The Impact of Parental Consent on the HIV Testing of Minors

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Introduction

Acquired immunodeficiency syndrome (AIDS) in adolescents was first documented, through retrospective diagnosis, in 1981. Within the adolescent population, the greatest legal barrier for minors in terms of human immunodeficiency virus (HIV) testing is the parental consent rule. Traditionally, minors have been deemed incompetent to consent to their own medical care. The common law rule follows that consent of a minor’s parent or guardian is generally required for medical care of the minor. States vary in their definition of HIV infection as a sexually transmitted disease, a reportable disease, or an infectious, contagious, or communicable disease, as well as in their statutes allowing minors to consent to testing and treatment of diseases defined as such. Very few states have specific statutes allowing minors to consent to HIV testing (unpublished data, Intergovernmental Health Policy Project, 1994).

Research has focused on adolescents’ knowledge of HIV transmission, and many studies have found knowledge not to be necessarily associated with behavior change. Research on adolescents’ use of HIV testing services is limited. A Houston study of teens tested for HIV found a seroprevalence rate of 10.2 per 1000, with 83% of the positive teens returning for posttest counseling. A study of homeless and runaway youth in California found that a quarter of the sample did not know they could receive an anonymous HIV test. Surveyed 9th- and 12th-grade students from metropolitan Boston public schools preferred to be tested for HIV by someone who did not know them.

Connecticut’s HIV confidentiality law was amended from its original form to include consent by minors for HIV testing effective October 1, 1992. This amendment was the result of an effort by a group of teens who successfully mobilized a campaign to alter existing legislation and obtain the right to consent to testing. This study assessed changes in use of HIV testing by minors after removal of the parental consent requirement in the state of Connecticut.

Methods

All minors accessing HIV counseling and testing sites funded by the Connecticut Department of Public Health during the period October 1, 1991, through September 30, 1993, were included in this study. This period represented 12 months before and 12 months after the legislative change.

Analyses included 1601 records from minors 13 to 17 years of age. The average age of these adolescents was 16.0 years (SD = 1.06). Girls accessing HIV counseling and testing services outnumbered boys by nearly three to one (74% vs 26%).

Data were derived from the standardized HIV Counseling and Testing Report Form provided by the Connecticut Department of Public Health AIDS Section. The variables examined in this study were date of visit, age, sex, race, risk factors, and site type.

Date of visit was coded as time 1 (parental consent requirement) or time 2 (parental consent rule removed). Characteristics of the total group of minors visiting test sites and the subset of minors who received tests for HIV antibodies were compared between time 1 and time 2. Chi-square statistics were used to examine differences between time 1 and time 2 in the tested subset.

Results

Over the 2-year period, 1601 minors visited HIV counseling and testing sites.

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Editor’s Note. See related annotation by Hein (p 1277) in this issue.
At time 1, 656 minors visited test sites. A 44% increase was seen at time 2, resulting in 945 visits. Over the 2 years, 1193 (74.6%) minors received a test for HIV antibodies. In addition to this increase in the number of minors visiting test sites, there was a significant difference in the outcomes of these visits: after the change in the legislation, the proportion of minors whose visit resulted in an antibody test increased \((P = .006)\). At time 1, 392 minors visiting HIV test sites received a test for antibodies, and 264 did not receive a test. At time 2, 801 minors received a test for antibodies, and 144 did not receive a test. This shift is displayed in Figure 1.

Characteristics of minors visiting test sites and of minors tested for HIV antibodies are displayed in Table 1. There was no significant difference in age between time 1 and time 2 in the group tested.

Testing of boys increased by 151%, while testing of girls increased by 90%. Similarly, in the total group of minors visiting test sites, the increase for boys (85%) at time 2 was nearly three times that for girls (32%). Of minors visiting test sites, the number identifying as White, non-Hispanic doubled at time 2, whereas the number identifying as Hispanic increased by slightly more than half and the number identifying as Black, non-Hispanic remained unchanged. Of minors tested for HIV, the number identifying as White, non-Hispanic increased twice as much (160%) as the number identifying as non-White (78%) at time 2.

In the total group visiting test sites, the number of minors at high risk (two or more risk factors) tripled from time 1 to time 2, while the number at low risk (one risk factor) remained essentially unchanged. The proportions tested increased at each risk factor level: in the one-risk-factor group, from 53% to 79%; in the two-risk-factor group, from 76% to 88%; and, in the three- or more-risk-factor group, from 89% to 92%. The most frequently reported risk factors in both the total group and the tested subset were sex with a male, sex with a female, sexually transmitted disease diagnosis, and sex while using noninjecting drugs.

The test sites most frequently reported for the total group were sexually transmitted disease clinics, followed by family planning clinics and HIV test sites. In the tested group, sexually transmitted disease clinics were followed by HIV test sites and family planning clinics. In both groups, the number of minors accessing HIV test sites increased nearly threefold at time 2, accompanied by a marked decrease in prenatal clinic use.

**Discussion**

The number of minors visiting test sites and receiving antibody tests increased after removal of the parental consent requirement. This testing pattern did not follow that of 18- to 22-year-olds visiting publicly funded sites in Connecticut. Over the same time period, the number of antibody tests conducted in the 18- to 22-year-old age category decreased from 4686 (time 1) to 4143 (time 2) (unpublished data, Connecticut Department of Public Health AIDS Division, 1996).

No significant change in age distribution occurred over the study period. The number of girls accessing test sites and receiving tests exceeded that of boys consistently at time 1 and time 2, yet testing of boys tripled at time 2. Again, this pattern differed from that of 18- to 22-year-olds visiting test sites, who showed an even male–female split in both time periods (unpublished data, Connecticut Department of Public Health, AIDS Division, 1996).

Minors identifying as White, non-Hispanic showed the greatest increase at time 2 in the total group as well as in the tested group. Increases in the non-Hispanic Black, Hispanic, and “other” racial categories were seen in the tested group, but these increases were not as great as that seen in the non-Hispanic White category. This may indicate that unidentified barriers to testing exist in non-White groups or that the parental consent requirement had a less constraining influence.

The increase seen at time 2 in minors with two or more risk factors for both the total and the tested group may reflect a change in knowledge of risk, a change in reporting of risk, or a behavior change resulting from the statutory amendment. As indicated earlier, the most frequently reported risk factors in both groups of minors were sex with a male, sex with a female, sexually transmitted disease diagnosis, and sex while using noninjecting drugs. Risk factors for AIDS cases reported to the Centers for Disease Control and Prevention in the 13- to 19-year age category through 1994 are similar in regard to a high frequency of this age group reporting heterosexual contact. Dif-
ferences exist between this sample and reported AIDS case patients, many of whom are in the hemophilia/coagulation disorder exposure category or are identifying as men who have sex with men. Neither exposure category was frequently reported in this sample.

Among this sample of predominantly female minors, most testing in both groups took place at sexually transmitted disease and family planning clinics. Female minors are more likely to access these sites for other medical services. Many HIV test sites are at locations that traditionally provide other medical services. Adolescents' direct access of HIV test sites increased after removal of the parental consent requirement. It is unclear whether those test sites showing the greatest increases had other characteristics that may have attracted minors, such as accessible clinic hours or HIV counselors more familiar with the legislative change. This latter factor is poorly understood, because no systematic notification to counseling and testing providers took place when the legislative change went into effect (R. Melchreit, conversation, December 1996).

In addition to granting minors the right to consent to testing, the legislative change also allows access to treatment without the consent of a parent or guardian if such consent would jeopardize treatment. Adolescent-specific AIDS services, available in the state, could accommodate additional cases resulting from expanded testing given the low seroprevalence rate (0.1%) of this sample.

Because of the self-selection of minors seeking testing, this sample cannot be considered representative of the population of minors at risk for HIV infection in Connecticut. Variables other than the amended legislation, such as HIV education programs or media campaigns that may have influenced the minors' behaviors, were not assessed in this study. Furthermore, this investigation examined only those HIV test sites that received funding from the Connecticut Department of Public Health AIDS Division. In 1993, this funding accounted for approximately 25% of all HIV testing in the state.14

Anyone who is at risk for HIV infection should be able to be tested. States that impose barriers to testing on minors (e.g., parental notification rules or difficult-to-interpret statutes) need to reexamine their efforts. HIV testing involves extensive counseling and prevention education by trained counselors.15 Imposing barriers to HIV testing on minors not only hinders efforts to diagnose the disease and control the epidemic but fails to promote healthy behavior in an at-risk population.

References

Screening for Adolescent Smoking among Primary Care Physicians in California

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Objective. This study determined how often primary care physicians ask adolescents about smoking.

Methods. We surveyed a stratified random sample of community-based, board-certified California physicians, using a mailed questionnaire.

Results. Overall, physicians (n = 343; 77% response rate) screened younger adolescents for regular smoking during 71.4% (95% confidence interval [CI] = 67.9, 74.9) of routine physical exams and older adolescents during 84.8% (95% CI = 82.3, 87.4) of such visits. For acute-care visits, the screening rates were 24.4% (95% CI = 20.6, 28.1) for younger and 40.2% (95% CI = 36.4, 44.0) for older adolescents. Physicians asked 18.2% (95% CI = 15.2, 21.3) of younger and 35.6% (95% CI = 32.0, 39.1) of older adolescents about experimental smoking. Screening varied by specialty.

Conclusions. These data imply that physicians are missing opportunities to screen adolescents for smoking. (Am J Public Health. 1997;87:1341-1345)

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