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 JOURNAL OF
 ADOLESCENT
 HEALTH

www.jahonline.org

Original article

Minor Consent and Delivery of Adolescent Vaccines

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Article history: Received April 2, 2013; Accepted July 26, 2013

Keywords: Vaccination; Adolescents; Adolescent health services; Informed consent by minors; Confidentiality; Privacy

ABSTRACT

Purpose: To explore whether, and to what extent, minor consent influences adolescent vaccine delivery in the United States.

Methods: A telephone survey was completed by 263 professionals with responsibilities for adolescent health care and/or vaccination in 43 states. Measures included perceived frequency of unaccompanied minor visits and perceived likelihood of vaccine delivery to unaccompanied minors in hypothetical scenarios that varied by adolescent age, vaccine type, visit type, and clinical setting.

Results: Among the 76 respondents most familiar with private primary care clinics, 47.1% reported perceptions that 17-year-old patients often present without a parent/legal guardian. Among the 104 respondents most familiar with public primary care clinics, 56.7% reported that 17-year-old patients often present alone. In response to hypothetical scenarios, approximately 30% of respondents familiar with private clinics and 50% of respondents familiar with public clinics reported perceptions that unaccompanied 17-year-old adolescents would not receive influenza, Tdap, or human papillomavirus vaccines during routine check-ups because they could not provide consent. Perceived likelihood of unaccompanied minors receiving vaccines when seen for confidential services in primary care, sexually transmitted disease, and Title X/family planning clinics varied significantly by vaccine type and clinical setting. On average, respondents reported that they would support minors having the ability to self-consent for vaccines at age 14.

Conclusions: The inability of minors to consent for vaccines is likely one barrier to vaccination. Interventions to increase adolescent vaccination should consider strategies that increase the ability of unaccompanied minors, particularly older minors, to receive vaccines within the context of legal, ethical, and professional guidelines.

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IMPLICATIONS AND CONTRIBUTION

This exploratory research suggests older adolescents are frequently seen in clinic settings without parents or legal guardians. Interventions to increase adolescent vaccination should consider strategies that increase the ability of unaccompanied minors, particularly older minors, to receive vaccines within the context of legal, ethical, and professional guidelines.

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There have been substantial changes in recommendations for routine vaccination among adolescents, including new recommendations for pertussis (Tdap), meningococcal (MCV4), human papillomavirus (HPV), and influenza vaccines [1,2]. Although the

proportion of adolescents who receive recommended vaccines has steadily increased, levels of adolescent vaccination coverage are suboptimal and below levels of coverage for recommended vaccines among young children [3–6]. In 2011, vaccination coverage among adolescents ages 13–17 was 78% for Tdap and 71% for MCV4; 53% of females in this age group received at least one HPV vaccination and only 35% completed the three-dose vaccine series [7]. In contrast, at least 90% of children 19–35 months of age have received at least one dose of measles/mumps/rubella and varicella vaccine, as well as three doses of DTP/DT/Tdap, *Haemophilus influenzae* type B, hepatitis B, and pneumococcal conjugate vaccine [8,9].

Multiple barriers to high rates of adolescent vaccination coverage have been described [10–14], but whether issues related to minor consent may act as a barrier to receipt of vaccines is not known [15,16]. During adolescence, there are circumstances in which minors may be permitted to provide their own informed consent for health care services and parental consent is not required. The informed consent requirements for minors vary by state and are guided by a combination of state and federal laws, the mature minor doctrine, and recommendations of professional organizations [17–23]. Circumstances in which a minor may consent for his or her own care typically include when a minor is emancipated or has another “status” that supports independent consent (e.g., married, homeless), or is receiving services related to sensitive health concerns (e.g., sexually transmitted diseases [STDs], pregnancy prevention, pregnancy, substance use, or mental health issues). State laws are generally silent on the specific issues of minor consent and vaccination. In a few states, however, minor consent laws specifically allow minors to consent to services for the *prevention* (as well as diagnosis and treatment) of STDs [15,23]. These laws have been or could be interpreted to allow HPV vaccination based on a minor’s consent [15]. It is within this context of varying circumstances that practitioners make decisions about whether unaccompanied minors can provide their own consent to receive vaccinations.

To better understand whether issues related to minor consent may act as a barrier to adolescent vaccination, we investigate perceived frequency of unaccompanied minor visits to health care settings, and providers’ perceptions of the extent to which minor consent issues influence delivery of vaccine by adolescent age, vaccine type, and clinical setting. Finally, we assessed whether key stakeholders would support minor consent for vaccines.

Methods

We conducted a telephone interview survey of professionals across the United States with direct responsibilities related to adolescent health care or vaccinations. The study was approved by our Institutional Review Board.

Survey sample

In this exploratory study, we were interested in the perspective of representatives from diverse clinic settings in which adolescent vaccines are delivered. Adolescent vaccines are delivered in public and private primary care clinics, STD clinics, and family planning clinics; furthermore, immunization program managers may be involved with vaccine delivery programs in all sites. We therefore used a purposive sampling design to survey

medical providers familiar with adolescent vaccine practices in public or private health care settings, immunization program managers, STD program managers, and Title X/family planning program managers.

We did not aim for a representative sample of providers. We intended to interview four medical providers in each state. Names of medical providers familiar with adolescent vaccine practices were solicited from the leadership of state American Academy of Pediatrics chapters and regional Society for Adolescent Health and Medicine chapters; nondiscriminative snowball sampling allowed us to contact multiple potential participants.

For public health officials, we intended to interview one immunization, one STD, and one Title X/family planning program manager in each Centers for Disease Control and Prevention–recognized state and jurisdiction. There are five jurisdictions for immunization programs, six jurisdictions for STD programs, and one jurisdiction for Title X/family planning. Lists of immunization and STD program managers were provided by the Centers for Disease Control and Prevention. Contact information for Title X grantees was obtained from the Office of Population Affairs. Program managers were allowed to designate proxy respondents if they felt a staff member would be more familiar with vaccine practices in their clinic settings.

Potential study participants were solicited via email with limited telephone and facsimile follow-up; contact information for those interested in participating was provided to the University of North Carolina Survey Research Unit. A minimum of 12 telephone call attempts were made by the Survey Research Unit. Respondents who provided verbal informed consent were interviewed upon initial contact when possible; otherwise, appointment times accommodated respondents’ schedules. Respondents were not compensated.

Interview surveys

Data collection occurred between February and April 2009 using Blaise computer-assisted interviewing system. After respondents were queried about demographic characteristics, interviewers determined whether respondents were most familiar with vaccine practices in private primary care, public primary care, STD, or Title X/family planning clinics in their state; skip patterns in the survey directed respondents to questions relevant to the settings with which they were most familiar. Respondents were instructed that the term “parent” would be used to represent “parent or legal guardian” for the entire survey, and that the survey was intended to assess vaccine practices for cognitively normal adolescents. On average, each interview lasted 20 minutes.

Measures

Sociodemographic characteristics included gender, age, and professional role (medical provider; immunization, STD, or Title X/family planning program manager).

Perceived frequency of unaccompanied minor visits in public and private primary care clinics was measured by asking respondents their perception of how often 17-, 15-, and 12-year-old adolescents visit primary care clinics for medical care without a parent in the building. Response options included often, sometimes, rarely, never, and don’t know.

Extent to which minor consent issues influence delivery of vaccine was investigated by a series of hypothetical scenarios.

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