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Case Report

Ethical Considerations in Caring for a Pregnant Youth in Foster Care

James Chambliss[1*], Grace S. Kim[2], Michael Naylor[1]

[1]Professor of Clinical Psychiatry at the University of Illinois at Chicago, Chicago, IL, USA

[2]Postdoctoral Research Fellow at the University of Iowa, Iowa City, IA, USA

[*]**Corresponding author**: James Chambliss, Department of Psychiatry, University of Illinois at Chicago; 1747 W. Roosevelt Rd., M/C 747, Rm 155; Chicago, IL 60608, USA

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Abstract

Pregnancy in pre-teens is often associated with behavioral or emotional disturbance and complicated by higher rates of adverse physical, psychological and social outcomes, particularly when involving youth in care. We explore the multifaceted ethical dilemmas encountered in caring for a pregnant pre-teen foster child with a history of psychiatric illness, trauma, sexual victimization, polysubstance abuse, and borderline intellectual functioning. This article raises critical questions about whose interests to prioritize between the mother and child regarding placement and guardianship.

Keywords: Childhood trauma; Foster Youth; Adolescent Pregnancy; Ethical Analysis

Introduction

Rates of teen pregnancy are markedly higher in the United States than in other developed countries [1]. Originally seen as a private, familial concern, teen pregnancy, and specifically teen motherhood, has more recently been viewed as a social problem. This perception of teen parenthood was due, in part, to the changing role and economic status of women in American society. Adolescent mothers and their children face several unique barriers that put them at increased risk for medical, psychological, developmental, and social problems [2]. In the US, adolescent mothers have lower educational attainment with consequent economic disadvantages compared to young women who delay parenting [3]; similarly, children of teen mothers have worse academic, employment, and behavioral outcomes, even when accounting for background [4]. Delaying pregnancy in the service of obtaining higher education and a high paying career became the social norm, and pregnancy at an early age was perceived as problematic. Teen pregnancy was viewed through the lens of the harm young mothers were causing themselves, their children, and society, including health problems for the young mother and child, a future of school dropout, unemployment, and welfare for the mother and developmental, behavioral, and educational problems for the offspring. Teen mothers were seen as socially deviant and were shamed and stigmatized.

More recently, the challenges faced by teen parents and their children (e.g., poverty and low educational attainment) have been shown to be less related to maternal age and more related to growing up in poverty and living in under-resourced communities [5]. In other words, teen pregnancy does not cause, but is caused by poverty, impoverished communities, and educational inequities. Additionally, adverse childhood experiences also play a role in teen pregnancy. Higher numbers of adverse childhood experiences, especially child maltreatment and sexual abuse, are directly correlated with an earlier debut of sexual intercourse, a larger number of sexual partners, and higher rates of pregnancy [5]. Those in foster care are 2.5x as likely as their peers not in foster care to become pregnant, many experiencing a repeat pregnancy by age 19, accounting for pregnancy in half of women transitioning out of foster care [6,7]. For an in-depth review, please

see Hans and White, 2019 [5].

We present a case of pregnancy in a pre-teen girl in foster care with a history of sexual victimization, polysubstance abuse, and borderline intellectual functioning. We discuss ethical considerations facing the extended treatment team, including whether to terminate the pregnancy, who would make that decision and how, and custody of the baby after birth.

Methods Section

All identifying information has been removed, Eva is not the patient's real name. Literature searches were conducted by topics of interest including pregnancy outcomes by age, guidelines for care of pregnant adolescents or adolescent parents, decision-making capacity in youth, general healthcare decision-making, and specific care issues for those in foster care. State-specific legal statutes and policies were found on state government websites and the Guttmacher Institute website. This case review is approved under the UIC Institutional Review Board (Study 2005-0366) and consent to publish was provided by the Illinois Department of Children and Family Services, the youth's legal guardian, as well as the patient.

Case Presentation

Eva (not her real name) is a 12-year, 11-month-old white female admitted to the Comprehensive Assessment and Treatment Unit (CATU) in transfer from an outside hospital.

Eva initially presented to the emergency department after reportedly holding a knife to her chest, threatening to end her life. She was irritable and reported seeing terrifying images of a demon. A serum pregnancy test was positive. A urine drug screen (UDS) was significant for methamphetamine. She was admitted to Garfield Park Hospital where she was diagnosed with major depression, PTSD, ADHD, oppositional defiant disorder, and polysubstance abuse. She was treated with fluoxetine, aripiprazole and guanfacine. During hospitalization, her hallucinations and suicidal ideation resolved, and she was discharged to foster care. She was not adherent to the treatment plan and eloped from care.

About 2 months later, she presented to the emergency department again, agitated, and disorganized, reporting auditory and visual hallucinations, with UDS again positive for methamphetamine. A urinalysis revealed trichomonas and chlamydia. She received Azithromycin PO 1000mg at the outside hospital. Out of concern for the patient's safety and the safety of the developing fetus, she was admitted to the CATU. At this time, she weighed 54.4 kg, was 1.57 m tall, and it was determined that the fetus was approximately 18 weeks gestational age. Psychiatric history revealed a long history of eloping from her home of origin and from foster homes. She had an extensive history of substance abuse, including methamphetamine, cocaine, marijuana, nicotine, and alcohol. Treatment of her depression was resumed with fluoxetine. It was not clear that she had been treated for trichomonas, so we treated with metronidazole 500mg twice a day for 7 days. Further testing then revealed she was also positive for Syphilis, for which she was treated with Penicillin G 2.4M units IM weekly for 3 weeks. We initiated prenatal care, and she was visited regularly by Obstetrics.

Social history revealed a significant history of complex trauma exposure. She has lacked structure and stability throughout her life. She has been witness to severe interpersonal violence between her mother and her mother's partners, including her biological father, and to criminal activity, notably parental criminal activity, including possession of drugs and firearms, and drug dealing. DCFS suspects that she is a victim of sexual trafficking and/or exploitation by her biological mother, who has a history of substance abuse, including methamphetamine use and distribution. Her biological father has a lengthy criminal history and is currently incarcerated. She went to live with her maternal grandma, but due to issues with elopement, domestic violence and polysubstance use became a youth in care in 2021.

Psychological testing was obtained which revealed an IQ of 76. Given her behavioral problems, history of substance abuse, and mild cognitive deficits, the DCFS Guardian raised the options of abortion, adoption, and keeping the baby and living in specialized parenting teen congregate care setting with her baby. Eva opted for the latter. We assessed Eva's knowledge of pregnancy to be quite poor. Indeed, she did not know how a baby was born. We worked to provide psychoeducation about pregnancy, labor, and delivery. We developed educational materials appropriate to her level of development. We provided psychoeducation about substance use and sexually transmitted diseases and how they can adversely affect the developing fetus.

With treatment, Eva's mood normalized, and she was free of substance-induced psychosis. She continued to present significant behavioral problems, including multiple attempts to elope from the hospital, recruiting her peers for some of the efforts, and an attempt through phone call to get an adult male to come "shoot up the hospital". She was discharged and transferred to a secure facility in Ohio which specialized in working with pregnancy, trauma, sexual trafficking, and substance use. Immediately on admission to the receiving facility she befriended a group of peers who had already planned a mass elopement. Her peers stole a staff member's keys and she eloped from the placement within 24 hours of arrival. She called her biological mother who drove from southern Illinois to Ohio and picked Eva and her friends up at a nearby gas station. She brought Eva back to Illinois, but Eva ran away from home after she had an argument with her mother. She was found with an adult male using methamphetamine. She was readmitted to

the CATU where we continued with psychoeducation, treatment, and stabilization, then transferred her back to that facility. While in treatment, she delivered a baby boy vaginally with no complications. Eva successfully completed treatment and was transferred to a residential treatment facility with a teen parenting program that houses teen parents and their babies. While she did well initially, on one occasion she eloped with her baby in the middle of winter without a coat or warm clothing for the baby. She continually acted in ways that placed herself and her baby in jeopardy and the decision was made to place her baby in foster care as her mother was deemed unfit and her grandmother refused due to health reasons.

Discussion

The main questions facing the extended treatment team in this young lady's care were: 1) should the pregnancy be carried to term, and 2) should Eva be granted custody of her baby with the attendant guardianship rights and responsibilities? We will examine the ethical considerations used to address these questions using the standard principles of medical ethics. These principles, commonly referred to as the Four Pillars, are beneficence, nonmaleficence, autonomy, and justice.

Beneficence

Health care providers are charged with doing all they can to benefit a patient, utilizing recommended procedures and treatments with the intention of doing the most good for the patient. As related to this case, we must consider if high risk labor and delivery, or the responsibility of parenthood are in fact doing the most good for our patient.

As related to the first point, Eva was at approximately Tanner Stage 3 and was quite petite. There was serious concern that she would not be able to deliver vaginally and would require a cesarean section. Additionally, using the 25-29 years age group as the reference, 11-14 year old females have higher rates than any other age group for labor and delivery complications. Specifically, they have higher rates of preterm delivery, chorioamnionitis, endometritis, and mild preeclampsia, even after adjusting for demographics, type of birth and medical comorbidities [8].

Concerning the issue of custody, a series of the Supreme Court cases has held that parents have a fundamental right to the custody of their children and to direct their upbringing. The state cannot remove a child from his or her parent without a compelling reason [9]. In considering the best interests of the child, Illinois law provides a list of the factors, taking the child's developmental needs, that "shall be considered" in determining best interest. Factors commonly considered include:

- The emotional ties and relationships between the child and his or her parents, siblings, family and household members, or other caregivers.
- The capacity of the parents to provide a safe home and adequate food, clothing, and medical care.
- The mental and physical health needs of the child.
- The mental and physical health of the parents.
- The presence of domestic violence in the home [10].

When dealing with a pregnant foster child, the inevitable question is, "*To whom do we owe the primary consideration?*" The guidelines address the wishes and needs of the young parent and the child. The interests of the developing fetus are not specifically addressed. What is in his or her best interest? We know that Eva strongly expressed the desire to keep the child, but is it in the best interest of the developing fetus to be in the care of its mother? Surely it has the right to adequate prenatal care, which has been found to be protective against infant deaths of adolescent mothers under the age of 15 [11]. The baby ultimately did receive prenatal care, but only because the patient was held against her will, through consent of her legal guardian, in a facility where prenatal care was provided. Had Eva not become psychotic after methamphetamine use and presented to the emergency department, there likely would not have been prenatal care, potentially adversely affecting the fetus' well-being and development. As it is, there are likely epigenetic factors from trauma, mental health, and substance use of its mother, that may impact the baby's development.

Nonmaleficence

Non-maleficence is typically considered concurrently with beneficence. Simply put, nonmaleficence refers to the concept that a clinician has the obligation to "*do no harm*" and to not allow harm to be caused to a patient via neglect.

Compared to women in their 20s, younger adolescents (10-14 years old), are at increased risk for preterm delivery, small-for-gestational-age infants, low birth weight, and neonatal mortality [12], even when accounting for important confounders including low socioeconomic status, inadequate prenatal care, and inadequate weight gain during pregnancy [13]. It has also been found that rates of comorbidities including obesity, mental health conditions, substance use disorder, asthma, and pregestational and gestational diabetes significantly increased, along with neonatal and maternal morbidity, postpartum hemorrhages, and hypertensive disorders of pregnancy [14].

By history, Eva had not started menarche before she became pregnant. As noted, she was a petite 12-year-old at Tanner Stage

3 of sexual development. There was legitimate concern for her ability to survive labor and delivery, with the belief that cesarean section would be highly likely. Given the known risks, the ethical question was whether the pregnancy should be carried to term.

Autonomy

Autonomy refers to the right of a patient to maintain control over decisions regarding his or her body. The patient has the ultimate responsibility for decision-making regarding their own treatment. Two considerations are central to the concept of autonomy. The first is informed consent. Patients have the right to know about their illness or condition, available treatments (including no treatment), and the risks and benefits of treatment (and of no treatment) to guide their decision making. Second, is the patient able to retain information, evaluate the relative merits of each option and make a decision? This is referred to as decision-making capacity.

Most states have a common set of "*status*" and condition-specific exceptions in which a minor has legal authority to make health-care decisions, regardless of decision-making capacity. "*Status*" for which minors may consent for health care services include when minors are married, are pregnant, are a parent, or are granted "*emancipated minor*" or "*mature minor*" status by the courts [15,16]. Many state laws hold pregnant adolescents responsible for and competent to consent to their own medical treatment during the pregnancy and to the medical decisions regarding the fetus or newborn infant [17]. The Illinois "*Consent by Minors to Health Care Services Act*" (410 ILCS 210) states that consent for health care services by minors who are married, pregnant, parents (even if placing child for adoption), or at least 18 years of age are "*deemed to have the same legal capacity to act and has the same powers and obligations as has a person of legal age* [18]."

Legal standards for decision-making capacity for consent to treatment generally apply four criteria: the abilities: 1) to communicate a choice, 2) to understand the relevant information, 3) to appreciate the medical consequences of the situation (and likely consequences of choices), and 4) to make a reasoned choice about treatment, weighing relative risks and benefits of the options [19,20]. These capacity standards can be evaluated systematically with the use of instruments, such as the MacArthur Competence Assessment (MacCAT) [21-23]. While the instrument was validated in adults, a prospective study of children's competence to consent to clinical research (6 to 18 years old) demonstrated that MacCAT could be used validly and reliably in children [24]. This study showed that age was a good predictor of competence on the MacCAT-CR. Competence was unlikely in those younger than 9.6 years and probable in those older than 11.2 years, with an estimated optimal cutoff age of 10.4 years [24]. There hasn't been a similar study establishing age limits empirically in a treatment context, but a pilot study did demonstrate feasibility for use of the MacCAT-T in children 8-17 years old, with all those above 12 years old deemed to be competent [25].

The youth must demonstrate mastery of specific skills and abilities in each of the four criteria to determine capacity. The first criterion, communication, requires verbal language development. The second criterion, understanding, requires sufficient intelligence and language proficiency to process the information, ability to orient and direct attention towards the information, and memory and recall skills to process and integrate the information. The third criterion, appreciation, requires abstract thinking, which includes theory of mind. The fourth criterion, reasoning, requires logical reasoning and the ability to weigh risk and benefits [26]. Neuroscience and psychological research have shown that children can have capacity to be decision-making competent at 12 years old [26]. Developmental and contextual factors also play a role in determining whether a youth is capable of decision-making. During adolescence, the development of the brain's reward system occurs faster than the development of control systems (e.g., impulse control and response inhibition), which leads to dissociation between the two decision-making processes and diminishes responsible decision-making competence (e.g., increased risk-taking), particularly in affective contexts involving emotional and social factors (e.g., substance use with peers) [26,27]. Additionally, short-term rewards become more important than long-term rewards, even if choosing an immediate reward can mean the loss of a long-term reward [26]. This is relevant in decisions to adhere to a healthy lifestyle, engage in long-term treatment, or plan for the future while considering consequences [26-28].

It is also worth noting that a child's environment can support the development of a child's decision-making capacity. Guardians and physicians can contribute to this development by providing information, answering questions, and helping make sense of the situation. These social interactions support acquisition of necessary cognitive and emotional skills to develop decision-making capacity in a child with the potential to learn these skills [29].

Guidelines published by the United Nations Convention on the Rights of the Child call on state entities to encourage youth to be involved in medical decision making in a manner that recognizes their "*evolving capacities*" [30], and the World Health Organization has recently published guidance for assessing and supporting adolescents' decision-making capacity [31,32]. The American Academy of Pediatrics and other medical societies, including the American Medical Association, Society for Adolescent Medicine, the American Academy of Family Practice,

and the American College of Obstetrics and Gynecology, have taken aligning positions that support the individualized assessment of an adolescent's capacity to make their own medical decisions and providing confidential care, while also encouraging parental involvement [33,34].

In Eva's case, at the age of 12, she is theoretically old enough to make her own decisions, however, psychological testing revealed a minor cognitive deficit with a full-scale IQ of 76. Along with this notion, there is individual development and maturity. Additionally, she was exposed to serious life situations and had not attended school regularly since the age of 10.

It is clear that her emotional and behavioral problems adversely affected her decisional capacity. During her time as a youth in care, she eloped from nine foster home placements. She also eloped from her maternal grandmother's home. When she eloped, she would stay with her mother or in an abandoned building with older males. In both settings she reported witnessing criminal activity and abusing substances. As noted, she has a significant history of substance abuse. Upon initial presentation, she denied realization that these substances could negatively affect the development of her fetus. In the hospital, she reported that she wanted her child more than to use substances, however, when she eloped from the residential treatment facility, she again tested positive for methamphetamines.

On admission to the CATU, Eva tested positive for syphilis. Although rare now, syphilis is fatal if left untreated [35]. Congenital syphilis causes severe, multisystem sequelae including reticuloendothelial abnormalities, resulting in hepatosplenomegaly due to extramedullary hematopoiesis, skeletal abnormalities with pathologic bone development, and neurological abnormalities leading to cerebral palsy, hydrocephalus, blindness and/or sensorineural deafness [36]. It is conceivable she could have died had she not experienced symptoms of psychosis after methamphetamine use, which fortunately resulted in hospitalization where she was appropriately diagnosed and treated.

Regarding whether the pregnancy should be carried to term, we know Eva's choice, however, it raises the question as to whether she has capacity to make that choice. Upon admission to the CATU, she did not have any actual understanding of what it was to be pregnant. She did not understand the changes her body was going to undergo, the process of labor, or even from where the baby would come. Furthermore, she did not understand how in utero exposure to drugs could affect her developing fetus. Additionally, she denied knowledge of the potential effects of her sexually transmitted on the developing fetus.

As for whether Eva should be granted custody and guardianship of her baby, her lack of decision-making capacity will likely adversely affect her ability to make reasoned parental decisions that put the child's best interests first.

Justice

As pertains to medical ethics, justice refers to whether a proposed course of action is compatible with the law and the patient's rights. Important considerations are whether the decision being considered is fair and balanced. Does the proposed decision prioritize one group over another? Does it interfere with the rights of others? Can the proposed decision be justified in terms of overall net benefit to society? In accordance with the concept of justice, we must ensure no one is unfairly disadvantaged when it comes to access to healthcare.

In alignment with principles of reproductive justice, pregnant Illinois youth in care or those with a child have the right to support for continued education/schooling, including transportation and day care services, medical care, counseling, parent training, financial assistance, and safe, stable housing placement that allows them to live with their child, unless separate placement is necessary for safety or treatment reasons (eg, need for mental health hospitalization) [37]. When they do not have physical custody of their child, they have the right to actively participate in the care and support of their child with regular visits [37].

Reproductive Justice is defined as the human right to maintain personal bodily autonomy, to have children or not have children, and to parent children in safe and sustainable communities. A component of reproductive justice is women's access to contraception and abortion, though it is not clear that Eva had adequate decisional capacity to make the decision as to whether or not to carry the pregnancy to term. When she was admitted to the CATU, she did not adequately understand all her options with regards to having an abortion, having the child but putting it up for adoption, or having and raising her child. We worked to present these issues to her so that she could make an informed decision. Had the determination been made that she did not have adequate decisional capacity after the attempted remediation, it would fall to the DCFS Guardian, to make the determination regarding abortion or having the baby. It is likely that, given Eva's conviction about having the child, the Guardian would have reached the same decision. Significantly, with the overturning of Roe v. Wade, the option to have an abortion is limited by the state in which the youngster resides. The planned disposition was to Ohio, a state that has severely limited access to abortion. Had she ultimately decided to have the abortion she would have had to been transported back to Illinois with all the attendant risks (e.g., elopement, relapse, sexual victimization).

We determined that Eva was able to understand the educational information provided, communicate a choice, understand the medical consequences of the situation and her choices, and appropriately weigh the risks and benefits of the available options. Once that determination was made, identifying a safe setting in which to raise her child took precedence. Placement with a relative was not an option. Her mother was in the throes of methamphetamine addiction which adversely affected her ability to provide a safe, nurturing environment for both Eva and her child. Furthermore, there were significant concerns that her mother was sexually trafficking her. Her grandmother was not an option. She originally relinquished guardianship of Eva to DCFS as she was unable to meet her needs and keep her safe. When queried, she stated her medical problems prevent her from caring for her granddaughter and her baby. Her father was in prison and could not function as a home of relative placement due to his criminal record.

As for whether Eva should be granted custody of her baby with the attendant guardianship rights and responsibilities, we now must consider another key part of reproductive justice, what is our role in providing a safe environment for her to raise her child? A traditional foster home was ruled out due to her penchant for elopement. Eva was ultimately placed in an unlocked congregate care setting for youth in care and their babies.

Conclusion

This paper illustrates the ethical considerations encountered in the care of a pregnant 12-year, 11-month-old girl in care. Several clinical factors, including a history of abuse, mild cognitive deficits, polysubstance abuse, mental illness, impulsivity, her upbringing and its potential impact on her parenting, and her living arrangement presented several ethical questions related to whether the pregnancy should be carried to term, and whether Eva should retain custody after the baby's birth.

Eva's autonomy was potentially impacted by her age and her mild cognitive deficits as related to decision-making capacity. Additionally, several behaviors called into question her ability to make reasoned decisions, including her impulsive elopements, her polysubstance abuse, and her risky sexual behaviors.

Considerations of beneficence, nonmaleficence and justice were complicated by the potential discrepancies between the interests of the baby and Eva's interests. As related to beneficence, the decision to proceed with the pregnancy respected Eva's wishes and was certainly in the baby's best interests.

Eva's and her baby's interests in regard to nonmaleficence diverged. Considerations of Eva's ability to deliver vaginally and the potential risks of pregnancy, labor and delivery were main considerations for Eva. In contrast, the question of whether there was potential harm for the baby by placing her with Eva was considered. The resolution was to proceed with the pregnancy and preserve the family unit through placement in a specialized setting with specific support for young mothers. In retrospect, however, one could question this decision as, clinically, the negative outcome of placing the baby with Eva was quite predictable.

As pertains to justice and reproductive justice, it is clear that Eva's interests were prioritized. Eva's decision to proceed with the pregnancy was respected. The best possible placement was identified for Eva since return to family was untenable. She was in a safe setting where all her needs could be met, both physical and emotional. Additionally, her baby's physical needs could be met there. Eva was receiving education about the care and raising of her baby and was able to go to school. When considering issues of justice, one considers several questions. First, does the proposed decision prioritize one individual over another? Does it interfere with the rights of others? One could argue that the baby's interests were not considered. Babies flourish with a nurturing caregiving relationship with a parent who is able to help him or her develop a sense of safety, a sense of well-being and self-worth, impulse control, frustration tolerance, trust, empathy, autonomy and resilience. The inevitable question is whether the baby's interests would have been best served by immediately placing him in an adoptive home.

This case raises some fascinating philosophical and ethical questions specific to youth in care. Assuming the mother has adequate decisional capacity, until a baby is born, the mother's interests are paramount. It is assumed that she will have the interests of her baby in mind when making decisions. Once the baby is born, however, the interests of the mother and those of the baby may differ. When they do, whose interests take precedence? How is that decision made? This question is especially salient in Illinois where DCFS is awarded guardianship for all youth in care. Once the baby was born, DCFS became his guardian and was empowered to make decisions regarding his welfare.

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