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Recommended Citation

Abigail English & Catherine Teare, *Statutory Rape Enforcement and Child Abuse Reporting: Effects on Health Care Access for Adolescents*, 50 DePaul L. Rev. 827 (2001)
Available at: <https://via.library.depaul.edu/law-review/vol50/iss3/3>

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STATUTORY RAPE ENFORCEMENT AND CHILD ABUSE REPORTING: EFFECTS ON HEALTH CARE ACCESS FOR ADOLESCENTS

*Abigail English**
Catherine Teare

INTRODUCTION

Ten years ago, in most areas of the country, statutory rape was considered a quaint holdover from an earlier time. It was a crime that, by itself, was infrequently prosecuted, and it was rarely if ever mentioned in discussions of adolescent health policy. All this has changed over the past decade, with a dramatic increase in attention to statutory rape embodied in public responses to information about the numbers of adolescent pregnancies involving older male partners, new legislation promoting or facilitating increased enforcement of statutory rape laws, and changes in the substance or interpretation of child abuse reporting laws and their relationship to statutory rape. In addition, health care professionals who provide services to adolescents have recently begun to express concern about the impact of these developments—particularly with respect to child abuse reporting—on adolescents' access to health care.

This article addresses the latter issue and seeks to shed light on the implications for adolescents' access to health care of increased enforcement of statutory rape laws and requirements that statutory rape be reported as child abuse. The article is premised on two principles.

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First, insofar as laws related to statutory rape enforcement and child abuse reporting deter adolescents from seeking health care or reduce the quality of the health care received, the resulting harm can only be justified by a corresponding benefit that outweighs that harm. Second, insofar as the harms or benefits are not quantifiable, doubts should be called in favor of promoting access to high quality health care for adolescents and limiting the scope of laws and policies that might undermine such access.

Part II of this article explains the backdrop against which we examine the issue of health care access. It discusses the evolving social views and legal definitions of statutory rape, the range of relevant epidemiologic data and competing interpretations of those data, and the types of laws involved in the complex responses to the issue of statutory rape. Part III considers the ways in which legal and policy responses to statutory rape might affect adolescents' access to health care. Part IV explores the varied approaches that several states have adopted. Part V presents options for health care providers and policy makers and recommends a framework for evaluating legal and policy responses to statutory rape.¹

II. THE CONTEXT

Since the mid-1990s the politics of welfare and teen pregnancy have raised the profile of the issue of statutory rape. Language in the 1996 federal welfare bill urging more prosecution of statutory rape, academic studies on the prevalence of childbearing among teenagers with older partners, the desire for new tactics to minimize teen pregnancy, concerns about sexual abuse of teenagers, and "get tough" attitudes on crime each combined to pull statutory rape out of the sleepy legal world it had inhabited.

This new focus on statutory rape has been tremendously popular politically. Defenders of sexual "predators" – the most common term for the adult men targeted by these policies – are understandably few, and, despite progress in the last few years, no one would say that the country's continued teen pregnancy rates are acceptable. However, it is not at all clear that recent legal and policy changes involving statutory rape offer teenage girls any more "protection" from older men, early pregnancy, or its attendant hardships, than the girls had previ-

1. Throughout this article, the authors refer to information gleaned from discussion with health care providers, prosecutors, and advocates, particularly in California, but also in other states. These conversations took place informally between 1995 and 2000, during the time that both authors worked on adolescent health issues in California, and at training events both in California and in other states.

ously. In the area of access to health care, these policies may even prove harmful by causing girls to delay or avoid care out of fear of lost confidentiality, entanglement with child welfare agencies, or criminal consequences.

Our national thinking about teenage pregnancy is characterized by a split view, according to which young mothers "are *either* babies having babies *or* cunning women wise beyond their years who exploit a morally bankrupt welfare system."² A bifurcated vision of young women is of long standing in the statutory rape arena as well. Thus it is not surprising that, beginning in the mid-1990s, pregnancy prevention campaigners from all parts of the political spectrum turned to statutory rape enforcement as the newest weapon in the battle against teen pregnancy.

The linkage of statutory rape and teen pregnancy is not entirely new, however. The best-known modern statutory rape case, *Michael M. v. Sonoma County Superior Court*,³ is remembered primarily for upholding California's gender-based statutory rape statute,⁴ and secondarily for Justice Blackmun's extraordinary concurring opinion, in which he "point[ed] out" that the young woman in the case "appears not to have been an unwilling participant . . . in the intimacies that took place," although he attempted to buttress this statement by reference to the girl's testimony, in which she describes being "slugged . . . in the face" two or three times by the petitioner.⁵ Less famous, but of equal importance, is the reasoning behind the decision to uphold the statute: the Court agreed with the State of California that the law would help prevent teen pregnancy.⁶ Nearly two decades later, statutory rape policies continue to be based as much on ideas about pregnancy prevention as they are on ideas about protecting young women, as suggested by two key reports published by important national legal and policy organizations in the mid-1990s.⁷

In 1994, the Progressive Policy Institute (PPI) published a report on statutory rape called *Preventable Calamity: Rolling Back Teen Preg-*

2. KRISTIN LUKER, *DUBIOUS CONCEPTIONS: THE POLITICS OF TEENAGE PREGNANCY* 37-38 (1996).

3. *Michael M. v. Sonoma County Superior Court*, 450 U.S. 464 (1981).

4. CAL. PENAL CODE § 261.5 (1999). The statute was finally amended to be gender neutral in 1993. 1993 Cal. Stat. Ch. 596 § 1.

5. 450 U.S. 464, 483, 483 n.* (Blackmun, J., concurring).

6. 450 U.S. at 479-480.

7. KATHLEEN SYLVESTER, *PREVENTABLE CALAMITY: ROLLING BACK TEEN PREGNANCY* (Executive Summary, Nov. 1994); SHARON ELSTEIN & NOY DAVIS, *SEXUAL RELATIONSHIPS BETWEEN ADULT MALES AND YOUNG TEEN GIRLS: EXPLORING THE LEGAL AND SOCIAL RESPONSES* (Oct. 1997). What is less certain is whether the policies actually have the effect of deterring teen pregnancy and, to date, little evidence exists that they do.

nancy.⁸ The PPI, a branch of the Democratic Leadership Council, suggested a four-part strategy for addressing teen pregnancy that included launching a national campaign to “end the moral relativism that has characterized discussions of teen pregnancy,” shifting government’s role to that of catalyst, redefining responsible sexual behavior, and creating new opportunities for young people at risk of “becoming parents too soon.”⁹ As part of shifting the government’s role, the PPI suggested “ending unqualified public assistance for unmarried teen mothers, requiring accountability for all fathers, and punishing sexual predators.”¹⁰

Subsequently, the American Bar Association published a report, *Sexual Relationships Between Adult Males and Young Teen Girls: Exploring the Legal and Social Responses*,¹¹ focusing specifically on statutory rape, and including data from interviews and focus groups with youth service providers, prosecutors, and teenagers, as well as a survey of all the states’ statutory rape laws.¹² This report recommended the following: public education on unlawful sexual relations; statutory changes including revision of minimum ages and age gaps, and removal of the mistake-of-age defense; prosecution focused on cases involving young teen girls, without regard to race or class, and regardless of pregnancy; and prevention programs for young children and teenage girls.¹³

Statutory rape thus stands out against a backdrop woven of concerns about teen pregnancy prevention, welfare dependency, predatory behavior of older men, and exploitation of young women. While a focus on statutory rape cannot provide a comprehensive solution to these complex problems, it has persisted into the new century as a topic of academic, policy making, and public concern. Against this backdrop, this article examines the relationship between societal responses to statutory rape and adolescents’ access to health care.

A. *What is Statutory Rape?*

“Statutory rape” itself is a somewhat imprecise term, and not one that usually appears in state criminal codes.¹⁴ It is often loosely used to describe sex between adults and minors, even in circumstances

8. See SYLVESTER, *supra* note 7.

9. *Id.* at 2.

10. *Id.*

11. See ELSTEIN & DAVIS, *supra* note 7.

12. *Id.* at iv-v.

13. *Id.*

14. The terms that are more frequently used are “rape,” “unlawful sexual intercourse,” or “sexual assault.” NOY S. DAVIS & JENNIFER TWOMBLY, AM. BAR ASS’N CENTER ON CHILDREN

when that description does not correspond to any specific legal crime or classification. In this article, we use it generally to refer to consensual sexual activity between a minor and an older person, recognizing that some state statutes do not require that the "offender" be older, and recognizing also that some state statutes encompass nonconsensual as well as consensual sexual intercourse or other activity. From a legal perspective, the concept of statutory rape (rather than the term itself) usually refers to sexual intercourse that involves at least one minor and is prohibited in a state's criminal code because the minor is below what is commonly referred to as the "age of consent." Thus, legally the term may be used to cover both consensual and nonconsensual acts.¹⁵

Statutory rape laws appear as far back as the Code of Hammurabi, and were found in the Statute of Westminster, promulgated in England in 1275.¹⁶ Age of consent was first defined in English law as twelve, but lowered to ten in 1576.¹⁷ In the United States, the age of consent inched upward over the course of the Nineteenth and Twentieth Centuries, and in most states is now defined as sixteen, seventeen, or eighteen.¹⁸ In the United States, many state criminal codes base sentencing for statutory rape offenses on age differences between "victim" and "perpetrator," and have defined lower age limits that increase either the seriousness of the crime or the severity of the penalty.¹⁹

Over the last twenty years, most jurisdictions in the United States have also repealed gender-based statutory rape laws.²⁰ As part of rape law reform, all but fifteen jurisdictions made the crime of statutory rape entirely gender-neutral by 1994.²¹ Courts, however, have

AND THE LAW, STATE LEGISLATORS' HANDBOOK FOR STATUTORY RAPE ISSUES 1 (Feb. 2000) [hereinafter LEGISLATORS' HANDBOOK].

15. The term "consensual" carries a certain ambiguity because it has both legal and colloquial meanings. A minor who is voluntarily engaging in a sexual act may have no legal capacity to consent to that act, while a minor who has technically given consent under the law may have participated in a less than fully voluntary way.

16. Michelle Oberman, *Turning Girls into Women: Re-evaluating Modern Statutory Rape Law*, 85 J. CRIM. L. & CRIMINOLOGY 15, 24 n.42 (1994), citing Rita Edison, Comment, *The Constitutionality of Statutory Rape Laws*, 27 UCLA L. REV. 757, 762 n.35 (1980).

17. See Oberman, *supra* note 16, at 24.

18. See ELSTEIN & DAVIS, *supra* note 7, at 49. There are exceptions: three states end the protection at the fifteenth birthday, two at the fourteenth birthday, and three at age thirteen. *Id.* at 62.

19. *Id.* at 62-63.

20. Oberman, *supra* note 16, at 31-32.

21. *Id.*

typically upheld gender-specific statutes, most prominently in the 1981 *Michael M.* case,²² but also in a number of state court decisions.²³

Because prosecution of statutory rape tends to focus on adult perpetrators, much of our discussion also has the same focus. As a result of our interest in reproductive health care access specifically, we focus primarily on girls and not boys as "victims," although, as described above, most states' statutes are gender-neutral. We also emphasize girls in our discussion regarding the effects of statutory rape laws and policies on health care access, although some of the same issues that influence them may also affect their male partners, particularly when those partners are themselves adolescents.

B. Epidemiologic Data

It should come as little surprise that many girls have older boy-friends, and that many girls who are minors (i.e. under the age of eighteen)²⁴ have boyfriends who are adults. In the United States, mothers are typically younger than fathers.²⁵ The age differences between teenage mothers and the fathers of their children received new attention beginning in 1992, with the publication of research on adolescent birthrates.²⁶ The research highlighted, for example, data on age differences, finding that in 1993, approximately one-third of births to California school-age mothers (ages ten to eighteen) involved peer fathers, while two-thirds involved post-school-age fathers (nineteen years or older).²⁷ In 1995, the Alan Guttmacher Institute's (AGI) *Sex and America's Teenagers* included a brief note showing similar numbers, and subsequent studies by researchers from AGI and the Urban Institute refined the analysis.²⁸ A single statistic—two-thirds over

22. See, e.g., *Michael M.*, 450 U.S. 464; but see *id.* at 490 n.3 (Brennan, J., dissenting) (citing cases in which gender-based statutory rape laws were struck down).

23. See *Michael M.*, 450 U.S. at 467 n.1 (citing federal and state cases in which statutory rape laws, including gender-based laws, were upheld). See also Oberman, *supra* note 16, at n.71 and accompanying text.

24. The age of majority is eighteen in all but three states. See ABIGAIL ENGLISH ET AL., STATE MINOR CONSENT STATUTES: A SUMMARY (2d ed. 2001) (in press).

25. Jacqueline E. Darroch et al., *Age Differences Between Sexual Partners in the United States*, 31 FAM. PLAN. PERSP. 160, 160 n.1 (1999) (citing National Center for Health Statistics data).

26. Mike Males, *Adult Liaison in the "Epidemic" of "Teenage" Birth, Pregnancy, and Venereal Disease*, 29 J. SEX RES. 525, 526-532 (1992); see also Michael Males & Kenneth S. Y. Chew, *The Ages of Fathers in California Adolescent Births, 1993*, 86 AM. J. PUB. HEALTH 565, 566-67 (1996) [hereinafter *Ages of Fathers*].

27. *Ages of Fathers*, *supra* note 26, at 567.

28. ALAN GUTTMACHER INSTITUTE, *SEX AND AMERICA'S TEENAGERS* 50 (1994); Darroch et al., *supra* note 25; Laura Duberstein Linberg et al., *Age Differences Between Minors Who Give Birth and Their Adult Partners*, 29 FAM. PLAN. PERSP. 61, 61-65 (1997).

nineteen—has been most frequently cited by both media and policy-makers, often quite recklessly.²⁹

The most relevant inaccuracy for the purposes of statutory rape policy is the use of the term “teen mother,” as more than sixty percent of these teens are adult women ages eighteen and nineteen.³⁰ Among teen mothers ages fifteen to seventeen years of age, forty percent have partners no more than two years older (although most of these are adults).³¹ Among sexually active teenagers as a whole, sixty-four percent of those fifteen to seventeen had partners within two years of their age in 1995, and only seven percent had partners six or more years older.³²

According to the AGI, however, those minors who have significantly older partners are at a very high risk for pregnancy, less likely to say that the pregnancy was unintended, and much less likely than others in their age group to have abortions.³³ The Urban Institute study referenced above analyzed the National Maternal and Infant Health Survey (NMIHS) and found that twenty-one percent of infants born to unmarried minors are fathered by men at least five years older than their partners.³⁴ These births account for only eight percent of those to fifteen through nineteen year-olds, the category most often counted as “teenage mothers.”³⁵

While there are many reasons to be concerned about young girls whose sexual partners are much older, from the perspective of access to health care, the age of an adolescent girl’s sexual partner or of the father of her baby is essentially irrelevant. A thirteen, or fifteen, or seventeen year-old girl who has been sexually active needs contraceptive services, pregnancy testing and counseling, abortion services, diagnosis and treatment of STDs, or prenatal and maternity care no more or less because her partner is a particular age. Thus, the epidemiology of statutory rape is of greater significance in understanding the evolution of statutory rape laws and policies than in determining the merits of health care access for sexually active adolescents. It is

29. Rebekah Saul, *Using – and Misusing – Data on Age Differences Between Minors and Their Sexual Partners*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Aug. 1999, at 10.

30. *Id.*

31. *Id.*

32. *Id.*

33. Commenting on this phenomenon, Mike Males, again, has said that relationships between girls and much older men seem to be more “marital.” Sylvia Pagan Westphal, *Partners of Underage Girls Focus of Study*, L.A. TIMES, Aug. 13, 1999, at A3.

34. Linberg et al., *supra* note 28, at 63.

35. *Id.* at 64. The researchers identify this eight percent as the pregnancies that result from statutory rape violations, and conclude that the increased statutory rape enforcement would have “limited results” on teenage childbearing rates. *Id.*

instructive, however, in understanding the potential scope of problems with health care access that may be created by the child abuse reporting-statutory rape link.

C. *Laws That Address Statutory Rape*

The new developments in statutory rape encompass both required child abuse reporting and increased enforcement of criminal statutes. As a result of our focus on health care access and health care providers, this article primarily addresses the issue of access. However, the threat of prosecution for statutory rape offenses, designed to deter men from sexual activity with girls, may also deter those girls from seeking health care.³⁶

Recent legal and policy developments fall into two categories: federal approaches and state approaches. The federal approaches, embodied primarily in the 1996 federal welfare reform law, are legally more limited in scope and less direct than the state approaches. Nevertheless, their significance exceeds their technical reach. The state approaches are more difficult to identify and catalogue because they take numerous forms. Also, some of the most significant activity for purposes of our analysis is not embodied in statute or regulation but rather in interpretations of existing laws that have not found their way into legally binding provisions.

1. *Federal Approaches*

In 1996, two pieces of federal legislation were enacted that increased the targeted federal focus on statutory rape. The first was the federal welfare law, which contained several provisions designed to promote increased prosecution of statutory rape and enhance awareness of the issue and its potential role in teen pregnancy prevention.³⁷ The second was an amendment to the Child Abuse Prevention and Treatment and Adoption Reform Act, which included statutory rape within the definition of sexual abuse.³⁸ In 1997, Congress enacted a rider to the Title X appropriation that was not specific to statutory rape but was related to helping girls resist exploitation.

36. A comprehensive study of the current state of statutory rape prosecution is beyond the scope of this article. See *infra* notes 39-54 and accompanying text (discussing the interaction between the threats of reporting and prosecution); see, e.g., ELSTEIN & DAVIS, *supra* note 7, at 25-29 (discussing statutory rape prosecution); Elizabeth Hollenberg, *The Criminalization of Teenage Sex: Statutory Rape and the Politics of Teenage Motherhood*, 10 STAN. L. & POL'Y REV. 267, 274-276 (1999).

37. 42 U.S.C. § 606 (1996).

38. 42 U.S.C. § 5106a (1996).

a. The 1996 Federal Welfare Law

The teen pregnancies for which statutory rape enforcement is viewed as the cure are inevitably linked to welfare politics as well. The *Michael M.* case foreshadowed these connections. In *Michael M.*, the plurality approvingly cited California's concern that "approximately half of all teenage pregnancies end in abortion . . . [a]nd of those children who are born, their illegitimacy makes them likely candidates to become wards of the state."³⁹

In a similar vein, the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA)⁴⁰ encouraged and required state and federal action, from both the criminal and welfare agencies, to combat statutory rape, and thus teen pregnancy, and an assumed resulting expansion of welfare rolls.

First, in a "Sense of the Senate" provision, the PRWORA encouraged aggressive enforcement of statutory rape laws.⁴¹ It further required the Attorney General to establish and implement a program to study the correlation between adult/teen sex and teenage pregnancy, focusing on "predatory older men committing repeat offenses," and to educate law enforcement officials on the prevention and prosecution of statutory rape.⁴² No monies were set aside in the statute for the recommended education or for enforcement. However, the Department of Justice has issued some educational materials, including a multidisciplinary training guide and a handbook for state legislators.⁴³

Second, the PRWORA, which established the cash assistance welfare program Temporary Assistance to Needy Families (TANF), also required all states to submit state TANF plans to the Department of

39. 450 U.S. at 471.

40. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996).

41. 42 U.S.C. § 14016(a) (Supp. 1998) (stating that "[i]t is the sense of the Senate that States and local jurisdictions should aggressively enforce statutory rape laws."). This amendment was sponsored by Senator Joseph Lieberman, who asserted that

[o]ne of the dreadful facts that comes out as we go over this problem of teen pregnancies is that a remarkable percentage of the babies born to teen mothers have been fathered by men who are considerably older And there is not much we can do from Washington to deal with that except to . . . try to encourage the States, the local prosecuting attorneys, the district attorneys to be very aggressive in working with welfare authorities to once again take statutory rape as a serious crime and to prosecute it, understanding that this is done to deter adult men from committing a sexual act that will result in a child born to poverty

CONG. REC. S12687 (daily ed. Sept. 6, 1995) (statement of Sen. Lieberman).

42. 42 U.S.C. § 14016(b) (Supp. 1998).

43. SHARON G. ELSTEIN & BARBARA E. SMITH, AM. BAR ASS'N CENTER ON CHILDREN AND THE LAW, VICTIM-ORIENTED MULTI-DISCIPLINARY RESPONSES TO STATUTORY RAPE: TRAINING GUIDE (Feb. 2000); LEGISLATORS' HANDBOOK, *supra* note 14.

Health and Human Services as a prerequisite to receiving their grants. As part of these plans, each state was required to describe how it would "conduct" an education and training program on the subject of statutory rape, with the objective of enhancing "teenage pregnancy prevention programs."⁴⁴ A 1997 review of states' initial TANF plans found that twenty-nine of the states merely indicated that they planned to conduct a statutory rape education program, tracking the language in the federal bill, while the remainder provided only limited detail on their plans.⁴⁵

b. The 1996 Amendments to the Federal Child Abuse Prevention and Treatment Act

The Federal Child Abuse Prevention and Treatment Act (CAPTA),⁴⁶ among its other provisions, authorizes grants to states for child abuse, neglect prevention and treatment programs,⁴⁷ and for programs relating to investigation and prosecution of child abuse and neglect cases.⁴⁸ In order to be eligible to receive a prevention and treatment program grant, a state is required to submit a plan.⁴⁹ The state plan must include an outline of the activities the state intends to carry out as well as an assurance that state law or a statewide program provides for the reporting of child abuse and neglect.⁵⁰ The CAPTA definition of child abuse and neglect includes "sexual abuse."⁵¹

Noteworthy among the changes to the CAPTA enacted by Congress in 1996 was an amendment of the definition of sexual abuse to include some forms of statutory rape.⁵² The amendment did not include all forms of statutory rape in the definition of sexual abuse, but rather included only those instances of statutory rape that involve caretakers or family members.⁵³ Specifically, the CAPTA definition of sexual abuse includes, in pertinent part, "the rape, and in cases of

44. 110 Stat. 2104. See JODIE LEVIN-EPSTEIN, CENTER FOR LAW AND SOCIAL POLICY, STATE TANF PLANS: OUT-OF-WEDLOCK AND STATUTORY RAPE PROVISIONS (1997).

45. *Id.* at 5. Advocates suggested that in the future the federal agency should request more specific information from the states. *Id.* (recommending that states be asked to include information on how the state's statutory rape program addresses the potential interface with paternity establishment and child support enforcement, and how it trains statutory rape educators).

46. 42 U.S.C. §§ 5101-5107 (1982).

47. 42 U.S.C. § 5106a (Supp. 1998).

48. 42 U.S.C. § 5106a (g) (Supp. 1998).

49. 42 U.S.C. § 5106a (b) (Supp. 1998).

50. 42 U.S.C. § 5106a (b)(1)(A) (Supp. 1998); 42 U.S.C. § 5106a (b)(2)(A)(i) (Supp. 1998).

51. 42 U.S.C. § 5106g (2) (Supp. 1998).

52. 42 U.S.C. § 5106g (4)(B), as amended and re-designated by An Act to Modify and Reauthorize the Child Abuse Prevention and Treatment Act, Pub. L. No. 104-235, Title I, Subtitle A, § 113 (a)(1)(B), 110 Stat. 3079 (1996).

53. 42 U.S.C. § 5106g (4)(B) (Supp. 1998).

caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other forms of sexual exploitation of children, or incest with children”⁵⁴ The term statutory rape is not defined in the CAPTA. However, the provision does seem to make clear that the federal government, at least, does not consider all forms of statutory rape to constitute child abuse for purposes of child abuse reporting laws, and does not mandate that states consider them as such. This federal perspective is important in the context of the varying approaches states have taken with respect to statutory rape and child abuse reporting.

c. The Title X Appropriation Rider

The federal appropriations bill for the Departments of Labor, Health and Human Services and Education for Fiscal Year 1998⁵⁵ contained a requirement that applied to the federal family planning program under Title X of the Public Health Service Act.⁵⁶ The appropriations rider specified that “[n]one of the funds appropriated . . . may be made available to any entity under Title X . . . unless the applicant . . . certifies . . . that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.”⁵⁷ While not directly addressing statutory rape per se, this requirement is designed to address the root cause of a problem that is fundamental to the concept of statutory rape enforcement and child abuse reporting by protecting young adolescents from sexual coercion and exploitation.

54. *Id.* The term “inter-familial” is not defined, but as it is coupled with the word caretaker, would appear to have a meaning consistent with the term “intra-familial,” meaning “within the family.” Of course, sexual activity between a minor and a family member would almost always violate a state’s criminal law as one or more of the offenses colloquially referred to as incest. Such offenses would also often fall within the terms of a state’s child abuse reporting requirements as well. Thus, it is difficult to determine how the CAPTA addition of statutory rape to the definition of sexual abuse added substantively to what was already in the statute.

55. An Act Making Appropriations for the Departments of Labor, Health and Human Services, and Education and Related Agencies for the Fiscal Year Ending September 30, 1998 and for Other Purposes, Pub. L. No. 105-78, 111 Stat. 1467 (1997).

56. 42 U.S.C. §§ 300-300a-8 (1994).

57. Pub. L. No. 105-78, § 212, 111 Stat. 1467, 1495 (1997). In response to this requirement, the federal Office of Population Affairs, which oversees the Title X program, updated the Title X Certificate of Compliance to include an assurance that the entity receiving the federal funds counsels minors on resisting coercive sexual activity. OFFICE OF POPULATION AFFAIRS, U.S. DEP’T HEALTH & HUM. SERV., OPA PROGRAM INSTRUCTION SERIES, OPA 98-1: CERTIFICATIONS FOR ENCOURAGING FAMILY PARTICIPATION AND COUNSELING TO MINORS ON HOW TO RESIST COERCIVE ATTEMPTS TO ENGAGE IN SEXUAL ACTIVITIES (Feb. 24, 1998), at <http://www.hhs.gov/opa/titlex/pis/opa98-1.txt> (last visited Mar. 15, 2001).

2. *State Approaches: Increased Criminal Enforcement and Child Abuse Reporting Requirements*

At least partially in response to the new federal legislative provisions, as well as to the epidemiologic data concerning statutory rape, some states have acted to change the way that statutory rape is treated in statute and in policy.⁵⁸ Three important categories of changes are the following:

- efforts to increase the prosecution of statutory rape offenses,⁵⁹ often accompanied by media campaigns to raise the profile of the issue;
- revision of statutory rape criminal codes to increase the age of consent, thus “covering” more minors;⁶⁰ and
- revision of child abuse reporting laws to make statutory rape a reportable offense or to encourage the reporting of statutory rape.⁶¹

It is the latter category of changes in child abuse reporting requirements that is of greatest significance for the purpose of this article.

In all states, child abuse reporting is mandated by law.⁶² Certain individuals, including health care providers, must report to a child welfare agency (often known as Child Protective Services) or to law enforcement any instances in which they reasonably suspect that a minor has been abused.⁶³ In all states, sexual abuse (sometimes under

58. See LEGISLATORS' HANDBOOK, *supra* note 14, at 2-3 (listing changes in state laws between January 1995 and January 1997 as including raising the age of the minor who is subject to protection by the law, imposition of age gaps, treating impregnation of a minor as a separate offense, targeting much older defendants, authorizing civil penalties, and encouraging reporting under child abuse reporting laws).

59. These efforts have included, for example, financial incentives for prosecutors to increase the enforcement of statutory rape laws, such as the financial assistance provided under California's Statutory Rape Vertical Prosecution program. See *infra* note 127, and accompanying text. See Hollenberg, *supra* note 36, at 274. New York and Connecticut considered authorizing grant programs for statutory rape prosecution, and Connecticut considered imposing criminal penalties against parents who fail to seek prosecution in certain cases of statutory rape. LEGISLATORS' HANDBOOK, *supra* note 14, at 4.

60. See LEGISLATORS' HANDBOOK, *supra* note 14, at 2 (citing changes in North Carolina and Pennsylvania that raised the age of the minor who is subject to protection to sixteen years of age).

61. See LEGISLATORS' HANDBOOK, *supra* note 14, at 3 (citing changes in Florida and Tennessee to require or encourage reporting of statutory rape under child abuse reporting laws).

62. See, e.g., ADMIN. CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUM. SERV., NATIONAL CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION, CHILD ABUSE & NEGLECT STATE STATUTES ELEMENTS, at Mandatory Reporters, No. 2 (current through Dec. 31, 1999), at <http://www.calib.com/nccanch/services/statutes.htm#Laws> (last visited Mar. 15, 2001) [hereinafter STATE STATUTES ELEMENTS].

63. *Id.*

another name) is included as a form of child abuse.⁶⁴ However, the exact definition of sexual abuse differs from state to state, and statutory rape is not always included within that definition.⁶⁵ Even when statutory rape is not explicitly included in a state statute's definition of reportable sexual abuse, some local prosecutors interpret the child abuse reporting law to require such reports.⁶⁶ Thus, statutory rape, however it is termed and defined by the law in a particular state, often triggers a mandate for health care providers to make a child abuse report. In its 1997 report, the American Bar Association estimated that "about half of the states' mandatory reporting laws include statutory rape as a reportable offense," but emphasized that statutory analysis of this issue is very difficult.⁶⁷

In the year 2000, both increased child abuse reporting and increased criminal prosecution of statutory rape were popular ideas in the teen pregnancy context. For example:

- In Nevada, the Legislative Committee on Health Care proposed strengthening statutory rape laws to combat teen pregnancy, with the goal of decreasing the state's teen pregnancy rate to thirty-five per 1,000 by 2005.⁶⁸
- In Texas, a rider attached to the 2000-2001 Texas Department of Health budget would provide funding only to clinics that make good-faith efforts to comply with the state's reporting law.⁶⁹
- In Maryland, where the teen birth rate fell from 54.3 per 1,000 in 1991, to 43.9 per 1,000 in 1997, the Governor's Council on Adolescent Pregnancy was urging increased prosecution of statutory rape offenses.⁷⁰

64. See, e.g., STATE STATUTES ELEMENTS, *supra* note 62, at Reporting Laws, No. 1, Definitions of Child Abuse and Neglect.

65. *Id.*

66. Telephone interview with Jamie Shluker, Policy Director of the Alliance for Young Families, Boston, Mass. (Nov. 8, 2000).

67. ELSTEIN AND DAVIS, *supra* note 7, at 66.

68. Nevada's rate, once as high as 58.9 per 1,000 in 1995, had dropped to 48.7 per 1000 by 1998. Cy Ryan, *Fight Against Teen Pregnancy Focuses on Adult Males*, LAS VEGAS SUN, April 19, 2000, at 1.

69. In Texas, reporting of "any indecency with a child" is mandated. TEX. FAMILY CODE ANN. § 261.101(b) (West 1996). The reporting statute incorporates by reference the statute that makes a broad range of sexual conduct with a minor under age seventeen a crime. TEX. PENAL CODE ANN. § 21.11 (West 1994). State Senator Steve Ogden cited studies finding that enforcement of statutory rape laws had "decreased teen pregnancies in Delaware, California, and Connecticut." Scott S. Greenberger, *Health Care Groups Worry Law Will Harm Sexually Active Teens*, AUSTIN AMERICAN-STATESMAN, May 1, 2000, at A1.

70. Kate Shatzkin, *Md. Looks to Rape Laws to Cut Teen Birth Rates; Fears About Care, Girls' Attitudes Hinder Enforcement*, BALTIMORE SUN, Feb. 5, 2000, at 1A.

- In Virginia, a member of the Richmond City Council pushed to revive a citywide partnership with the goal of prosecuting males involved in the statutory rape of teenage girls.⁷¹

Despite the popularity of these ideas, the supposed link between increased statutory rape reporting and enforcement, and decreasing teen pregnancies has not been empirically proven.⁷² One welcome confounding factor is the fact that teen pregnancies decreased fairly rapidly across the country throughout the 1990s, in states that aggressively required reporting of statutory rape cases and enforced statutory rape laws,⁷³ as well as in states that did not have such requirements. Nevertheless, based on media reports and conversations with health care providers and advocates, as well as statutory analysis, the popularity of increased enforcement and expanded reporting requirements does not appear to be on the wane.

III. EFFECTS OF LEGAL AND POLICY RESPONSES

In view of the popularity and the broad sweep of the current federal and state approaches to statutory rape, it is critically important to understand their implications for adolescents. In particular, to the extent that these approaches have the potential for unintended consequences—harming adolescents rather than helping them—must be understood, so that their actual effects can be examined and, if necessary, the approaches reevaluated. The possible harms to adolescents include a variety of effects that may result from either prosecution or reporting, as well as some important implications of these for health care access.

A. Possible Harms to Adolescents

The general harms that may affect adolescents include criminalization⁷⁴ for sexual activity that is truly consensual for both parties, de-

71. Gordon Hickey, *Teen Pregnancy Target of Councilman's Mission*, RICHMOND TIMES DISPATCH, Mar. 6, 2000, at A-2. However, in response to this initiative, significant members of the community (physicians, police, prosecutors) voiced doubts regarding issues such as race, culture, family trauma, and health care access. *Id.*

72. The linkage between Connecticut's new media campaign and statutory rape prosecution unit, and its ten percent drop in teen birth rates, for example, is not watertight. Cheryl Wetzstein, *Reduced Teen Pregnancy Linked to Rape Enforcement: Several States Targeting Older Men for Prosecution*, WASH. TIMES, Apr. 7, 2000, at A2.

73. Jacqueline E. Davroch and Susheela Singh, *Why is Teenage Pregnancy Declining? The Roles of Abstinence, Sexual Activity, and Contraceptive Use*, THE ALAN GUTTMACHER INSTITUTE, OCCASIONAL REPORT NO. 1, Dec. 1999.

74. Although the term criminalization is a vague one, it is used here inclusively to refer to involvement in one or more aspects of the criminal prosecution process: arrest, prosecution, trial, or incarceration.

portation for undocumented immigrants, loss of income and support for a teen mother if the father is jailed or deported, and entanglement in the child welfare system. It is impossible to generalize law enforcement's response to a statutory rape report, which varies from state to state and county to county. Perhaps the only constant is the disruption that a report entails for the young woman involved, who is likely to feel "victimized all over again"75 In some cases, the girl may rightly feel that she is being used as a pawn. A recent American Bar Association report on "best practices" in statutory rape enforcement described law enforcement's use of statutory rape charges to arrest suspected gang members when evidence of other crimes is insufficient.⁷⁶ Where the sexual activity in question involves force, abuse, or exploitation, there may well be sufficient reason to go forward with prosecution. In cases that involve sex that is voluntary for both partners, however, particularly if there is no great difference in age, the justification for prosecution, with the attendant costs for the victim, may be more difficult to identify.

In addition to the burdens associated with the prosecution process itself, the costs for a victim who is a teen mother may include loss of income or support if her boyfriend or partner, the father of her child, is jailed or deported. Newspaper accounts as well as conversations with health care providers, advocates, and teens themselves have indicated that this is a serious concern. It is especially so in geographic areas with large immigrant populations, and even more so if the immigrant groups include young people and families from cultures where youthful marriage is considered desirable, and relationships between younger teen girls and older partners is viewed as acceptable.⁷⁷

Even when the consequences of reporting do not include prosecution, incarceration, or deportation, they may include entanglement in the child welfare system. Many state child abuse reporting laws provide an option for mandated reporters to file their reports either with the child protective services agency or with the police; usually there is a cross-reporting obligation between these agencies.⁷⁸ Thus, when a requirement to report statutory rape as child abuse applies, the report

75. Patricia Donovan, *Caught Between Teens and the Law: Family Planning Programs and Statutory Rape Reporting*, 1 THE GUTTMACHER REPORT ON PUBLIC POLICY (June 1998), at <http://www.agi-usa.org/pubs/journals/gr010303.html>. (last visited Apr. 19, 2001).

76. Sally Small Inada, *Improving the Criminal Justice Response to Statutory Rape*, 17 CHILD LAW PRACTICE 157, 157 (1998) (reporting the strategy used by the prosecutor in one California county to increase police enthusiasm for investigation of statutory rape by informing them that it may serve as an alternative basis for arresting gang members).

77. See *supra* note 1.

78. See, e.g., STATE STATUTES ELEMENTS, *supra* note 62.

is likely to reach the child welfare agency. Unfortunately, this reporting in no way guarantees that an adolescent girl who has been involved in voluntary sexual activity with her boyfriend will benefit from her involvement with the child welfare system.

Certainly there is reason to question the child welfare and criminal justice systems' abilities to help or protect adolescent girls.⁷⁹ The child welfare system as a whole is famously overburdened, and this is true for the "front-end" functions of report investigations as well. In some jurisdictions, child welfare workers state up front that allegations involving adolescents are only pursued in cases of intra-family abuse.⁸⁰ Even in cases that involve serious physical or sexual abuse, the adolescent age group is the one that the child welfare system has had the poorest record of helping.⁸¹ Not only are these cases typically assigned a low priority, when the cases are investigated and adolescents are removed from their homes, they are often the most difficult to place and consequently experience numerous moves from one foster home to another, or placement in an institutional or group care setting.⁸² Often, no action is ultimately taken by a child welfare agency, but the girl and her family may have been disrupted simply by the initial effects of the report.⁸³

79. A recent Special Report in the *Atlanta Journal-Constitution*, "Prostituting Our Young," included a series of articles detailing the extensive involvement of very young adolescents, as young as age ten, in prostitution and exposing the failure of either the criminal justice system or the child welfare system to protect them. See, e.g., Jane O. Hansen, *Selling Atlanta's Children: Runaway girls lured into the sex trade are being jailed for crimes while their adult pimps go free*, ATLANTA JOURNAL-CONSTITUTION, Jan. 7, 2001, A1 (explaining that a lack of children's programs has left some judges no choice but to place exploited children, such as these, in detention for their own safety). The report also quotes judges as saying that not enough is being done for children whose lives may already have been destroyed because it's "not a priority" and police officer who "was concerned that someone was prostituting these girls . . . and I could not even get an investigator to give advice." *Id.*

80. Such statements were reported by San Francisco Bay Area health care providers at a training on statutory rape reporting, on March 22, 2000. Providers stated that when they do make reports of consensual activity involving minors, they either are told that these cases are "not a priority" and that the agency only investigates when intra-familial abuse is involved, or the report is taken but nothing happens. As indicated by the definition of sexual abuse in the Federal Child Abuse Prevention and Treatment Act, intra-family abuse is the category that the federal government considers the most important, even though some states' reporting laws currently have a broader reach, creating a disconnect between the reporting requirements and the child welfare response. See *supra* notes 46-54 and accompanying text.

81. A particularly glaring recent example of this is the failure of the child welfare and criminal justice systems in Georgia to protect even very young adolescents who are clear victims of exploitation. Hansen, *supra* note 79.

82. Interview with Shannan Wilber, Staff Attorney at the Youth Law Center (Feb. 5, 2000).

83. See *supra* note 1.

B. Implications for Health Care Access

1. Effects on Adolescents

In addition to the potential direct effects of prosecution and child welfare involvement, which are unquestionably important, the implications for health care access of an adolescent victim of statutory rape can be profound. The American Bar Association was one of the first to call attention to this issue, writing that:

The issue of mandated reporting . . . to child protective services raises serious, previously not addressed, public policy problems and needs further, careful study. Awareness by girls that their relationships may be 'reported' to authorities may deter girls from seeking medical or social services attention related to contraception, sexually transmitted diseases, prenatal care, or domestic violence.⁸⁴

Similarly, Professor Michelle Oberman, an academic expert on statutory rape, has raised concerns that "[t]he threat of criminal sanctions might . . . [discourage] minors from seeking reproductive health care and counseling. They may fear that their health care providers will report them to the police, and in fact, they may be right."⁸⁵ More recently, a former Surgeon General of the United States, commenting on the implications of aggressive prosecution stated, "such measures may prove to be deleterious for teenage girls. Enforcement of current statutory rape laws may deter sexually active and pregnant teens from seeking medical care or social services because of fear of having to reveal the identity and age of their partners."⁸⁶

The fears of teenage girls may be less for themselves than for their partners, who, as mentioned above, may face criminal sanctions or deportation if they are convicted of statutory rape offenses. In more than a few cases, they may not only fear for their partners, but also fear their partners' reactions, avoiding health care due to the threat of repercussions from these men.⁸⁷ A recent study of adolescent health and well-being in the United States revealed that one in five high school girls surveyed (twenty-one percent) had been physically or sexually abused,⁸⁸ and eight percent of high school girls reported abuse by dates or boyfriends, including "date-forced sex."⁸⁹ Domestic vio-

84. ELSTEIN AND DAVIS, *supra* note 7, at 69.

85. Oberman, *supra* note 16, at 75.

86. M. Joycelyn Elders, *Adolescent Pregnancy and Sexual Abuse*, 280 JAMA 648, 649 (1998).

87. *Id.* at 649 (pointing out that "[i]n addition, teenage girls may put themselves at risk of physical abuse in reprisal for identifying these men.").

88. CATHY SCHOEN, ET AL., *THE COMMONWEALTH FUND SURVEY OF THE HEALTH OF ADOLESCENT GIRLS* 1 (1997).

89. *Id.* See also Roger J.R. Levesque, *Dating Violence, Adolescents, and the Law*, 4 VA. J. SOC. POL'Y & L. 343, 345 (1997) (citing Denise Gamache, *Domination and Control: The Social*

lence researchers have long pointed to pregnancy as a trigger for abuse in adult relationships, and the pattern holds true for teenagers as well. One study of pregnant teens found that one-quarter reported a history of physical or sexual abuse, and that forty percent of those with a history of abuse had been hit during pregnancy. While the most common perpetrator of physical assault was a member of their family of origin, a boyfriend or spouse was the perpetrator in eighty percent of the cases in which abuse had increased during pregnancy.⁹⁰ Although there is little data to document this effect, a boyfriend's anger over intervention by the authorities might intensify the likelihood of an abusive response in a situation that already presents a high risk of violence. Thus, when they protect their partners from contact with the authorities, young women may in fact be protecting themselves.

In states or communities where, either by statute or by prosecutorial interpretation, statutory rape is treated as sexual abuse for purposes of child abuse reporting, health care providers are required to report either to the police or a child welfare agency. Depending on state law, where statutory rape is classified as child abuse the provider may also be required to report the activity to a parent. The fears inspired in an adolescent by the possibility of such reporting may lead her to forego needed health care. While anecdotal accounts of such behavior are common, no formal studies quantifying the extent of this deterrent effect exist. Aside from the anecdotes, literature on confidentiality concerns and teenage battering make this possibility seem, unfortunately, very real.

Regardless of the reason, adolescents' delay in seeking or complete avoidance of health care services can have very serious consequences. This may be particularly true where the health care in question is related to pregnancy, sexually transmitted disease, or mental health concerns.

Teenage women typically enter prenatal care later than older women, and receive fewer prenatal visits, even though they are at higher risk than adult women for certain complications of pregnancy.⁹¹ Teenagers who wish to terminate their pregnancies face parental consent and notification laws in most states, and the requirements of these laws tend to delay abortion procedures for this

Context of Dating Violence, in *DATING VIOLENCE: YOUNG WOMEN IN DANGER* (Bartie Levy ed., 1991)).

90. Abbey B. Berenson et al., *Prevalence of Physical and Sexual Assault in Pregnant Adolescents*, 13 *J. ADOLESCENT HEALTH* 466, 467 (1992).

91. Michael D. Kogan et al., *The Changing Pattern of Prenatal Care Utilization in the United States, 1981-1995, Using Different Prenatal Care Indices*, 279 *JAMA* 1623 (1998).

age group.⁹² To the extent that statutory rape requirements similarly work to keep teenagers out of care, they may be pushed into later termination procedures, which are more expensive and more difficult to access.⁹³

In addition, rates of sexually transmitted disease (STD) and human immunodeficiency virus (HIV) are high among adolescents.⁹⁴ To the extent that adolescents with a sexually transmitted infection delay or avoid care, they may suffer complications with high personal and public health costs, sometimes with lifelong implications.⁹⁵

Adolescents also frequently experience depression and other mental illness. Rates of suicide and suicide attempts, as well as less serious mental health problems, are high in this age group.⁹⁶ If the strain of relationships with older men were to trigger mental health concerns for adolescent girls, it would be detrimental and counter-productive if the effect of public policy responses to those relationships were to deter the girls from seeking the mental health services that might help them.

2. *Effects on Health Care Professionals*

One of the fundamental tenets of adolescent medicine, and indeed medicine in general, is the principle that a physician or health care provider should not disclose confidential information about the patient or her care without the patient's consent. This serves numerous important purposes. Adolescent patients are encouraged to provide a complete health history, sharing information that might be embarrassing or harmful if it were disclosed to parents or became widely known. Particularly in view of the high incidence of risk behaviors among adolescents, a candid health history is an essential element of providing appropriate, high quality health care to this age group.

92. Heather Boonstra & Elizabeth Nash, *Minors and the Right to Consent to Health Care*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Aug. 2000, at 5. "Thirty-one states have laws in effect that require the involvement of at least one parent in their daughter's abortion decision." *Id.* See Stanley K. Henshaw, *The Impact of Requirements for Parental Consent On Minors' Abortions in Mississippi*, 27 FAM. PLAN. PERSP. 120, 121 (1995).

93. Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 FAM. PLAN. PERSP. 54, 56-57 (1995).

94. Mary Ann Shafer, *Sexually Transmitted Diseases in AM. MED. ASS'N, HEALTHY YOUTH 2000: A MID-DECADE REVIEW* 42 (Missy Fleming ed., 1996); CENTERS FOR DISEASE CONTROL AND PREVENTION, 9 HIV/AIDS SURVEILLANCE REPORT 14 (tbl. 7) (1997).

95. Shafer, *supra* note 94, at 43.

96. See, e.g., PUBLIC HEALTH SERVICE, U.S. DEP'T HEALTH & HUM. SERV., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT SUICIDE: AT A GLANCE - SUICIDE AMONG THE YOUNG (1999), at <http://www.surgeongeneral.gov/library/calltoaction/fact3.htm> (last visited Mar. 15, 2001).

Health care providers who are confronted with a legal obligation to report the sexual activity of their minor adolescent patients to child welfare or law enforcement agencies as child abuse are confronted with a difficult dilemma. Even if the law makes clear that the child abuse reporting requirement trumps the confidentiality obligation, an ethical quandary remains. In violating the trust of the adolescent patient and making the child abuse report, will the health care provider discourage this patient or others from seeking health care in the future, or from providing candid answers in a health history interview?

Not surprisingly, diverse views about statutory rape exist among health care providers. While many providers have expressed concerns that statutory rape reporting will undermine the consent and confidentiality schemes under which they have operated for years,⁹⁷ some health care providers are supportive of increased enforcement of statutory rape laws. For example, a 1999 report from Kansas surveyed family planning program managers in that state about their attitudes toward statutory rape enforcement.⁹⁸ From a sample of sixty-eight managers, seventy-nine percent supported aggressive enforcement, and forty-three percent thought that it would reduce pregnancy rates.⁹⁹ With increased enforcement, thirty-eight percent thought teenagers would be discouraged from seeking reproductive health care, while forty-one percent thought they would not.¹⁰⁰ Assuming that these health care providers were accurate in predicting the responses of teenagers, there could be a substantially harmful impact on the health of young people if more than one-third are discouraged from seeking health care. Such a result may counterbalance any positive effects resulting from increased reporting.

Providers operating in jurisdictions where statutory rape is a reportable offense face difficult decisions. Many providers describe feeling torn between their legal responsibilities and their fear of scaring their patients.¹⁰¹ Some providers avoid questions that might make them

97. See, e.g., Greenberger, *supra* note 69 (quoting the reaction of the head of the Texas Family Planning Association to the proposed rider to the 2000-2001 Department of Health budget that would have allowed funding to clinics that show good faith efforts to comply with the state's reporting law: "It's not going to take long for it to get out that we're reporting all the boyfriends to law enforcement[.] So what's going to happen is that sexually active teenagers are not going to go to clinics."). *Id.*

98. Corinne E. Miller et al., *Issues in Balancing Teenage Clients' Confidentiality and Reporting Statutory Rape Among Kansas Title X Clinic Staff*, 16 PUB. HEALTH NURSING 329, 330 (1999).

99. *Id.*

100. *Id.*

101. Personal communications with adolescent health care providers: Second Bay Area Adolescent Health Conference (May 5, 2000), San Francisco Dep't of Pub. Health Training (March 22, 2000), National HIV/AIDS Update Conference (March 26, 1999).

aware of a reportable offense, but risk missing important information about their patients' lives. Others seek the information and deal with the reporting as it comes up.¹⁰² Still others ask the questions but fail to make the required reports.¹⁰³ In the Kansas study cited above, willingness to report cases was mixed, with all respondents who would report wanting the flexibility to judge on a case-by-case basis.¹⁰⁴ For those not reporting, confidentiality concerns overrode beliefs in any positive outcome, and this was a sample in which nearly four in five supported aggressive enforcement.¹⁰⁵

While most health care providers take their reporting responsibilities very seriously, it is difficult to gauge the extent to which statutory rape offenses are reported according to statute. Some providers do not ask many questions of their adolescent patients anyway, and not because they worry about the consequences of reporting. In a study of California physicians treating adolescents, fewer than half always asked their patients about sexual activity; only thirty-six percent always provided STD/HIV education to those patients they knew to be sexually active.¹⁰⁶

Conversely, other evidence suggests that a knowing failure to report may be fairly widespread. The American Bar Association study found that fifty-nine percent of providers of health and social services to teenagers said that they do not report relationships between teenage girls and adult men to law enforcement or child protective service agencies.¹⁰⁷ However, the providers' locations were not included and presumably not all such reports were mandated. In a mandatory reporting context, a California study found low levels of compliance. Since 1994, California law has required health care providers to report suspected cases of intimate partner violence, with identifying information, regardless of the patient's wishes.¹⁰⁸ A 1995 study of California primary care and emergency physicians found that fifty-nine percent "might not comply" with the reporting law if a patient objected.

102. *Id.*

103. *Id.*

104. Miller et al., *supra* note 98, at 333-34.

105. *Id.*

106. Susan G. Millstein et al., *Delivery of STD/HIV Preventive Services to Adolescents by Primary Care Physicians*, 19 J. ADOLESCENT HEALTH 249, 252 (1996). See also Angela Diaz, *Questioning Adolescent Patients About Sexual Abuse*, 25 J. ADOLESCENT HEALTH 313, 313-14 (1999) (citing the Commonwealth Fund survey on the health of adolescent girls, which suggests that many physicians are not asking their adolescent patients about sexual abuse, and arguing that they should do so).

107. ELSTEIN AND DAVIS, *supra* note 7, at 28-29. The providers' locations were not included, and it is unknown whether in fact such reports were mandated.

108. CAL. PENAL CODE §§ 11160-11163.2 (West 1985).

While compliance was even lower among physicians who were not aware of the law, almost half of those who were familiar with it reported that they would not report over a patient's objection.¹⁰⁹ While a large majority of the physicians agreed that the reporting law had potential benefits, similar percentages felt that it required ethical violations, created barriers to care, and could escalate violence or abuse.¹¹⁰ Similar rationales might well apply to the reporting of statutory rape, although, on the other hand, providers might be more likely to report where the "victim" is a child and not an adult.

3. *Determining the Scope of the Problem*

As mentioned above, most of the evidence on health care avoidance is anecdotal. It is extremely difficult even to imagine a study that could sort out the deterrent effects of statutory rape reporting on health care access. For one thing, adolescents' rate of health care utilization is notoriously low for reasons including poor health insurance coverage, lack of adolescent-friendly providers, and the confidentiality concerns raised above.¹¹¹ As a group, adolescents see a doctor far less often than younger children or adults. Adolescents and young adults ages fifteen to twenty-four made on average only 1.6 office visits each in 1996, the lowest rate of any age group. By comparison, children under fifteen had 2.4 visits per year.¹¹² Adolescent males and black adolescents are particularly unlikely to make physician visits.¹¹³ Pregnant adolescents typically enter prenatal care later than do older women.¹¹⁴ Thus, the marginal effect of adolescents' fear of statutory rape consequences is difficult to determine.

Nevertheless, some data is available that sheds light on the potential scope of the problem. First, the state child abuse reporting laws themselves are evidence of the dilemma that confronts health care professionals. The American Bar Association has estimated that approximately half of the states require reporting of statutory rape in

109. Michael A. Rodriguez et al., *Mandatory Reporting of Intimate Partner Violence to Police: Views of Physicians in California*, 89 AM. J. PUB. HEALTH 575, 577 (1999).

110. *Id.*

111. See, e.g., Carol A. Ford et al., *Foregone Health Care Among Adolescents*, 282 JAMA 2227 (1999); see also ELIZABETH OZER, ET AL., *AMERICA'S ADOLESCENTS: ARE THEY HEALTHY* (1998).

112. DAVID A. WOODWELL, NAT'L CENTER FOR HEALTH STATISTICS, NATIONAL AMBULATORY MEDICAL CARE SURVEY: 1996 SUMMARY, ADVANCE DATA FROM VITAL & HEALTH STAT. No. 295, Dec. 17, 1997, at tbl. 2.

113. For women fifteen to twenty-four, the rate of office visits was 2.2 per person per year; for men it was only 1.1. White individuals in the same age group made 1.7 visits per person per year, while black adolescents rated only 1.4 visits annually. *Id.*

114. Kogan, *supra* note 91.

their child abuse reporting laws.¹¹⁵ While this article does not contain a comprehensive analysis of the number of states with laws that require reporting of statutory rape as child abuse, Part IV of this article does include examples of the different types of state laws and the ways in which they treat statutory rape for reporting purposes.

In addition, extensive information is available that documents the importance of confidentiality to adolescents.¹¹⁶ Studies related to contraception and abortion have repeatedly documented that some adolescents are unwilling to seek care unless they can do so on a confidential basis.¹¹⁷ Moreover, a very large number of organizations of health care and social services professionals have adopted policies supporting confidential care for adolescents in recognition of the important role confidentiality plays in their access to care.¹¹⁸

Of course, in order to be scared away from health care services by reporting policies, young women would have to be aware of them. Although there appear to be no surveys that track this information, in at least one state, California, the media campaign publicizing the fact that statutory rape will be prosecuted has been extremely visible.¹¹⁹ Certainly, anecdotal accounts by providers suggest that adolescents frequently are quite aware of providers' reputations for keeping information confidential, if not of changes to the law per se. In addition, similar and numerous anecdotal accounts have documented that at least some adolescents have an awareness of the reporting problem and are deterred from seeking health care as a result.¹²⁰

Even for adolescents who are not initially scared away from seeking health care, the broad application of child abuse reporting requirements to instances of statutory rape is potentially problematic. The system pits the existing framework of consent and confidentiality laws

115. ELSTEIN AND DAVIS, *supra* note 7, at 66.

116. See, e.g., Council on Scientific Affairs, Am. Med. Ass'n, *Confidential Health Services for Adolescents*, 269 JAMA 1420 (1993); POLICY COMPENDIUM ON CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS (Janet E. Gans ed., 1993) [hereinafter POLICY COMPENDIUM]; Tina L. Cheng et al., *Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes Among High School Students*, 269 JAMA 1404 (1993); Carol A. Ford et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care*, 278 JAMA 1029, 1032 (1997).

117. Cheng, *supra* note 116.

118. POLICY COMPENDIUM, *supra* note 116.

119. Print, billboard, and television advertisements from the statutory rape campaign can be viewed at the California Department of Health Services' Partnership for Responsible Parenting website, at http://www.responsibleparenting.org/billboard_ads/index.html (last visited Apr. 20, 2001).

120. This issue was discussed at length in a meeting of California providers and advocates convened by the authors in Berkeley, California in October, 2000. Attendees are listed in *supra* note 1.

that apply to adolescent health care against the child abuse reporting laws, with both adolescents and health care professionals trapped in between them.¹²¹

Over a period of more than thirty years, every state has enacted a set of statutes that permit minors to give their own consent for health care. These statutes either authorize specific groups of minors to consent to all care based on their legal status or authorize some minors to consent to specific services. Among the latter, statutes authorizing minors to consent to reproductive or sexuality related health care, including contraceptive services, pregnancy-related care, or diagnosis and treatment of STDs, are among the most common. In addition to allowing minors to give their own consent for health care, many of these statutes also provide confidentiality protection for the information related to that care. In addition, certain federal laws related to family planning clinics, federal drug and alcohol programs, and medical privacy also protect adolescents' ability to obtain health care on a confidential basis.

The existence of these laws has led adolescents to believe that they can seek health care, at least for certain issues, confidentially. The laws have also led health care providers to believe that they can offer the care on a confidential basis. Although health care providers have also, over the same time period, been accustomed to having to report child abuse, including sexual abuse, they generally have not been required or expected to report sexual activity that does not involve coercion, exploitation, or abuse. With the new trend toward requiring exactly this, neither adolescents nor health care providers can rely, as they have in the past, on the legal framework that has allowed young people to seek care related to sexual activity with a basic expectation that their health care providers will protect the confidentiality of that care except where specific types of harm are involved. For law or policy to require the reporting of sexual activity that does not involve specific harm would appear to undermine the very foundation and rationale for creating the minor consent and confidentiality laws in the first place: encouraging young people to seek care for the protection of their own health and the public's health.

121. Kathleen Sylvester of the Social Policy Action Network acknowledged that aggressive prosecution of statutory rape may "undermine a girl's sexual autonomy If an adolescent girl isn't competent to consent to sex, then she isn't competent to contraception without parental permission" Wetzstein, *supra* note 72 at A2.

IV. LEARNING FROM STATE APPROACHES

Analysis of the child abuse reporting statutes and policies of all fifty states is beyond the scope of this article. Nevertheless, a detailed look at two specific states—California and Wisconsin—confirms the existence of the problem, if not its scope, and helps to delineate possible solutions. Moreover, if the estimates provided by others are to be believed, the scope of the problem is significant, with as many as half the states requiring that statutory rape be reported as child abuse.¹²²

State child abuse reporting statutes vary in numerous ways that may determine whether and to what extent statutory rape is required to be reported. For example, some states only require reports in cases of abuse or neglect by a parent, family member, or caretaker,¹²³ others include abuse by non-family members,¹²⁴ and still others include statutory rape but grant the health care provider some measure of discretion.¹²⁵ The first requirement would not generally encompass statutory rape as the term commonly understood, while the latter two might. The terms of a state's statute itself, however, are not the only factors determining whether statutory rape is reportable. For example, in some jurisdictions without a clear statutory mandate, prosecutors have interpreted the law to require reporting and have instructed health care providers that they are obligated to make such reports.¹²⁶

Two states that have adopted widely differing approaches to the reporting of statutory rape are California and Wisconsin. California explicitly amended its child abuse reporting statute in 1997 to require

122. ELSTEIN AND DAVIS, *supra* note 7, at 66.

123. *See, e.g.*, 325 ILL. COMP. STAT. ANN. 5/4 (West 1993) (requiring professionals to report when they have reasonable cause to believe a child may be an abused or neglected child); 325 ILL. COMP. STAT. ANN. 5/3(c) (West 1993) (defining abused child to include one whose parent, caretaker, or family member "commits or allows to be committed any sex offenses [as defined in the Criminal Code]" if the child is under age eighteen).

124. *See, e.g.*, OR. REV. STAT. ANN. § 419B.010 (West 1993) (requiring professionals to report abuse); OR. REV. STAT. ANN. § 419B.005 (West 1993) (defining abuse to include many sexual crimes involving children); OR. REV. STAT. ANN. § 163.315(1) (West 1993) (stating that a person is considered incapable of consenting to a sexual act of the person is under age eighteen); OR. REV. STAT. ANN. § 163.355 (West 1993) (defining rape in the third degree as sexual intercourse with a person under age sixteen).

125. *See, e.g.*, LA. CHILDREN'S CODE ANN. art. 609A(1) (West 1994 & Supp. 2000) (professionals must report when they have reasonable cause to believe that the child's physical or mental health or welfare is *endangered* as a result of abuse or neglect); LA. CHILDREN'S CODE ANN. art. 603(1)(c) (West 1994 & Supp. 2000) (defining abuse to include the involvement of the child in any sexual act with a parent or any other person or any other involvement of a child in sexual activity constituting a crime under Louisiana laws); LA. REV. STAT. ANN. §§ 80, 81, 81.2, 43.1, 43.3, 43.4 (West 1994 & Supp. 2000) (defining sexual offenses that make consensual acts with a minor criminal based upon differences in age).

126. *See, e.g.*, Interview with Policy Director of the Alliance for Young Families, *supra* note 66.

reporting of statutory rape when a specific age difference exists. Wisconsin, by contrast, also requires that statutory rape be reported as child abuse but includes a specific exemption for certain providers of health care services for adolescents. Reviewing the implementation of these two approaches and considering their potentially contrasting effects on adolescents and their health care providers is instructive for future policy development.

A. California

1. Statutory Scheme for Statutory Rape Reporting

Perhaps more than any other state, California has made the campaign against statutory rape a central piece of its teen pregnancy prevention efforts. Led by the Governor's office and beginning in 1996, California implemented a new statutory rape vertical prosecution (SRVP) program¹²⁷ and an extensive public relations campaign, both designed to deter adult men from engaging in sex with minor girls. At around the same time, the state altered its child abuse reporting law to encompass statutory rape as a reportable crime. In 1997, the California Legislature passed Assembly Bill 327 (AB 327), which requires health care providers and other mandated officials to report as child abuse certain instances of sexual activity (consensual or not) between partners of disparate ages.¹²⁸

Specifically, AB 327 added two additional crimes to the definition of "sexual assault." Sexual assault is one element of child abuse that must be reported under the child abuse reporting law.¹²⁹ Mandated reporters in California are now required to report some cases of statutory rape¹³⁰ and some instances of lewd and lascivious acts upon a

127. The Statutory Rape Vertical Prosecution (SRVP) Program, administered by the Office of Criminal Justice Programs, provides grants to establish specialized "vertical prosecution" units—with a deputy district attorney assigned solely to these cases—in county district attorney's offices, to prosecute adults for unlawful sexual intercourse with a minor. Established in Fiscal Year 1995/1996 as a pilot program in sixteen counties, the program provided \$8.3 million in grants to fifty-four district attorneys' offices in Fiscal Year 2000/2001. See STATUTORY RAPE VERTICAL PROSECUTION PROGRAM, at http://www.ocjp.ca.gov/programs/pro_cb_srvp.htm (last visited Feb. 8, 2001).

128. The new reporting requirements were signed into law by Governor Pete Wilson on July 21, 1997 and took effect on January 1, 1998. 1997 Cal. Stat. ch. 83 § 1.

129. CAL. PENAL CODE §§ 11165.1, 11165.6 (West 1999 & Supp. 2000).

130. The California Penal Code does not use the phrase "statutory rape," but refers instead to "unlawful sexual intercourse," defined as sexual intercourse with a minor under age eighteen who is not the spouse of the perpetrator. CAL. PENAL CODE § 261.5(a) (West 1999 & Supp. 2000).

child,¹³¹ regardless of their judgment concerning the nature of the sexual relationship. Not all offenses in either category are reportable. The amendments to the statute require reporting of unlawful sexual intercourse (statutory rape) between a minor who is under the age of sixteen and an adult who is over the age of twenty-one, while the lewd and lascivious acts section requires reports whenever a fourteen or fifteen year-old minor is sexually active with a partner at least ten years older.¹³²

Within these age parameters, the California child abuse reporting statute does not allow provider discretion in reporting.¹³³ For other statutory rape offenses, health care providers and other reporters maintain their discretion: sexual intercourse between a sixteen year-old and a twenty year-old does not require a report. No information is available from the state or from counties about the number of new child abuse reports engendered by the new requirements, or about the outcome of these reports.

2. *Impact on Provision of Adolescent Health Care*

Among adolescent health care providers, news of the SRVP program and changes to the child abuse reporting scheme spread quickly, and so did confusion over the exact provisions. County district attorney's offices in a number of counties produced notices for mandated reporters describing the changes in the law, although some providers reported receiving misinformation: being told, for example, that all instances of statutory rape required reporting.¹³⁴

131. California Penal Code Section 288(a) states that "[a]ny person who willfully and lewdly commits any lewd or lascivious act . . . upon or with the body . . . of a child who is under the age of fourteen years, with the intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires of that person or the child, is guilty of a felony . . ." CAL. PENAL CODE § 288(a) (West 1999 & Supp. 2000). This definition is incorporated by reference in sections referring to older minors as well. While charges brought under this section have generally involved severely exploitative behavior, in the reporting statute it is interpreted to include all sexual activity. *Id.*

132. California law already required some age-based reporting of sexual activity with minors, specifically when one partner is under age fourteen and one partner is age fourteen or older. *Planned Parenthood Affiliates of California v. Van de Kamp*, 226 Cal. Rptr. 361, 366 (1986); *People v. Stockton Pregnancy Control Medical Clinic*, 249 Cal. Rptr. 762, 765 (1988); 67 Op. Atty. Gen. 235, 6-1-84 (Cal. 1984).

133. This is in direct contrast to the general approach adopted by the California Child Abuse Reporting law, which requires health care professional to make reports when they know or reasonably suspect that a child has been abused. CAL. PENAL CODE § 11166(a) (West 1999 & Supp. 2000). The definition of reasonable suspicion refers to the professional's opinion being informed by training and experience, thereby incorporating a degree of judgment or provider discretion. *Id.*

134. *See, e.g.*, Memorandum from Carole Sarkisian-Bonard, Administrator, Fresno Unified School District, Instructional Services, to Sandra Carsten, Ass't Superintendent (June 24, 1999) (regarding "Child Abuse Reporting"); Memorandum from Susan Powers, Ass't Head Deputy,

In the three years since the amended reporting law went into effect, the confusion has abated to some degree. Unfortunately, no studies have been done to assess the extent of providers' understanding of and compliance with the new reporting scheme. Extensive conversations with health care providers, however, reveal a range of reactions to the reporting requirements, from dismay to resignation to satisfaction. Numerous health care providers have expressed their concern about the effect of the requirements on their relationships with their patients. Most agree that the high-profile SRVP prosecution program affects their attitudes toward reporting, in that the consequences of a statutory rape report in California have potentially very serious direct effects for the adult partner,¹³⁵ and potentially equally serious indirect effects for the adolescent girl.¹³⁶ At the same time, few health care providers have much sense of the extent to which their child abuse reports are the basis for statutory rape prosecutions.¹³⁷ Neither are they aware, in most cases, of the effects of their reports in the child welfare arena. Most health care providers state that they adhere to the law, although many California providers have repeatedly described their strategies to avoid asking for a partner's age, and thus being forced to report relationships that they do not believe are dangerous.¹³⁸ Most of these tactics, such as asking whether the partner

Sex Crimes Division, Los Angeles County District Attorney, (n.d.)(regarding "Statutory Rape and Reporting Laws: What You Need to Know").

135. Some counties are much more aggressive than others in pursuing statutory rape cases, even though the SRVP program has been extended to all counties. Conversations with a variety of health care providers suggests that they are well aware of the jurisdictional differences. See *supra* note 1.

136. See *supra* notes 74-96 and accompanying text.

137. The Statutory Rape Vertical Prosecution Program's annual report states that case referrals come from "a variety of sources, including law enforcement, medical services, schools, and social services agencies." CALIF. OFFICE OF CRIMINAL JUSTICE PROGRAMS, STATUTORY RAPE VERTICAL PROSECUTION, FOURTH YEAR REPORT 6 (2000).

138. The potential for such limitation was implicitly acknowledged by a California appellate court in a case that involved child abuse reporting of "lewd and lascivious conduct" with a minor under age fourteen. *People v. Stockton Pregnancy Control Medical Clinic*, 249 Cal. Rptr. 762, 763 (1988) (upholding in part the state Attorney General's interpretation of the child abuse reporting law to require a report when one sexual partner was under the age of fourteen and the other age fifteen or older). In that case, the court stated, "[h]owever, nothing in the [Child Abuse Reporting] Act requires professionals such as health practitioners to obtain information they would not ordinarily obtain in the course of providing care or treatment. Thus, the duty to report must be premised on information obtained by the health practitioner in the ordinary course of providing care and treatment according to standards prevailing in the medical profession." *Id.* at 239-40. Although the court went on to state, "[w]e have no reason to believe that health practitioners would refrain from obtaining information required by prevailing medical standards in order to avoid reporting under the Act," *id.* at 240, n.7, that is precisely what some California health care providers suggest has occurred. See *supra* note 1.

attends school with the patient, or where she met him, seek to uncover age differences suggestive of abuse.

California has launched a serious and multi-pronged attack on statutory rape offenses, using a sophisticated media campaign, a funded prosecution program, and the new health care reporting requirements. From the state's perspective, the child abuse reporting requirement is the least of these programs, neither the Partnership for Responsible Parenting nor the SRVP Program refers to child abuse reporting in their official materials.¹³⁹ Therefore, the functions of the reports are unclear to many health care providers: whether the child welfare system offers real assistance to girls whose relationships are reported, whether the SRVP program uses the reports to find potential cases, or whether nothing at all happens. The jury is still out on whether mandatory reporting of statutory rape offenses as required under AB 327 has any salutary effects at all.

B. Wisconsin

The statutory scheme and its implementation in Wisconsin present a useful case study of an attempt to balance increased enforcement of statutory rape laws and broad reporting requirements with protection of adolescents' access to confidential health care. At least one county in the state has a special pilot project for prosecuting statutory rape offenses that is attempting to implement procedures to make the process less stressful for the adolescent victims.¹⁴⁰ At the same time, the state's child abuse reporting law makes statutory rape reportable, while including an exemption from reporting for providers of certain health care services. One adolescent health clinic in the state has developed guidelines for its providers to use in implementing the reporting requirements. Nonetheless, the state has also been the site of some extreme and anomalous enforcement incidents.¹⁴¹

139. See, e.g., materials available at <http://www.responsibleparenting.org/statutory/index.html> (last visited Mar. 13, 2001); see also http://www.ocjp.ca.gov/programs/pro_cb_srvp.htm (last visited Mar. 13, 2001).

140. See DIANE M. NICKS, DISTRICT ATTORNEY OF DANE COUNTY, WISCONSIN, DANE COUNTY STATUTORY RAPE PROSECUTION PROJECT (n.d.). The pilot project, which was created with a grant authorized by the Wisconsin Legislature, focuses on the criminal prosecution of adults over twenty years of age who engage in sexual acts with children under fifteen. *Id.* The project created a specialized prosecution team including an attorney and a sensitive crimes investigator. *Id.*

141. For example, in an incident occurring in January 2001, a Wisconsin woman who allegedly bought condoms for her thirteen year-old son and did not discourage him from having sex with his fifteen year-old girl friend is charged with failing to prevent her child from being sexually abused and faces the possibility of up to fifteen years in prison and \$10,000 in fines. See <http://>

1. *The Reporting Requirement*

Wisconsin, like many other states, has enacted a child abuse reporting law that includes a long list of health care professionals and other individuals who are required to report child abuse.¹⁴² The list includes, among others, physicians, nurses, social workers, and other medical or mental health professionals.¹⁴³ These reporters must report to child welfare, the sheriff, or police if they have “reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected”¹⁴⁴ Wisconsin’s Children’s Code defines “abuse” to include various categories of sexual intercourse or sexual contact, including sexual assault.¹⁴⁵ “Sexual assault of a child” includes both consensual and nonconsensual sexual intercourse or contact with a minor under age sixteen.¹⁴⁶

Thus under the Wisconsin child abuse reporting law any “sexual contact” or “sexual intercourse” with a minor under age sixteen would be reportable. In view of the breadth of Wisconsin’s definition of sexual contact,¹⁴⁷ many instances of consensual sexual activity involving minors would be reportable, including sexual activity between teenage minors who are boyfriend and girlfriend.¹⁴⁸ Were the broad reporting mandate of Wisconsin law to be fully implemented and enforced with respect to consensual teenage sexual activity, the effect might be to

www.channel4000.com/sh/news/wisconsin/stories/news-wisconsin-20010115-100120.html (last visited Apr. 20, 2001).

142. WIS. STAT. § 48.981(2) (1998 & Supp. 2000).

143. *Id.*

144. *Id.*

145. WIS. STAT. § 48.01(1)(b) (1998 & Supp. 2000).

146. WIS. STAT. § 948.02(1) and (2) (1998 & Supp. 2000). The crime is separated into two felony classifications, one for “sexual contact or sexual intercourse with a person who has not attained the age of thirteen years” and the other for “sexual contact or sexual intercourse with a person who has not attained the age of sixteen years.” *Id.*

147. “Sexual contact” is defined in Wisconsin’s criminal code as “the intentional touching of the clothed or unclothed intimate parts of another person with any part of the body clothed or unclothed or with any object or device, the intentional touching of any part of the body clothed or unclothed of another person with the intimate parts of the body clothed or unclothed, or the intentional penile ejaculation of ejaculate or intentional emission of urine or feces upon any part of the body clothed or unclothed of another person, if that intentional touching, ejaculation or emission is for the purpose of sexual humiliation, sexual degradation, sexual arousal or gratification.” WIS. STAT. § 939.22 (34) (1998 & Supp. 2000).

148. An opinion of the Wisconsin Attorney General confirms this broad interpretation of the statute, finding that all sexual conduct involving minors age fifteen or younger, regardless of whether consent was given, must be reported. 72 Op. Atty. Gen. Wis. 93 (July 28, 1983). The opinion further clarifies that although sexual intercourse involving minors age sixteen or seventeen might constitute the crime of fornication, the acts would not be reportable under the child abuse reporting law. *Id.* The opinion stressed that the purpose of the child abuse reporting statute “is to prevent physical harm and the psychological or emotional harm which may accompany it.” *Id.*

require health care professionals to make reports in almost any instance in which a minor under the age of sixteen sought reproductive or sexuality related health care. This would defeat one of the primary purposes of other laws in Wisconsin that allow minors to give their own consent for specified health services and to receive such care on a confidential basis.¹⁴⁹ To mitigate such an effect, however, the state has included an innovative exception in its reporting law.

2. *The Exception for Confidential Health Services*

The child abuse reporting statute includes an exception, the express purpose of which is “to allow children to obtain confidential health care services.”¹⁵⁰ Based on this exception, physicians, physicians assistants, and nurses who provide family planning services, pregnancy testing, obstetrical care, or diagnosis and treatment for sexually transmitted diseases are not required to report sexual intercourse or sexual contact involving a minor as suspected or threatened abuse.¹⁵¹ In addition, a person who obtains information about a minor who is receiving any of the specified health care services from a designated health care provider is also not required to make a report.¹⁵²

The section containing the reporting exception also specifies circumstances in which reporting is required, even in the case of health care providers who are delivering specified health services to minors.¹⁵³ A report is required if the health care provider has reason to suspect any of the following:

1. That the sexual intercourse or sexual contact occurred or is likely to occur with a caregiver;
2. That the [minor] suffered or suffers from a mental illness or mental deficiency that rendered or renders the [minor] temporarily or permanently incapable of understanding or evaluating the consequences of his or her actions;
3. That the [minor], because of his or her age or immaturity, was or is incapable of understanding the nature or consequences of sexual intercourse or sexual contact;

149. *See, e.g.*, WIS. STAT. § 252.11(1m) (1998 & Supp. 2000) (providing that a physician may treat a minor infected with a sexually transmitted disease or examine a minor for the presence of such a disease without the consent of the minors parents or guardian); WIS. STAT. § 252.15(2)(a)(4) (1998 & Supp. 2000) (requiring the consent of a minor over the age of fourteen for an HIV test); WIS. STAT. § 51.47 (1998 & Supp. 2000) (providing that a physician may render preventive, diagnostic, assessment, evaluation, or treatment services for the abuse of alcohol or other drugs to a minor over the age of twelve without the consent of the minor’s parent or guardian).

150. WIS. STAT. § 48.981(2m)(a) (1998 & Supp. 2000).

151. WIS. STAT. §§ 48.981(2m)(b), (c)(1) (1998 & Supp. 2000).

152. WIS. STAT. § 48.981(2m)(c)(2) (1998 & Supp. 2000).

153. WIS. STAT. § 48.981(2m)(d) (1998 & Supp. 2000).

4. That the [minor] was unconscious at the time of the act or for any other reason was physically unable to communicate unwillingness to engage in sexual intercourse or sexual contact; and
5. That another participant in the sexual contact or sexual intercourse was or is exploiting the [minor].¹⁵⁴

In addition, health care providers are not exempt from reporting requirements if they have “any reasonable doubt as to the voluntariness of the [minor’s] participation in the sexual contact or sexual intercourse.”¹⁵⁵ These exceptions to the exception represent a clear attempt on the part of the state to ensure that truly exploitive and involuntary sexual activity involving minors under the age of sixteen will be reported, without being over-inclusive.

In response to Wisconsin’s statutory scheme for reporting of consensual and nonconsensual sexual activity involving minors, an adolescent health clinic in Milwaukee has developed a policy and procedure for screening adolescent sexual violence and abuse.¹⁵⁶ The objective of the policy and procedure is “[t]o provide health care providers with an assessment and intervention tool that will ensure a consistent approach and response to all patients with a suspected or actual history of sexual abuse.”¹⁵⁷ The policy sets out the circumstances in which the statute requires reporting, while the procedure specifies the steps that a provider must take. Additionally, the screening tool of Wisconsin’s statutory scheme contains a series of questions designed to help the provider evaluate issues such as mental deficiency or mental illness, maturity and understanding of consequences, or exploitation to determine when a report should be made.¹⁵⁸

Overall, Wisconsin law and policy strikes an unusual balance. Prosecution of statutory rape is encouraged, but the impact on the victim is seriously considered. Reporting of a broad range of consensual sexual activity, including activity among minors of similar age, is statutorily mandated, but a serious effort is made to protect adolescents’ access to confidential health services. A more detailed study of the effect of this approach on the behavior of both adolescents and health care providers would be instructive for policy makers.

154. *Id.*

155. WIS. STAT. § 48.981(2m)(e) (1998 & Supp. 2000).

156. POLICY/PROCEDURE, MILWAUKEE ADOLESCENT HEALTH PROGRAM, MILWAUKEE ADOLESCENT HEALTH PROGRAM, ADOLESCENT SEXUAL VIOLENCE/ABUSE SCREENING TOOL (AS-VAST) (n.d.).

157. *Id.*

158. *Id.*

V. A FRAMEWORK FOR EVALUATING LAWS AND POLICIES

Based on our review of federal and state laws, and extensive conversations with policy makers, advocates, and health care providers in California, Wisconsin, and other states, we have identified three primary bases on which child abuse reporting statutes and policies might be amended with a goal of more effectively protecting young women. These bases are age difference, behavioral definitions, and exceptions to reporting. Each of these, along with their benefits and drawbacks, is discussed below.

A. Age Differences

One model for increasing the reporting of statutory rape offenses is to require reports when the age differences exceed certain guidelines. California has adopted this model by requiring reports of sexual intercourse between one partner who is under the age of sixteen and another partner who is twenty-one or older, and also requiring reports of any sexual activity when there is an age difference of ten years or more between a fourteen or fifteen year-old and his or her partner. On the one hand, this approach offers the potential benefit of uniformity and clarity, although the benefit is only a potential one because, in the case of California, the reporting statute's multiple references to obscure subsections of the penal code, and the differing requirements for different types of sexual activity appear to confuse providers more than they help them.¹⁵⁹

Nonetheless, by requiring reports of statutory rape designed to target larger age differences or older perpetrators, states could arguably avoid some of the health access and confidentiality problems associated with more sweeping reporting, i.e. of all statutory rape offenses, while targeting those cases in which the state actually wants to intervene. An age-based approach, handled correctly, also offers the benefit of consistency,¹⁶⁰ and avoids potential discriminatory application of the reporting statute. Finally, such an approach is transparent to provider and patient alike.

The actual usefulness of reporting laws that define requirements based strictly on age differences is limited, however. Specifically, such

159. See *supra* note 1.

160. The Adolescent Sexual Violence/Abuse Screening Tool developed by the Milwaukee Adolescent Health Program, *supra* note 156, was also designed to promote consistency in provider behavior, although it was developed in the context of a very different statutory scheme. Interestingly, the tool includes an instruction in its guidelines for providers to make reports when there is an age difference of five or more years, even though the Wisconsin statute does not include a mandatory requirement based on age difference. *Id.*

an approach risks both under- and over-reporting. Under-reporting may occur because of the gray areas involved and the providers' frequent discomfort in drawing lines between acceptable and coercive or dangerous sexual behavior. This creates a risk that those who may be less experienced or less comfortable in treating adolescents may place too much faith in the laws' definitions, and may fail to report sexual activity that really requires intervention. In California, sexual intercourse between a sixteen year-old and a twenty year-old does not automatically trigger a report, but instances of real coercion or exploitation in relationships of this type are easy to imagine. A strict age-based reporting requirement offers providers a level of false security, and may discourage them from seeking the sort of information that they need in order to make a report. As described above, California providers have developed strategies to avoid asking for a partner's age, and thus being forced to report relationships that they do not believe are dangerous.¹⁶¹ While these providers still seek to uncover age differences suggestive of abuse, it seems ironic that policies may be structured to encourage health care providers to limit, in any way, the questions they ask their adolescent patients. On the contrary, virtually every leading medical and health care group that has developed guidelines for comprehensive health assessments of adolescents have strongly encouraged asking extensive questions about intimate aspects of the adolescent patient's behavior and relationships in order to enhance the appropriateness and quality of care provided and increase opportunities for preventing serious health problems.¹⁶² Any policy that directly or indirectly discourages health care professionals from taking complete health histories or asking searching questions is contrary to these consensus recommendations which have become the foundation of good health care for adolescents.

Defined age differences also risk over-reporting of statutory rape offenses. Differences in personal values and cultural norms make an "acceptable" age difference impossible to define. While most providers would quickly take action in a case where one partner was twelve and the other forty, as the minor becomes older and the age discrepancy narrower, providers typically become less certain. In California, as in many other states, cultural diversity makes any single age distinction suspect. Girls in some Asian immigrant communities, for exam-

161. *See supra* note 1 and accompanying text.

162. ARTHUR B. EWTER AND NAOMI JKUZNETS, *AMA GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES (GAPS): RECOMMENDATIONS AND RATIONALE* (1994); BRIGHT FUTURES: *GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS* 127 (Morris Green ed., 1994).

ple, commonly marry in their mid-teens; these unions, some of which involve legal marriage, while others involve more informal but no less serious ties, often have family support and are not coerced.¹⁶³ Leaving aside the question of whether the dominant culture should accept sexual and marital practices outside of the mainstream, it is not hard to imagine a health care provider encountering a relationship that falls under the state's definition of abuse, but that is clearly uncoerced, non-abusive, and responsible.

Related to this question of over-reporting, of course, is the question of whether the intervention that results from a child abuse report is actually protective or valuable to the "victim." If the only result is that the young woman loses her relationship with her health care provider, but her relationship with the older partner continues, she is unlikely to gain much. Similarly, if her boyfriend is jailed or deported and she is left with a child to raise, she may not find herself better off. Also, if she and her family become entangled in investigations by the child welfare system or the police, without any identifiable specific benefit to her, little has been gained in exchange for the potential loss of trust for her health care provider, or even loss of health care if she or her friends avoid seeking it in the future. Unless the state matches its reportable age limits or age disparities to the actions it takes to protect and assists the young women in question, age-based reporting will result in too many reports and needless disruptions of provider-patient relationships.

Ultimately, reporting requirements based on rigid age limits seem to reflect one or more of three societal premises: (1) either that sex involving a specific age disparity (such as five years) when one partner is of a young age (such as fifteen) is by definition immoral and abusive; (2) that the risk of sexual activity is always too great when one partner is young and a specific age disparity exists; (3) or that consent by a young person below a certain age can never be voluntary in any meaningful sense if there is a specific age disparity with the partner. As an empirical matter, each of these premises would be borne out some, but not all of the time, making them flawed as the basis for absolute requirements with as much attendant downside risk as child abuse reporting.

Finally, age-based reporting is generally unnecessary. Other criteria exist that can be more finely tuned to identify coercive and exploitive sexual activity involving minors. Such criteria can avoid the under-reporting and over-reporting associated with reporting requirements

163. *See supra* note 1.

based strictly on age differences, while avoiding some of the more serious risks of health care avoidance and without sacrificing whatever benefits may be attendant on reporting for some adolescents.

B. Behavioral Definitions

Arguably, the more coercive, exploitive, or abusive the behavior involved, the greater the chance that child abuse reporting will result in benefits rather than harm to the minor.¹⁶⁴ If that is the case, then reporting which is based on carefully refined definitions of what constitutes such abuse in the arena of sexual activity of minors seems more likely to achieve the goal of protection than reporting based strictly on age differences. Thus, given the limits of age-based statutory rape reporting, policy makers might more effectively spend their time trying to define behaviors that are exploitive, rather than targeting age differences. Virtually every state already makes some version of sexual abuse, sexual exploitation, or sexual assault reportable, although according to the existing definitions, not every state requires reporting of statutory rape or consensual sexual activity that does not take place within the family. However, many of the definitions or criteria in state statutes are vague, over-inclusive, or under-inclusive, and provide little real guidance to the health care professionals who are mandated reporters in their efforts to elicit protection when it is warranted and not when it is unnecessary.

When Wisconsin created an exception to its broad statutory mandate to report consensual sexual activity involving minors in order to protect access to confidential health care for those minors, the criteria it included in that statutory exception specifying when a report would be required represents a good example of a legislative attempt at a more refined definition of the conduct which is actually coercive, exploitive, or abusive. If such criteria were used at the outset as the basis for reporting, the statutory exception would be unnecessary.

C. Exceptions to Mandatory Reporting

A third means of addressing statutory rape reporting, compatible with either of the prior approaches and potentially an improvement to both, would be to provide exemptions from reporting for providers of confidential health care under certain conditions.¹⁶⁵ These conditions might include:

164. It is possible, of course, that in cases of serious abuse, the intervention of child welfare, if it is badly done, could result in greater harm.

165. This is the model proposed by the Wisconsin statutory scheme. *See supra* notes 142-158 and accompanying text.

- when the report, in the judgment of the reporter, is not necessary to protect the safety of the young woman (and/or her child); or
- the report might cause significant harm to the young woman including disruption of the health care relationship or avoidance of needed health care in the future.

Were a reporting statute to include an exception based on such criteria, it might also appropriately require the health care provider to document the reasons why a report was not made and any other action taken designed to protect the young woman, such as counseling about how to avoid participation in coercive or exploitive sex.¹⁶⁶ If the statutory criteria for making a report initially were based on carefully targeted behavioral factors, providers would only rarely need to rely on these exceptions. This approach recognizes the state's interest in discouraging statutory rape, while taking into account the inevitable variation in individual situations.

D. Provider Discretion

Finally, some states have chosen to include a broad range of sexual offenses, including statutory rape, in the definition of sexual abuse that is required to be reported, but mitigate the effect of doing so by allowing the professionals who are mandated reporters a degree of discretion in making the reports. Specifically, some states require that a report be made by "any mandated reporter who *has cause to believe* that a child's physical or mental health or welfare *is endangered* as a result of abuse or neglect . . ."¹⁶⁷ In light of such language, a health care professional who has examined an adolescent girl, taken a comprehensive health history, and learned that the girl has a sexual relationship might conclude that even though the sexual conduct technically fell within the statutory definition of abuse, the physical or mental health of the girl was not endangered as a result. In order to reach this conclusion, the health care professional would have to carefully evaluate a variety of factors to determine the voluntariness of the relationship and its potential impact on the girl's physical and mental health and welfare. If the weighing of the factors led the health care provider to "have cause to believe" that the girl was endangered, then a report would be required; otherwise it would not.¹⁶⁸ This approach

166. Such an approach was included in the rider to the Fiscal Year 1998 appropriation for the Title X program. See *supra* notes 55-57 and accompanying text.

167. LA. CHILDREN'S CODE ANN. art. 609A(1) (West 1994 & Supp. 2001) (emphasis added).

168. Although it is possible that reporting in cases of actual abuse may adversely impact adolescents' willingness to seek care to the same extent that reporting in cases of consensual or non-exploitive relationships, health care professionals who are experienced in the care of adolescents do not believe that this is the case. See, e.g., Diaz, *supra* note 106, at 13.

has the advantage of allowing for case by case determinations, encouraging providers to take full responsibility for evaluation of the nature of the sexual relationship, and stressing the seriousness of reports that are made to child welfare agencies.

VI. CONCLUSION

Adolescents, particularly adolescent girls, are at high risk for sexual victimization. Sometimes their victimization takes the form of sexual conduct that violates statutory rape laws, sometimes it does not. However, to use enforcement of statutory rape laws and the related reporting of statutory rape under child abuse reporting laws as a primary tool for addressing adolescent sexual victimization falls wide of the mark. First, it affects young women who are involved in consensual sexual relationships as much as it affects those who truly are victims. Second, it runs the unnecessary risk of undermining these young women's access to health care, which for some is already tenuous, while failing to provide them with a countervailing benefit or sometimes actually putting them in harm's way. Alternative legal and policy approaches are available, however, that can provide the potential for some protection for those who are victims, while offering less of a threat to health care access. For example, child abuse reporting statutes could be targeted based on carefully drawn behavioral definitions, could include exceptions to encourage access to confidential health care, or could allow for health care provider discretion. Each of these alternatives would lessen the burden on child welfare services agencies of unwarranted reports, enable health care providers to maintain the trust of their adolescent patients based on their ability to provide confidential care, and allow adolescents who have engaged in sexual conduct to seek health care without fear that doing so will automatically result in a report to child welfare or law enforcement authorities. Ultimately, these alternatives have a better chance of protecting adolescent girls than many of the current approaches.