in financial assistance programs,<sup>5</sup> in child and family services,<sup>6</sup> child support enforcement,<sup>7</sup> and in abuse and neglect reporting.<sup>8</sup> The State of North Carolina greatly favors open government. Our public record laws are among the nation's most sweeping.<sup>9</sup> Still, our law recognizes, in part because federal

3. The subject is best explained in John L. Saxon, "Confidentiality and Social Services (Part I): What is Confidentiality?" *Social Services Bulletin No. 30*, Chapel Hill, N.C.: Institute of Government, The University of North Carolina at Chapel Hill, Feb. 2001; "Confidentiality and Social Services (Part II): Where Do Confidentiality Rules Come From?" *Social Services Bulletin No. 31*, Chapel Hill, N.C.: Institute of Government, The University of North Carolina at Chapel Hill, May 2001; and "Confidentiality and Social Services (Part III): A Process for Analyzing Issues Involving Confidentiality," *Social Services Bulletin No. 35*, Chapel Hill, N.C.: Institute of Government, The University of North Carolina at Chapel Hill, April 2002.

4. Federal case law is less clear. The U.S. Supreme Court recognized a psychotherapist privilege under the federal rules of evidence for a police officer counseled by a licensed clinical social worker, *Jaffee v. Redmond*, 518 U.S. 1 (1996). (A legal privilege exempts someone who receives information within a confidential relationship from having to disclose it when called as a witness.) However, the Supreme Court stopped short of finding a constitutional right to have government protect the confidentiality of personal information. *Whalen v. Roe*, 429 U.S. 589 (1977). North Carolina's federal court of appeals has held that parents had no federal constitutional or statutory right to make DSS discard an unfounded report of maltreatment, *Hodge v. Jones*, 31 F3d 157 (4th Cir. 1994).

5. 45 C.F.R. 205.50.

6. 42 U.S.C. § 671(a)(8)(2001 Supp.), 45 C.F.R. 1355.21 and 1355.30 (1993).

7. 42 U.S.C. § 654(26)(2001 Supp.).

8. 45 C.F.R. 1340.14(i).

9. "The public records and public information compiled by the agencies of North Carolina government or its subdivisions are the property of the people," G.S. 132-1(b).



funding requires it,<sup>10</sup> that social services involve highly personal matters. As a result, many state confidentiality obligations bind DSS.<sup>11</sup> In addition, while not legally binding, the ethical standards of the social work profession are a source of guidance for DSS social workers. The National Association of Social Workers (NASW) informs members that confidentiality has been part of social work since its beginnings<sup>12</sup> and remains central to the practice. NASW's code and professional standards strongly advise confidential relationships with clients,<sup>13</sup> including minors.<sup>14</sup> If minors who receive DSS services are clients, they are entitled to considerable confidentiality.<sup>15</sup>

The North Carolina Administrative Code defines “client” for confidentiality purposes very broadly. The definition includes anyone who makes an inquiry of DSS or is interviewed as well as anyone served.<sup>16</sup> There is one mention in the section of a client who is a minor,<sup>17</sup> proving that the drafters recognized the possibility, and the section does not exclude minors as clients in their own right. Other code sections acknowledge minors' rights regarding confidential information. For example, protective services records may be shown to the “child or the child's attorney.”<sup>18</sup> While the point has not been settled in law, it seems reasonable to assume that in many instances a minor may be a DSS client entitled to confidentiality.

10. For state statutes paralleling federal funding conditions, see G.S. 108A-80, G.S. 7B-302(a) and 7B-2901.

11. Preeminently, G.S. 108A-80 and 10 NCAC Subchapter 24B.

12. National Association of Social Workers, Inc., *Client Confidentiality and Privileged Communications*. NASW 1997, at 2.

13. Sec. 107, “Privacy and Confidentiality,” states that social workers are not to disclose information unless the client consents, disclosure is required by law or “is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person.” Available at [www.naswdc.org](http://www.naswdc.org)

14. Standard 9, *NASW Standards for the Practice of Social Work with Adolescents*. “Social workers shall maintain confidentiality in their relationship with youths and of the information obtained within that relationship.”

15. The primary exceptions are found at 10 NCAC 24B.0501 through .0505.

16. 10 NCAC 24B.0102(1).

17. 10 NCAC 24B.0403(3).

18. G.S. 7B-2901(b) and 10 NCAC 41I.0313.

# DSS Directors' and Employees' Liability

BECAUSE DSS WORKS WITH PEOPLE IN DIFFICULTY, directors and staff members risk involving themselves in grievous circumstances. Sometimes their best efforts are not enough to save a client from harm. Occasionally, DSS action might cause harm. What are the likely legal consequences if DSS staff members are sued, either as individuals or as representatives of the agency or the county?<sup>1</sup>

State law largely governs this area.<sup>2</sup> Under state law, DSS (in effect, the county) is liable for the negligence<sup>3</sup> of DSS employees.<sup>4</sup> DSS directors can be liable in an official capacity (the county pays), but will not be personally liable (have to pay a judgment themselves) unless they acted for corrupt or malicious reasons or outside the scope of their authority.<sup>5</sup> Until recently, besides the county's being liable for DSS negligence, employees other than the

1. In North Carolina the distinction between a local DSS and its county as defendants is unimportant. Our Supreme Court has said, "[A]n action against a county agency which directly affects the rights of the county is in fact an action against the county," *Meyer v. Walls*, 347 N.C. 97, 104, 489 E.E.2d 880, 884 (1997).

2. The United States Supreme Court has held that DSS is not liable under the U.S. Constitution when it negligently fails to protect children from their family. In the particular case, DSS left a child in his home despite ample notice of his father's brutality and the father severely and permanently injured the child. The Court implied, however, that DSS does have to protect children in its custody and cannot discriminate against certain groups of children. *DeShaney v. Winnebago Soc. Serv.*, 489 U.S. 189 (1989).

3. Negligence for which one may be liable means failing to take the care that a reasonable and prudent person would in a similar situation. Anita R. Brown-Graham, A PRACTICAL GUIDE TO THE LIABILITY OF NORTH CAROLINA CITIES AND COUNTIES 2-3, citing *Hart v. Ivey*, 332 N.C. 299, 305, 420 S.E.2d 174 at 177-78 (1992).

4. *Lovelace v. City of Shelby*, 351 N.C. 458, 526 S.E.2d 652 (2000). However, a county cannot be liable unless it has purchased liability insurance (G.S. 153A-435) and not all counties have done so.

5. *Id.* at 351 N.C. 460, 526 S.E.2d 654.

director could be personally liable.<sup>6</sup> Now, though, the state Court of Appeals has ruled that social workers making placement decisions are acting for the director—and therefore have the same protection from personal liability for negligence that the director has.<sup>7</sup> The Court based its decision on a statute allowing a DSS director to delegate duties to staff<sup>8</sup> and also on the fact that the placement activities of the social workers in question required “personal deliberation, decision and judgment.”<sup>9</sup> In other words, when placing a child, social workers are not simply carrying out orders. As a result of this case, unless the state supreme court decides otherwise at some point, North Carolina law offers greater protection to DSS employees whose work requires discretion. However, DSS workers might still be personally liable for performing more automatic tasks<sup>10</sup> poorly and, like the director, they are still liable for behavior that is corrupt, malicious, or outside their authority.

6. *Coleman v. Cooper*, 102 N.C. App. 650, 403 S.E.2d 577, disc. review denied, 329 N.C. 786, 408 S.E.2d 517 (1991).

7. *Hobbs v. N.C. Dept. of Human Resources*, 135 N.C. App. 412, 520 S.E.2d 595 (1999).

8. G.S. 108A-14(b).

9. *Meyer v. Walls*, 347 N.C. at 112, 489 S.E.2d at 888.

10. The legal term is “ministerial duties.”

# Issues Associated with Immigrants and Limited-English-Proficient Clients

**BY JILL MOORE**

A PREGNANT OR PARENTING MINOR who is an immigrant poses unique and difficult legal issues for public agencies. An immigrant minor may not be eligible for the full range of public benefits and services that are available to her peers who are citizens. If she has difficulty understanding or speaking English, her ability to communicate with agency staff and obtain services and benefits for which she is eligible may be impaired. A minor who entered the United States without her parents may find it difficult to obtain health care or other services. Like minors who are citizens, an immigrant minor who is inadequately cared for or mistreated may need child protective services, or her child may need them.

This section introduces some key terms and concepts that pertain to immigrants and their eligibility for publicly funded benefits and services. It briefly describes the federal law governing benefit eligibility and explains which immigrants are eligible for several significant benefits and services. Finally, it summarizes DSS's legal duty to provide language assistance to limited-English-proficient (LEP) clients. All of these legal provisions apply to immigrants who are minors just as they would to adults.

Many concerns that DSS may have regarding immigrant minors who are pregnant or parenting cannot be addressed here. However, the adolescent pregnancy project will provide updates and additional information about these issues through its Web site, [www.adolescentpregnancy.unc.edu](http://www.adolescentpregnancy.unc.edu).

## WHO IS A CITIZEN? WHO IS AN IMMIGRANT?

People become citizens of the United States either by birth or by a process called “naturalization.” Anyone who is born in the U.S., Puerto Rico, the U.S. Virgin Islands, or Guam automatically becomes a U.S. citizen at birth.<sup>1</sup> A person born outside the U.S. to a parent who is a U.S. citizen usually becomes a citizen at birth.<sup>2</sup> A person who is born in the “outlying possessions” of the U.S.—American Samoa or Swains Island—is considered a U.S. national, but not a citizen.<sup>3</sup> Some immigrants become citizens of the U.S. by naturalizing—that is, by successfully applying for citizenship.<sup>4</sup> The law makes no distinction between naturalized citizens and citizens by birth; the same rights and privileges apply to each.

The term *immigrant* refers to any noncitizen who is in the United States with the intention of remaining indefinitely.<sup>5</sup> A noncitizen who is in the United States temporarily—such as a tourist, a business traveler, or a student with a temporary visa—is not considered an immigrant, but a visitor. The term *nonimmigrant* is often used to describe noncitizens in this category.

Federal immigration law establishes several different categories of immigrants who may lawfully enter and remain in the United States. These include lawful permanent residents, refugees, persons seeking asylum in the United States (“asylees”), and others. Lawful permanent residents have “green cards,” which are no longer green in color. A green card looks simi-

1. 8 U.S.C. §§ 1401(a), 1401(b), 1402, 1406, 1407.

2. 8 U.S.C. §§ 1401(c), 1401(d), 1401(e), 1401(g). The citizen parent must have met residency requirements that are specified in the law for a child born abroad to become a citizen at birth.

3. 8 U.S.C. § 1408. A U.S. national does not have all the rights and privileges of citizenship, but owes permanent allegiance to the U.S.

4. To naturalize, a person must be 18 years of age or older, a lawful permanent resident of the United States for five years (three years if the person has been married to a U.S. citizen for at least three years), and of good moral character. The person also must demonstrate a basic understanding of the English language and the fundamentals of U.S. government and history. 8 U.S.C. §§ 1427, 1423. The person must also take an oath of allegiance to the United States. *Id.* § 1448.

5. The law uses the term “alien,” a term that many consider to be offensive and less accurate than “noncitizen” or “immigrant.”

lar to a driver's license and is officially known as an Alien Registration Receipt Card, a Permanent Resident Card, or INS Form I-551. It is important to recognize that some immigrants who are legally in the United States do not have green cards.

Other immigrants are in the United States illegally. These immigrants are usually referred to as “undocumented immigrants” or “illegal aliens.”

When an immigrant gives birth to a child in the United States, the child is a citizen, even though the mother is not. This is a very important point to keep in mind when determining a child's eligibility for benefits and services. A child who is a citizen may be eligible for benefits and services that his or her immigrant parent does not qualify for. When a parent applies for benefits such as Medicaid or Health Choice for his or her child, it is the *child's* citizenship or immigration status that must be assessed to determine eligibility—not the parent's. If the child is a citizen, he or she is not subject to the restrictions on immigrants' eligibility for those programs, even if his or her mother would be.

Some immigrants may believe that having a child in the United States changes their own citizenship or immigration status. It does not. The mother's immigration status remains the same after she gives birth to a citizen child—so, for example, if she was undocumented, she remains undocumented and without legal authority to be in the U.S.

## **ARE IMMIGRANTS ELIGIBLE TO RECEIVE DSS SERVICES?**

Immigrants are eligible to receive many DSS services, but they are not eligible for the full range of benefits and services that are available to citizens. Some benefits and services are available to all immigrants, regardless of whether they are documented. Some are available only to those who meet the federal welfare reform law's<sup>6</sup> definition of “qualified alien.” Some are

6. The official title of the welfare reform law is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 8 U.S.C. and 42 U.S.C.) (hereinafter *Welfare Reform Act*).

available only to those who meet the qualified alien definition *and* have been in the United States for at least five years.

The main categories of immigrants who are considered qualified aliens for purposes of benefit eligibility are lawful permanent residents, refugees, political and religious asylees, and immigrants classified as Cuban/Haitian entrants or Amerasian immigrants.<sup>7</sup> Some of these individuals will have green cards and some will not. However, all should have some form of official documentation.

Any noncitizen who does not meet the definition of qualified alien is considered a “nonqualified alien” for the purpose of determining eligibility for benefits. A person who is a nonqualified alien is not necessarily an illegal or undocumented immigrant. Undocumented immigrants fall into the nonqualified alien category, but so do several categories of noncitizens who are lawfully in the United States—such as nonimmigrants and persons who have applied for asylum but have not yet been granted it.

### **WHICH BENEFITS AND SERVICES ARE AVAILABLE TO WHICH CATEGORIES OF IMMIGRANTS?**

It is impossible to address immigrant eligibility for *all* benefits and services provided by all DSS’s in North Carolina. Each agency must make some determinations about immigrant eligibility on its own, according to guidelines established in the federal welfare reform law and federal agency interpreta-

7. Other immigrants who fit the qualified alien definition are immigrants granted “withholding of deportation” status (that is, noncitizens who ordinarily would be deported, but the U.S. Attorney General has determined that they would be subject to persecution if they were required to return to their home countries), persons who have been “paroled” into the U.S. for at least one year (that is, persons who ordinarily would not be allowed to enter the U.S. but have been allowed to enter temporarily for humanitarian, medical, or legal reasons), immigrants who have been present in the U.S. since before April 1, 1980, as “conditional entrants” under federal immigration laws, and certain immigrants who have been battered or subject to extreme cruelty.

tions.<sup>8</sup> This section describes benefit eligibility for several major benefits or services that are administered or provided by DSS and that may be of particular relevance to pregnant or parenting minors.

### **TANF**

To be eligible for TANF, an immigrant must: (1) satisfy the usual criteria for eligibility for TANF; (2) fit within the definition of “qualified alien,” and (3) have been lawfully in the United States for at least five years.<sup>9</sup>

### **Medicaid**

To be eligible for regular Medicaid benefits, an immigrant must: (1) satisfy the usual criteria for eligibility for Medicaid, (2) fit within the definition of “qualified alien;” and (3) have been lawfully in the United States for at least five years.<sup>10</sup> A pregnant immigrant minor will qualify for regular Medicaid benefits only if she meets all those criteria. Remember that an immigrant minor’s child may qualify for regular Medicaid, even if the mother

8. For more information about the federal law and federal agency interpretations, see Jill D. Moore, *Immigrants’ Access to Public Benefits: Who Remains Eligible for What?* POPULAR GOV’T 65 (Fall 1999), at 22. Available at <http://ncinfo.iog.unc.edu/pubs/electronicversions/pg/f99-2232.pdf>.

9. See Welfare Reform Act § 403 (requiring immigrant applicants for “federal means-tested public benefits” to be qualified aliens and to satisfy a 5-year waiting period) and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA): Interpretation of “Federal Means-Tested Public Benefit,” 62 F.R. 45256 (Aug. 26, 1997) (concluding that TANF is a federal means-tested public benefit). There is an exception to the 5-year waiting period for qualified aliens who have long work histories in the U.S. (40 or more qualifying quarters under the Social Security Act), qualified aliens with military connections (active duty members of the military and their dependents, veterans and their dependents, and certain others), and qualified aliens who were admitted to the U.S. for humanitarian reasons (refugees, asylees, and certain others).

10. See Welfare Reform Act § 403 and PRWORA: Interpretation of “Federal Means-Tested Public Benefit,” 62 F.R. 45256 (Aug. 26, 1997) (concluding that Medicaid is a federal means-tested public benefit). There is an exception to the 5-year waiting period for the same groups of qualified aliens who are exempted from the waiting period for TANF (see footnote 9).



does not. If the child was born in the U.S., he or she is a citizen and needs only to satisfy the usual criteria for eligibility for Medicaid. A parent's immigration status is irrelevant.

Emergency Medicaid eligibility is different from regular Medicaid. All immigrants are eligible for emergency Medicaid, regardless of whether they are qualified aliens and regardless of whether they are legally in the United States.<sup>11</sup> Emergency Medicaid covers health-care services for labor and delivery. A pregnant immigrant minor who satisfies all other eligibility criteria for Medicaid therefore qualifies for emergency Medicaid to cover her child-birth expenses, regardless of whether she is documented and without regard to how long she has been in the U.S.

Finally, any immigrant—regardless of qualified or legal status—may be granted presumptive eligibility for Medicaid by a qualified provider, such as the local health department, for services such as prenatal care. Pregnant immigrant minors qualify for this benefit, regardless of whether they are documented and without regard to how long they have been in the U.S. Once the presumptive eligibility period expires, the immigrant minor will not be able to continue to receive Medicaid unless she meets the criteria outlined for regular Medicaid benefit eligibility (see above).

### **N.C. Health Choice (State Children's Health Insurance Program)**

To be eligible for Health Choice, an immigrant must (1) satisfy the usual criteria for eligibility for Health Choice, (2) fit within the definition of "qualified alien;" and (3) have been lawfully in the United States for at least five years. A pregnant immigrant minor is eligible for Health Choice if she meets all these criteria. However, Health Choice does not cover maternity care, regardless of the minor's immigration status. An immigrant minor's child may be eligible for this program, if the usual eligibility criteria for Health Choice are satisfied and the child is *either* a U.S. citizen *or* a qualified alien who has been lawfully in the U.S. for at least five years.

11. See Welfare Reform Act § 401(b) (making emergency Medicaid an exception to the general rule that a person must be a citizen or qualified alien to receive benefits).

**WIC**

Any immigrant, regardless of whether she is a qualified alien or is legally in the U.S., may be eligible for WIC benefits. As long as she meets the usual eligibility criteria for WIC, her immigration status is not relevant to her eligibility for benefits.<sup>12</sup>

**Child Protective Services**

Any immigrant—regardless of qualified or legal status—is eligible for child protective services.<sup>13</sup> Citizenship or immigration status is not a legitimate consideration in making a determination about whether to accept or investigate a report, whether to substantiate abuse or neglect, or whether to provide services. However, being a CPS recipient or being in the custody of DSS does not alter an immigrant child's eligibility for other services, such as Medicaid. A pregnant or parenting immigrant minor may need child protective services herself, or her child may need the services.

**Health Care Services from Other Agencies**

DSS staff should be aware that pregnant and parenting immigrant minors are eligible for many important health-care services for themselves and for their children. Immigrant minors are eligible for all personal health-care services provided through the local health department, regardless of whether they are documented or meet the definition of qualified alien. Among the ser-

12. Welfare Reform Act § 742 states that nothing in the Welfare Reform Act shall prohibit or require a state to provide services to a person who is not a citizen or qualified alien under several programs, including WIC. The U.S. Department of Agriculture has interpreted that provision to mean that a state must affirmatively elect not to provide WIC benefits to nonqualified aliens before it may deny the benefits. North Carolina has not done so.

13. See Welfare Reform Act § 401(b) (making community programs necessary for the protection of life and safety an exception to the general rule that a person must be a citizen or qualified alien to receive benefits) and Specification of Community Programs Necessary for Protection of Life and Safety under Welfare Reform Legislation, 61 F.R. 45985 (Aug. 30, 1996) (specifically designating child protective services as a community program necessary for the protection of life and safety).

vices immigrant minors may receive are family planning, prenatal care, diagnosis and treatment of STDs, immunizations for themselves and their children, and well-child care for their children.<sup>14</sup> Most health departments in North Carolina provide all of these services. All immigrant minors are also eligible for transportation by ambulances and other emergency medical services.<sup>15</sup>

Some of the health-care services for which immigrant minors are eligible have fees. In some cases, an immigrant minor may be eligible for a service but not eligible for a program that would pay for it. However, some significant services are provided by local health departments at no cost. These include diagnosis and treatment of STDs and immunizations that are required by law for entry into school.<sup>16</sup> Other services have “sliding scale” fees that are based on what the patient can afford to pay.

Some difficult issues may arise when an immigrant minor who needs health-care services is in the U.S. without her parents. As explained earlier in this book, there are some significant health-care services that may be provided to minors upon their own consent, including family planning services, prenatal care, and diagnosis and treatment of STDs.<sup>17</sup> What if a minor needs health care to which she cannot consent on her own—say, for a strep throat, or an ear infection? Health-care providers may be reluctant to treat her under those circumstances. However, North Carolina law may permit the treatment, depending upon the circumstances. A provider should first at-

14. See Welfare Reform Act § 401(b) (making immunizations and communicable disease control services exceptions to the general rule that a person must be a citizen or qualified alien to receive benefits); Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA): Interpretation of Federal Public Benefit, 63 F.R. 41657 (Aug. 4, 1998) (determining federally funded programs such as prenatal care may be provided to immigrants without respect to their immigration status).

15. See Welfare Reform Act § 401(b) and Specification of Community Programs Necessary for Protection of Life and Safety under Welfare Reform Legislation, 61 F.R. 45985 (Aug. 30, 1996).

16. N.C.G.S. § 130A-144(e) (sexually transmitted diseases); § 130A-153(a) (immunizations).

17. N.C.G.S. § 90-21.5; *see* Consent to Treatment for Minors and Their Children, Consent from the Minor Only, page 24.

tempt to determine if there is someone who is acting *in loco parentis* for the minor. A person acting *in loco parentis* may consent to her care. (If there is no such person, the minor may be a neglected or dependent juvenile in need of child protective services.) In the absence of anyone with legal authority to consent to her care, a health-care provider may still provide treatment in an emergency, or in a nonemergency situation if her parents cannot be located or contacted with reasonable diligence during the time within which the minor needs the treatment, or in specified other circumstances.<sup>18</sup>

### **SHOULD DSS ASK ABOUT IMMIGRATION STATUS OR ATTEMPT TO VERIFY WHETHER SOMEONE IS LEGALLY IN THE U.S.?**

DSS must not ask about or attempt to verify a client's citizenship or immigration status unless it is required to verify status before providing a particular benefit or service.<sup>19</sup> As explained above, in some cases DSS must deny services or benefits to a potential client who is an immigrant if she is not a qualified alien, or if she is a qualified alien who has not been in the U.S. for at least five years. In order to determine if services or benefits must be denied, at some point individuals who apply for those services or benefits must be asked to verify their citizenship or immigration status. However, there are specific steps that DSS must follow *before* it inquires about citizenship

18. N.C.G.S. § 90-21.1; *see* Consent to Treatment for Minors and Their Children, Adult Consent Not Needed in Emergencies, page 22. A second opinion is usually required before a provider may perform surgery on a minor without first obtaining her parents' consent. *See* N.C.G.S. § 90-21.3.

19. This conclusion and the steps that are outlined in this section are derived from a U.S. Department of Justice guidance document. Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 62 F.R. 61344 (Nov. 17, 1997). For more information, *see* Alison Brown, *When Should Agencies Inquire About Immigration Status?* POPULAR GOV'T 65 (Fall 1999), at 29. Available at <http://ncinfo.iog.unc.edu/pubs/electronicversions/pg/agencies.htm>.

or immigration status.

First, DSS must determine whether the program or benefit the client wishes to receive is one that is available to all eligible applicants or if it must be denied to certain classes of immigrants. For example, TANF is a benefit program that must be denied to certain immigrants, while child protective services may not be denied to immigrants.

Second, DSS staff must determine whether the person seeking the service or benefit meets all other eligibility criteria—for example, financial or categorical criteria—before assessing whether the person meets the citizenship or immigration criteria.

Third, if the person has satisfied the other eligibility criteria, DSS staff must verify whether the person is a U.S. citizen, a U.S. national, or a qualified alien. This step should never be reached if the benefit or service is not contingent upon the person's citizenship or immigration status. Also, if a person is applying for benefits on behalf of another person, DSS should verify only the status of the person who is to receive the benefit. For example, if a minor mother is applying for Medicaid for her child, only the child's status should be assessed. As noted earlier, if the child was born in the United States, he or she is a citizen, regardless of whether the parents are citizens or documented or undocumented immigrants.

Finally, if the person is a qualified alien, the provider should determine if additional restrictions—such as the five-year waiting period for Medicaid—apply to the services that are sought. If additional restrictions apply, DSS must determine whether they are satisfied.

Information about how to verify status and eligibility is available from the U.S. Department of Justice<sup>20</sup> or the DSS program manuals.

20. Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 62 F.R. 61344 (Nov. 17, 1997).

## WHAT ASSISTANCE MUST DSS PROVIDE LEP CLIENTS?

Departments of social services must provide language assistance to their clients who have limited English proficiency.<sup>21</sup> A person is considered limited-English-proficient (LEP) if she cannot speak, write, read, or understand the English language sufficiently well to interact effectively with service providers. DSS may encounter LEP clients in any of its services. Some of those clients will be immigrants and some will be citizens. Some will be eligible for services or benefits and some will not. DSS must have the ability to communicate with LEP persons in order to make those determinations at the outset, and then to continue to communicate effectively with those who qualify for and receive services.

DSS must do a number of things to ensure its compliance with federal laws governing language assistance. For complete information, agencies should consult a guidance document prepared by the U.S. Department of Health and Human Services' Office for Civil Rights.<sup>22</sup> This section summarizes only a few of the most significant requirements.

21. This legal requirement is derived from Title VI of the federal Civil Rights Act of 1964, 42 U.S.C. § 2001d. Title VI prohibits providers who receive federal financial assistance from denying benefits to a person or excluding a person from participating in a program or service because of the person's race, color, or national origin. Neither Title VI nor its implementing regulations explicitly address language assistance for LEP persons. However, the U.S. Supreme Court has held that failure to provide language assistance to LEP students in a public school violated Title VI, because it had a disparate impact on students based on their national origin and denied non-English-speaking students a meaningful opportunity to participate in the educational program. *Lau v. Nichols*, 414 U.S. 563 (1974). For more than thirty years, the U.S. Department of Health and Human Services, through its Office for Civil Rights (OCR), has required agencies that receive federal financial assistance to provide language assistance to LEP persons.

22. Policy Guidance: Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, 65 F.R. 52762 (August 2000) (available at <http://www.hhs.gov/ocr/lep/>). The specific language-assistance requirements described in this section come from the guidance document. For a summary of the guidance document, see Jill D. Moore, *Health and Social Services Agencies' Legal*

DSS must ensure that LEP persons have meaningful access to the programs or services for which they are eligible. This means that DSS must ensure that LEP clients receive adequate information that they can understand about the services and benefits that are available, that they are able to receive benefits and services for which they are eligible, and that they can effectively communicate the relevant circumstances of their situations to the service provider.

The type of language assistance that must be provided to ensure meaningful access to services and benefits will vary, depending upon the circumstances. However, an effective language assistance program must include procedures for obtaining interpretation services for LEP clients and providing them promptly. There are a number of ways that interpretation services may be provided. A DSS may choose to hire bilingual staff or staff interpreters. This may be particularly appropriate for an agency that serves a large LEP population. Or it may contract with outside interpreter services or arrange for volunteer interpreters. Some telephone translation services are available and may also be used, but DSS should not rely solely on such a service.

Friends and family members usually should not be used as interpreters. Before using a friend or family member, DSS staff should inform the LEP client that DSS will arrange for an alternative interpreter at no cost. If the LEP client declines the offer and asks to use the friend or family member instead, DSS may use that person *only if* it determines that doing so does not compromise the effectiveness of the service or violate the LEP client's confidentiality.

*DSS must never charge LEP clients for language assistance or require clients to provide or arrange for their own interpreters.*

Written materials that are routinely provided in English to DSS clients and to the public must also be available in other languages that the agency

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*Duties to Clients with Limited English Proficiency: New Federal Guidance*, LOCAL GOV'T LAW BULLETIN 97 (February 2001) (available at <http://ncinfo.iog.unc.edu/pubs/electronicversions/pdfs/lglb97.pdf>).

encounters frequently, such as Spanish. It is particularly important that “vital” documents be translated. These include documents such as applications, consent forms, letters with important information about benefit eligibility or participation in a program, notices regarding reduction, denial, or termination of services or benefits, and notices advising LEP clients that free language assistance is available to them.

Finally, DSS must give LEP clients notice of their right to free language assistance. The notice must be given in a language the LEP person can understand.<sup>23</sup>

23. For tips on how to provide the required notice, see the resources in footnote 22.