

THE LEGALITIES OF CARING FOR HOMELESS YOUTH

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By

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### Abstract

Homelessness is an ever-present social and economic issue worldwide that affects the healthcare field. The United States Housing and Urban Development (U.S. HUD) (2015) reported that there were 578,424 homeless people in the United States during the 2014 *Point in Time* count. Almost one quarter of that number was children under the age of 18 and 10% were ages 18-24 years (National Alliance to End Homelessness (NAEH), 2015). Alaska has a higher rate of homelessness at 24.3 per 10,000 people compared to the national average of 18.3 per 10,000 people (NAEH, 2015). Although there is a decreasing rate of homelessness in the United States, Alaska has experienced an increase of 1.73% from 2012-2013 and a 4.06% increase from 2013-2014 (NAEH, 2013 & 2014). Homeless youth were reported to be 10.9% of the Alaskan homeless population (NAEH, 2015). The purpose of this project was to educate Alaskan healthcare providers on the legalities of caring for homeless youth. A webinar, with continuing education units, was developed and made available online to Alaskan healthcare providers. The focus of the educational presentation was on common situations healthcare providers are confronted with when seeing homeless youth in a clinic and if parental or guardian consent should be obtained. Evaluation was conducted via pre and post webinar testing to measure knowledge change. The pre and post webinar testing showed that all participants had an increase in knowledge and interpretation of healthcare situations that involved the minor consent law.

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### **Background and Significance**

Homelessness is an ever-present social and economic issue worldwide that affects the healthcare field. Every year, each state does a *Point in Time* count where in one 24-hour period, as many homeless that can be found are physically counted. The counts are done to determine how many homeless individuals are in their communities, which helps appropriate funding for homeless services. *Point in Time* counts are the best way to estimate the amount of homeless in the United States, but they most likely are not catching the entire population. The entire population cannot be captured in *Point in Time* counts because not all homeless may be present on the day of the count, rates of homelessness fluctuate depending on the season, and homeless youth may not congregate in the same areas as adults. The United States Housing and Urban Development (U.S. HUD) (2015) reported that this night in January 2014, there were 578,424 homeless people in the United States. Almost one quarter of that number was children under the age of 18 and 10% were ages 18-24 years (National Alliance to End Homelessness (NAEH), 2015). The national average of homeless is 18.3 per 10,000 however; Alaska reported a homeless rate of 24.3 per 10,000 people (NAEH, 2015).

The United States has been slowly recovering from the economic recession in 2008, which resulted in a loss of 8.4 million jobs nationwide, and the numbers of homeless have decreased by 10% since 2010 (Economic Policy Institute, N.D.& U.S. HUD, 2014). The rate of overall homelessness in the United States decreased by 3.7% between 2012 and 2013 and decreased by another 2.3% between 2013 and 2014 (NAEH, 2014). During both times, all subpopulations of homeless experienced a decrease throughout the nation (NAEH, 2013 & 2014). Although there was a decreasing rate of homelessness in the nation, Alaska experienced

an increase of 1.73% in 2012 and a 4.06% increase in 2013, but had a decrease in 2014 of 8.3% (NAEH, 2013, 2014, & 2015). These numbers are important, but may not be the complete picture as discussed previously.

Two of the largest cities in Alaska, Fairbanks and Anchorage, have the highest concentrations of homeless in the state. In Fairbanks, a small town of approximately 32,324 people within the Fairbanks North Star Borough which has a population of 100,436, local agencies have estimates that are significantly higher than the national counts (US Census Bureau, 2014). According to the Fairbanks Rescue Mission 2013 Annual Report (n.d.), 37% of the people who stayed in their emergency shelter in 2013 were ages 30 years and younger. Fairbanks Youth Advocates (2014) reported that in 2013, 164 youth were served in their emergency shelter.

Anchorage is the largest city in Alaska, with a population of 301,010 people (US Census Bureau, 2014). In 2011, the Covenant House in Anchorage, a local street youth program, served 5,726 youth at their facilities (Covenant House, 2015). In contrast, *Point in Time* counts for youth 17 and under in Anchorage were significantly lower; 48 in 2011, 3 in 2012, and 163 in 2013 compared to agency estimates (Anchorage Coalition to End Homelessness, 2015). These numbers are most likely a misrepresentation due to the reasons discussed earlier.

The Alaska *Point in Time* counts specific to homeless youth are relatively low, with 14 youth under the age of 18 years counted (NAEH, 2015). In 2014, it was estimated that 10.9% of the Alaskan homeless population were homeless youth, which includes youth up to the age 24 years (NAEH, 2015). This number is likely a very low estimation due to the lack of housing facilities and the low number of beds in available facilities that can house homeless youth (NAEH, 2013). Homeless youth rarely congregate in the same areas and places that homeless adults do and the *Point in Time* counts usually target areas that homeless adults congregate

(NAEH, 2013). The majority of homeless youth are living in unsheltered situations, which includes public or private areas that are not designed for human habitation (i.e. a car, park, bus stop, or a wooded area), which puts them at higher risk for health disparities (NAEH, 2015).

### **Reasons for youth homelessness**

There are a number of psychosocial, economic, and religious reasons why youth become homeless. Prior to becoming homeless, it has been common for youth to have a history of traumatic events. Coates and McKenzie-Mohr (2010) interviewed 102 homeless youth who reported experiencing an average of 6 to 7 stressful life events prior to becoming homeless most commonly included being bullied, isolated, assaulted, fear of being killed, and experienced or witnessed physical abuse in their family (Coates & McKenzie-Mohr, 2010). Physical and sexual abuse were more prevalent in the female youth, although still present in males, before they became homeless (Coates & McKenzie-Mohr, 2010). Another common theme was that youth reported having moved numerous times between friends and family members before exhausting their relationships and becoming homeless (Coates & McKenzie-Mohr, 2010).

Thompson, Bender, Windsor, Cook, and Williams (2010) found that family discord was found to be the most common underlying factor contributing to youth homelessness. Low parental involvement, poor communication, and high levels of familial conflict were reported (Thompson et al., 2010). Reasons for conflict ranged from parental substance use, sexual orientation, religious beliefs, school and personal style, i.e. dress, hair color, or piercings (Thompson et al., 2010). Family transitions were other common occurrences that caused conflicts and resulted in homelessness; these included death of a parent, remarriage, divorce and foster care (Thompson et al., 2010). Stressful events and family discord can all result in youth

homelessness. Stressful and traumatic events may keep homeless youth from accessing care and makes it important to provide empathetic healthcare.

### **Definitions**

There are a number of definitions for homelessness that are dependent on the agency, state law, or federal law; many are used interchangeably. For the purposes of this project, the following definition of homelessness was used as it incorporates all aspects of homelessness:

“An individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation” (National Health Care for the Homeless Council, 2014, para. 1).

There are many definitions of what is considered youth in the realm of the law and homelessness. Common, interchangeably used terms for this group are unaccompanied minors, runaway youth or minor, and homeless youth. The Runaway and Homeless Youth Act (2012) defines homeless youth as an individual who is “less than 21 years of age...for whom it is not possible to live in a safe environment with a relative; and who has no other safe alternative living arrangement” (Section 387). A child, youth or minor is defined in the Alaska Stat. § 47.12.990 (2014) as “a person who is under 18 years of age”. Alaska Stat. § 47.10.390 (2014) defines a runaway minor as “a person under 18 years of age who is habitually absent from home; or refuses to accept available care”. Alaska law does not give a specific definition for homeless or homeless youth, so Alaska’s statutory definition of runaway minor will be used as a definition for homeless youth in this project.

### **Healthcare for homeless youth**

All 50 states have laws defining minor consent to medical treatments; Alaska has two statutes, Alaska Stat. § 25.20.025 and § 18.16.020, that provide the framework for minor consent to medical treatment (See Appendix C). Alaska Stat. § 25.20.025 Examination and Treatment of Minors (2014) states that minors may consent to medical or dental treatment in five different situations: a minor living apart from the parent or guardian and managing his/her own finances; if the parent cannot be contacted or is contacted and unwilling to grant or withhold consent; the minor is a parent and may consent to care for himself/herself and the child, he/she may consent diagnosis, prevention or treatment of pregnancy and for diagnosis and treatment of sexually transmitted infections. Alaska Stat. § 18.16.020, Consent Required before Minor's Abortion (2014) requires that an unmarried, unemancipated minor have parental consent before an abortion is performed, unless there is a court order allowing the minor to consent. These laws are helpful, but are vague, difficult to interpret and apply, and do not cover important issues like consent for mental health or substance abuse treatment.

Based on the Alaska rates of youth homelessness, it is inevitable that nurse practitioners who provide care in family practice and other specialties in communities across Alaska will see patients who are considered homeless youth. Due to the likelihood that the homeless youth have experienced prior traumatic events, they may be apprehensive about accessing care. Thus, it is essential to approach the youth with empathy and confidence.

There are many situations where the healthcare provider may feel it necessary to contact the parents of the homeless youth for consent, but it may not be necessary to do so. More importantly, unnecessary contact attempts could damage the healthcare relationship and potentially impact the completion of care with the homeless youth. It is important for healthcare

providers to understand the legalities of caring for homeless youth and for homeless youth to feel comfortable in the healthcare relationship to promote ongoing access to care.

### **Literature Review**

Although there are numerous studies regarding homeless youth experiences with healthcare, a literature review revealed few studies available which represents the healthcare provider's perspective regarding care for homeless youth. . A thorough search of CINAHL, University of Alaska Anchorage Library, Google Scholar, and Google was completed on the topic with the key terms homeless, youth, adolescent, healthcare, consent, healthcare provider, legal, law, and Alaska. The search yielded no research articles regarding the healthcare provider's understanding of the legalities of caring for homeless youth. This lack of research demonstrates a gap in knowledge and the need for more research on this topic.

### **Reasons to Access Care**

There are health issues common in all youth, but they may go untreated in homeless youth due to poor access to care. Homeless youth in Baltimore City identified AIDS/HIV, sexually transmitted infections (STIs), teen pregnancy, injuries/cuts, depression, drugs, and skin problems as their main health concerns (Ensign & Gittelsohn, 1998). Homeless youth are more likely to have a mental health diagnosis, higher rates of STIs, chronic health conditions, malnutrition, respiratory and infectious diseases, and substance use. (Beharry, 2012 & Wilder Research, 2013). Homeless youth are two to ten times more likely to have HIV and ten to twelve times more likely to have hepatitis C and hepatitis B (Feldman & Middleman, 2003). Tuberculosis rates are twenty times higher than that of non-homeless youth (Feldman & Middleman, 2003). Aside from infectious diseases, homeless youth are more likely to abuse drugs and to suffer from mental health disorders (Feldman & Middleman, 2003). These

concerning conditions should not be left untreated, but due to numerous barriers, homeless youth may not access the care that is needed.

There was no specific data on Alaskan homeless youth and their health concerns, but it can be extrapolated that they have relatively similar concerns. One concern is that Alaskans have some of the highest rates of chlamydia and gonorrhea in the nation; Alaskan youth ages 15-19 years had the second highest rate of chlamydia compared to other age groups and counted as 25% of the reported cases in the state (Section of Epidemiology, 2014). Gonorrhea is less common than chlamydia, 205 versus 725 cases respectively in 2014, and 60% of the reported cases were in persons under the age of 29 years (McLaughlin & Castrodale, 2015). These infections do not require parental consent for care and treatment should not be delayed.

### **Barriers to Care**

Homeless youth face many barriers to accessing health care. Chelvakumar et al., (2016) surveyed homeless youth in central Ohio and found that these youth commonly accessed the emergency department when they needed healthcare. The homeless youth reported barriers to accessing care included transportation, lack of health insurance and cost (Chelvakumar et al., 2016). Ensign and Gittlesohn (1998) surveyed homeless youth and found that additional barriers to access care included: being asked for proof of insurance, the inability to schedule their own appointment without their parent, being judged by the health care provider, and having to wait to see a provider. Ensign and Bell (2004) found similar barriers among homeless youth accessing care. For example, youth had difficulty physically getting to a clinic when sick due to transportation issues. In addition, the authors found that youth reported rarely having a primary care provider, which led to frequent use of the emergency department. Once at the clinic, health care providers were not clear if the under 18 years homeless youth were able to consent to care

(even though at some clinics they were able to) (Ensign & Bell, 2004). The authors noted that inconsistencies in clinic practice deterred them from seeking care. Nickasch & Marnocha (2009) interviewed homeless individuals on their views of healthcare and discovered an overarching theme of external locus of control, which meant that the homeless individuals did not feel in control of their lives or health because they lacked basic needs, which impeded their ability to take care of their essential physical needs. The authors also noted barriers include lack of financial resources to access healthcare, even at the “free clinics,” and the feeling that healthcare providers lacked compassion towards their situation.

In a study specific to female homeless youth, Ensign and Panke (2002) identified five barriers to care for this group of youth. The authors identified structural issues associated with getting healthcare including: issues with consenting to care, having to provide an address and identification card, and having to provide insurance information. Additionally, the authors reported that these homeless youth reported they did not have social support to seek care, and, once they decided to seek care, it was difficult to get to a clinic (Ensign & Panke, 2002). The overall characteristics of the clinic deterred some of the youth from accessing care. They felt that things like poor confidentiality practices, not being remembered as a patient, being called back by a number and not their name, and having to fill out too many forms were all barriers to accessing care at clinics (Ensign & Panke, 2002). The authors also noted that many of the participants felt healthcare providers did not respect them and treated them as ignorant about their own health. The participating youth reported they felt healthcare providers had less than ideal communication skills with them because of the providers’ use of medical terminology and failure to listen to the youth’s beliefs about their healthcare (Ensign & Panke, 2002). These barriers may keep homeless youth from seeking care when they truly need it.



Christiani, Hudson, Nyamathi, Mutere, and Sweat (2008) had similar findings about access to care for homeless youth, including financial, structural, and personal barriers. Financial barriers were a huge problem with the youth; they were frustrated with agencies constantly sending bills that they were unable to pay and receiving prescribed medications that they were unable to afford. Healthcare structure was a large barrier for many of the youth, who expressed the need to have a one stop shopping type of clinic, so they were not waiting for referrals or calls from other agencies (2008). The youth also reported frustration that they were lumped into the same group as older homeless people; they felt that there should be separate services specific to the younger homeless population. Geber's (1997) findings also aligned with many other studies of homeless youth on barriers to care. Gerber found that while 88% of runaway youth accessing community services in Minneapolis, Minnesota reported positive experiences with health care, all of the participants reported some type of barrier to care. Payment for services was a main concern among all the youth, but the youth who identified as non-white had strong concerns about racism from the healthcare provider (Geber, 1997). All of the barriers presented in the literature kept vulnerable youth from accessing the care they needed.

### **Healthcare Providers' Perspectives**

Homeless and other vulnerable populations often represent a culture unto themselves. Ideally, healthcare providers should demonstrate cultural competence to all populations, including the homeless. It is important to promote education related to homelessness for all healthcare providers. Stanley (2013) noted that nursing students assigned to do health teaching projects in a local homeless shelter during their public health rotation reported a greater understanding of the health issues of homeless individuals, an increased sense of empathy towards the population, and developed a sense of advocacy for them. This teaching project

shows the importance of having education about, and exposure to, other cultures in order to empathize with them and to provide better treatment.

Seiler and Moss (2010) interviewed nurse practitioners (NPs) who provided health care to homeless patients in Wisconsin. The NPs expressed that caring for homeless can be challenging because they usually come in with no other resource or social support (Seiler & Moss, 2010). This population is often “just trying to survive”, may not have access to resources and social support, and may not be accepting of some healthcare advice, such as recommendations to eat healthier food or exercise regularly (Seiler & Moss, 2010). In order to establish a productive relationship between healthcare provider and homeless patient, the NPs felt that, with homeless patients, this meant recognizing that they had personal assumptions and biases, providing acknowledgment to the patient, being empathetic, having respect, and meeting the patients at their level (Seiler & Moss, 2010). These NPs acknowledged the importance of establishing relationships and understanding that homeless patients are different from the average patient.

Morrison, Roman and Borges (2010) identified attitudes of emergency room and psychiatric medical students before and after their respective rotations. Before their rotation, the medical students showed a good understanding of homelessness and its causes (Morrison, Roman & Borges, 2010). The authors reported that the students who had more exposure and education on homelessness were more comfortable and empathetic towards the homeless patients. This research shows the importance of making education on homelessness available to all healthcare providers.

### **Understanding Legal Issues**

Bruce, Berg and McGuire (2009) reviewed state laws regarding minor consent and confidentiality and found that each state varied greatly in its laws. Each state had a law that

allowed minors to consent to treatment for STIs, 80% of states allowed minors to consent to substance abuse treatment, but in less than half of states, minors could consent to mental health treatment and reproductive health appointments (Bruce, Berg & McGuire, 2009). Even if the state had a law regarding minor consent to treatment, many of the laws were vague which led to issues with interpretation (Bruce, Berg, & McGuire, 2009). There was confusion regarding confidentiality of the visit and parental access to records. Variation in the state laws and vagueness can lead to significant confusion and possible legal issues for all health care providers. If a minor is a runaway or homeless youth, this could complicate the situation even more. In order to provide the best care possible, it is important that providers have current updates on applicable state laws.

In some states youth are able to consent to substance abuse and mental health treatment and in other states such treatment requires the consent of the parent; laws vary state to state and it can be unclear even within the same state on what happens when the parents and child disagree (Kerwin et al., 2015). The authors reviewed all state laws about minor consent laws regarding substance abuse and mental health treatment and found that Alaska does not have any specific laws regarding who is able to consent or not to these types of treatment. Alaska Stat. § 25.20.025 Examination and Treatment of Minors (2014) specifies that minors can consent to medical and dental treatment in situations when they are financially independent from their parent or guardian or when the parent is unwilling to consent or will not provide consent, but there is no mention of consent related to substance abuse or mental health treatment in the statute. The vagueness of the statute poses a problem for the parent, youth, and provider who may have differing opinions and will need to come to some type of decision.

### **Purpose/Objectives**

The purpose of this project was to promote healthcare provider understanding on how to care for homeless youth within the confines of the Alaska statutes. Stanley (2013) noted that Healthcare providers who reported that the more education and exposure they had to homeless individuals, the more comfortable they felt providing care. In many instances, a homeless youth would not need parental consent for certain services, although other services may require consent. Ensign and Bell (2004) noted that homeless youth reported being denied care because they were not old enough to consent to care, but at other clinics they would be able to consent to care. Health care providers need to understand the legal requirements and limits of consent to promote access to healthcare for the youth and to avoid a situation that could get the healthcare provider in legal trouble. The authors also found that when homeless youth feel that they are understood by healthcare providers and not shunned, they are more likely to feel respected and seek care for their many comorbidities.

Although homeless youth may feel that healthcare providers are biased, Dela Cruz, Brehm, and Harris (2004) found that once Family Nurse Practitioner (FNP) students engaged in experiences with homeless patients, their attitudes towards the patients changed. While the FNP students reported no bias prior to interacting with the patients, afterwards, they reported positive feelings toward the homeless (Dela Cruz, Brehm, & Harris, 2004). So also, healthcare providers will be more comfortable with providing care to homeless youth when they are more educated and have more experience with this population. This project will be a key part in helping healthcare providers become more comfortable with caring for homeless youth. The goal of this project was to increase the knowledge of Alaskan health care providers offering care to homeless

youth within the confines Alaskan law. With increased knowledge, it is hoped that healthcare providers will feel more comfortable in caring for homeless youth.

### **Methods**

The web-based training was developed based on an andragogical concept of adult learners. Andragogy assumes that adult learners direct their own learning, are internally motivated to learn, and likely able to apply the knowledge immediately (Merriam, 2001). Adults should feel respected in a classroom due to their already large breadth of knowledge (Merriam, 2001). A pretest-posttest design was used for the web-based training to track increase in knowledge of participants. A webinar that healthcare providers can access on their own time was developed with the goal to add to their current knowledge on legal issues of caring for homeless youth.

The content of the presentation and handout were reviewed by Kristin Knudsen, Assistant Professor with the University of Alaska Anchorage Justice Center. The Alaskan minor consent laws were reviewed with the researcher to ensure understanding. Knudsen reviewed each case study and an accurate answer was discussed. Once the information was approved and found to be legally sound, the webinar was completed.

The educational intervention was designed to be available online. The initial presentation was presented live and recorded. The content was then made available online through the Alaska Nurses Association's website. Email notifications were sent through the Alaska Nurses Association, Alaska Nurse Practitioner's Association, University of Alaska Anchorage Graduate Program, and through personal contacts. The webinar provided 1.25 continuing education credits to participants who completed the webinar.

The webinar reviewed the background and significance of the homeless problem in United States and in Alaska, summarized the common complaints of homeless youth, and discussed the pertinent Alaska Statutes. This was followed by the presentation of eleven case studies about common clinical situations with homeless youth to promote synthesis and application of information. The participants were asked to identify how Alaskan law applied to each situation and each case was followed by a discussion on the appropriate way to handle the situation. Each scenario was followed by an appropriate solution and review of Alaska statutes for clarity. Links to the Alaska Statutes and other resources for homeless youth were included and a handout with the Alaska statute information was provided for participants to use as a reference. (See Appendix B).

Pre and post-test webinar surveys were completed by participants to assess knowledge change. Demographic questions were asked in the pre webinar survey. The surveys assessed the knowledge of the healthcare provider on specific situations covered in the webinar. (See Appendix A)

### **Rights of Human Subjects**

The Institutional Review Board at the University of Alaska Anchorage approved the project prior to any contact with human subjects began. No direct research was done on human subjects. The participants were informed prior to participation that the webinar and survey were voluntary. The researcher, the Alaska Nurses Association continuing education department, and the project chair only accessed the information collected from the surveys. The information was maintained electronically and is password protected. The information will be kept for three years and then destroyed.

## Findings

The researcher and project chair reviewed and organized the information from the demographics, pretest and posttest data from each participant (See Appendix A). Demographics were obtained from participants as part of the pretest, which was meant to identify basic information about the participants, their field of practice, and their familiarity with youth homelessness and application of minor consent laws. See Table 1 for demographic information of participants.

**Table 1**  
***Demographics N=31***

<b><u>Occupation</u></b>	<b>%</b>	<b><i>N</i></b>
RN	74.2	23
APRN	22.6	7
Nursing student	3.2	1
<b><u>Age Ranges</u></b>		
Under 25	3.2	1
25-34	35.5	11
35-44	12.9	4
45-54	19.4	6
55-64	19.4	6
65-74	6.4	2
75 & above	3.2	1
<b><u>Gender:</u></b>		
Male	6.4	2
Female	93.5	29

There were 31 participants and of these participants 74.2% ( $n = 23$ ) were registered nurses) and 22.6% ( $n = 7$ ) were advanced practice registered nurses (nurse practitioners or certified nurse midwives), and 3.2% ( $n = 1$ ) was a nursing student. The average years the participants were in their current field of work was 15.6 years ( $SD = 12.40$ ). The age ranges of the participants were from under age 25 years to over age 75 years, with the majority of the population, 35.5% ( $n = 11$ ), in the ages 25-34 years range. The other age groups reported were under age 25 years (3.2%,  $n = 1$ ), ages 35-44 years (12.9%,  $n = 4$ ), ages 45-54 years (19.4%,  $n =$

6), ages 55-64 years (19.4%,  $n = 6$ ), ages 65-74 years (6.4%,  $n = 2$ ) and over age 75 years (3.2%,  $n = 1$ ). Most of the participants were female at 93.5% ( $n = 29$ ) and the remaining 6.4% ( $n = 2$ ), were male. When asked about what type of clinic or specialty they worked; there was an array of different specialties. The two highest reported specialties were family practice and obstetrics/gynecology.

The pretest and posttest were developed to identify if participants' knowledge increased after viewing the webinar. The tests contained eleven multiple-choice questions about different patient scenarios. The scenarios were designed to duplicate common situations a healthcare provider might encounter while caring for homeless youth and were all reviewed during the webinar. Two participants were omitted from the results because they did not fully complete the pretest and posttest.

To further understand participants' interactions and knowledge of homeless youth, they were asked to quantify on average how often they see homeless youth in their work environment (See Table 2). The majority of the participants reported that they saw homeless youth "a couple times per year" (35.5%,  $n = 11$ ). One participant (3.2%) reported seeing homeless youth daily, five participants (16.1%) reported seeing homeless youth at least once per week, three (9.8%) reported seeing homeless youth at least once per month and 25.8% ( $n = 8$ ) reported never seeing homeless youth in their practice. Three participants (9.8%) checked "other", but did not expand on what other meant.



**Table 2*****How often do you come in contact with homeless youth in your practice?***

	%	<i>N</i>
Daily	3.2	1
Once per week	16.1	5
Once per month	9.8	3
A couple times per year	35.5	11
Never	25.8	8
Other	9.8	3

As part of the pretest, participants were asked how they would rate their understanding of legal issues in caring for homeless youth in the healthcare setting, this was rated on a scale from one (low or no understanding) up to ten (expert understanding). The average rating for participants was 2.83 ( $SD = 2.00$ ), with two participants rating themselves at a seven and one at an eight. Most of participants did not feel comfortable ( $n = 45.2\%$ ) or somewhat comfortable ( $n = 41.9\%$ ) with interpreting laws that pertained to minors consenting to medical care. The final question asked prior to the pretest asked the participants on what they would do if they had a homeless youth come into their clinic to receive care. The most prevalent answer was that the participants would look up the minor consent law or clinic policy prior to seeing the patient (54.8%) and 32.3% reported that they would ask a knowledgeable coworker. Only 3.2% would refuse to see the patient and 6.4% of the participants reported they knew the laws and would not have to look them up prior to seeing the patient. The questions asked after the demographics section of the pretest was meant to help better understand the participants' knowledge of caring for homeless youth seeking healthcare.

The average test score for the pretests was 67.69% ( $SD = 12.54$ ), with the highest score being 90.9% (10%,  $n = 3$ ) and the lowest score at 45.4% (10%,  $n = 3$ ). All participants had an increased posttest score, compared to their pretest, with an average posttest score of 91.25% ( $SD = 9.25$ ). Eleven participants scored 100%; the lowest score of 63.6% was an increase from the participant's pretest score. A paired samples t-test was performed to compare the pre and posttest scores. There was a significant difference in the scores for the pretest ( $M = 67.69$ ,  $SD = 12.54$ ) and posttest ( $M = 91.25$ ,  $SD = 9.25$ );  $t = 9.86$ ,  $p < 0.01$ .

In the posttest, participants were asked again to rate themselves on a scale of 1-10 on how comfortable they felt with understanding the legal issues pertaining to caring for homeless youth. The participants all reported an increase in comfort level, with the average going from 2.83 ( $SD = 2.00$ ) to a 6.69 ( $SD = 1.41$ ). They also were asked again how comfortable they felt with interpreting minor consent laws after taking the webinar. All participants either reported that they felt more comfortable after the webinar or felt the same, 48.3% ( $n = 14$ ) reported that they did feel comfortable now, 51.7% ( $n = 15$ ) reported that they were somewhat comfortable and no one reported that they did not feel comfortable.

For analysis in SPSS, the pretest and posttest answers were recoded to correct or incorrect and then awarded 1 point for each correct answer and 0 points for an incorrect answer. A paired  $t$  test was calculated to analyze descriptive data and explore relationships. The difference scores were evaluated and found to meet the assumption of the paired  $t$  test (*Shapiro-Wilke* = .930 [28],  $p = 0.060$ ). The paired  $t$  test showed significant differences between pre and posttest scores ( $t$  [27] = 9.89,  $p < .001$ ). Confidence interval ranged from 1.95 to 2.98 with a mean pretest score = 7.57 ( $n = 28$ ,  $SD = 1.3$ ) and a mean posttest score of 10.04 ( $n = 28$ ,  $SD = 0.92$ ). The mean difference was 2.46. The analysis revealed that participants with fewer years

worked had higher test scores with a negative correlation = -0.38 and  $p = 0.48$ . A Spearman's nonparametric test was done to analyze the relationship between participant age difference of score ( $r_s = -0.47, p = 0.12$ ).

### **Discussion**

Findings from this project showed that there was an increase in knowledge after participation in the webinar. The data analysis showed a significant difference in the pre and posttest scores, which shows that the webinar was an effective educational tool. Participants showed an increase in comfort level with the subject of minor consent laws, understanding legal issues in caring for homeless youth and personal understanding of minor consent laws. The data analysis found that the participants' years of practice correlated with a lower score on their tests, which supports the need for continuing education. The literature review found that healthcare providers felt more comfortable with a subject after being exposed or educated on the subject and this project aligns with the previous findings. This webinar could easily be adapted to other state laws and expanded to include a broader scope.

### **Limitations**

A significant limitation of this project was that the posttest was given immediately after the webinar. The posttest should be given after a longer period of time between the webinar and test. The exact same test was used in the pretest and posttest, which may have led to higher posttest scores. The presentation was only available in person one time on a weekend, which may have deterred people from participating. The webinar was focused on the Alaskan minor consent laws, so the findings would not be generalizable to other states without adaptation to reflect the individual state's laws.

### **Clinical Implications**

The clinical implications of this project is that providing education to healthcare providers increases their knowledge of the subject. It was found that when healthcare providers are closer to their initial training, they had improved scores on their pre and posttests. This finding translates to the need for continuing education related to minor consent laws.

### **Recommendations**

Further study needs to be done on the Alaskan homeless youth population and their barriers to healthcare. More information should be collected on the healthcare providers' perspective on caring for homeless youth, their perceived barriers, and their understanding of the laws pertaining to this group. This presentation could be expanded upon and be made available online for a longer period to reach a large group of people. Sending out reminders with deadlines was helpful in recruiting participants, but more in depth recruitment could have been done.

### **Dissemination Plan**

This project will be submitted to *The Journal of Adolescent Health*. This peer reviewed journal publishes articles that pertain to adolescent health, including manuscripts of original research.

### **Conclusion**

Homelessness is a pervasive issue in the United States and, in Alaska, homeless youth represent a group with unique health issues. The review of literature revealed a lack of research assessing knowledge of healthcare providers' understanding of legal issues. The review of literature showed that healthcare providers felt more comfortable with taking care of homeless individuals when they had more education and more clinical contact with the population. Many homeless youth seek health care when needed, but youth identified many barriers to care,

including feeling judged by the healthcare providers. Many nurse practitioners and other healthcare providers will come in contact with homeless youth at some point in their career and, if care is to be given, it is imperative to understand the complexity of minor consent laws. This project provided health care providers with education to help clarify clinical situations using Alaska statutes and demonstrated an increase in knowledge. With increased knowledge, participants will be more comfortable caring for homeless youth, which will increase access to care.

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**Appendix A****Pre Webinar Demographic Questions**

1. What is your profession? (MD, NP, PA, RN, etc.) \_\_\_\_\_
2. How many years have you been in your profession? \_\_\_\_\_
3. What is your age?
  - Under 25 years old
  - 25-34 years old
  - 35-44 years old
  - 45-54 years old
  - 55-64 years old
  - 65-74 years old
  - 75 years or older
4. Gender:    Male                  Female                  Other: \_\_\_\_\_
5. What type of clinic and/or specialty do you work in? \_\_\_\_\_
6. Approximately how often do you come in contact with homeless youth in your practice?
  - Daily (at least one patient or more per day)
  - Once per week (at least one patient per week or more)
  - Once per month
  - A couple times per year
  - Never
  - Other: \_\_\_\_\_

7. How would you rate your understanding of the legalities of caring for homeless youth?

1 (low or none) 2 3 4 5 (somewhat comfortable) 6 7 8 9 10 (expert)

8. Do you feel comfortable with interpreting laws that pertain to adolescents consenting to medical care?

- Yes
- Somewhat
- No

9. If you have a homeless youth come into the clinic and you are unsure if you are able to see them without a parent, what do you do?

- Ask a knowledgeable co-worker
- Look up the law or clinic policy (via google or workplace policies)
- I call the parent regardless of the situation
- I see the patient regardless
- I refuse to see the patient or I will have another provider see them
- I know the laws and do not have to look them up

**Questions for Pre and Post Webinar survey:**

1. If a homeless youth comes in for a sexually transmitted infection appointment, do they need parental consent?

- a. Yes
- b. No
- c. I don't know

2. If a female under the age of 18 comes into a clinic to obtain birth control, do they need parental consent?
  - a. Yes
  - b. No
  - c. I don't know
3. A homeless youth is at your clinic and requesting treatment for their drug addiction. Does Alaska have a specific law that allows them to consent to treatment without parental consent?
  - a. Yes
  - b. No
  - c. I don't know
4. A homeless female under the age of 18 is at Planned Parenthood requesting an abortion. According to the Alaska statute, does the healthcare provider have to inform the youth's parent?
  - a. Yes
  - b. No
  - c. I don't know
5. A homeless youth is in your clinic requesting mental health treatment, does Alaska have a law allowing them to consent to their own treatment?
  - a. Yes
  - b. No
  - c. I don't know

6. If a homeless youth is legally emancipated from their parent, but still under the age of 18, do they need parental consent for medical treatment?
  - a. Yes
  - b. No
  - c. I don't know
7. If a homeless youth is financially independent from their parents, but not legally emancipated, can they legally consent to their healthcare?
  - a. Yes
  - b. No
  - c. I don't know
8. If the parent of a homeless youth refuses to grant or withhold consent when contacted, can the healthcare provider make the decision for treatment?
  - a. Yes
  - b. No
  - c. I don't know
9. If a homeless youth has their own child, are they able to consent to treatment for their child?
  - a. Yes
  - b. No
  - c. I don't know
10. If a homeless youth has their own child, are they able to consent to their own treatment?
  - a. Yes
  - b. No

- c. I don't know
11. A homeless youth comes in for treatment of cold-like symptoms, does parental consent need to be obtained prior to seeing the patient?
- a. Yes
  - b. No
  - c. I don't know

*Answers: 1. B 2. B 3. B 4. A 5. B 6. B 7. A 8. A 9. A 10. A 11. A*

### **Additional Questions for the Post Webinar Survey**

1. After participating in this webinar, how would you rate your understanding of the legalities of caring for homeless youth?
- 1 (low or none) 2 3 4 5 (somewhat comfortable) 6 7 8 9 10 (expert)
2. After participating in this webinar, do you feel comfortable with interpreting laws that pertain to adolescents consenting to medical care?
- Yes
  - Somewhat
  - No
3. Other comments: \_\_\_\_\_

## Appendix B

**Local Resources:**

Covenant House  
755 A Street Anchorage, AK 99501  
Phone: (907) 272-1255  
<https://ak.covenanthouse.org/>

Juneau Youth Services  
Phone: (907) 523-6560  
[www.jys.org](http://www.jys.org)

The Door (youth shelter)  
138 10th Ave  
Fairbanks, Alaska 99701  
Phone: 907-374-5678  
[www.fairbanksyouthadvocates.org/](http://www.fairbanksyouthadvocates.org/)

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### Understanding Alaskan Minor Consent Laws in Caring for Homeless Youth

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*If you have questions or need more in depth information, you should consult your own lawyer or a lawyer for your healthcare organization.*

### Understanding Alaskan Minor Consent Laws in Caring for Homeless Youth

L

### Quick Facts about Homeless Youth

- ▶ In 2014, it was estimated that 10.9% of the Alaskan homeless population were homeless youth, which includes youth up to the age 24 (NAEH, 2015)
- ▶ Homeless youth usually experience numerous stressful life events before homelessness such as: being bullied, isolation, assault, fear of being killed, experiencing or witnessing physical abuse, physical and sexual abuse, (Coates & McKenzie-Mohr, 2010).
- ▶ Low parental involvement, poor communication and high levels of familial conflict were reported as significant reasons for youth to become homeless (Thompson et al., 2010).
- ▶ Homeless youth are more likely than non homeless youth to have infectious diseases, STIs, Hepatitis C & B, chronic health conditions and mental health diagnoses (Feldman & Middleman, 2003, Baharry, 2012 & Wilder Research, 2013).
- ▶ Homeless youth perceive significant barriers to accessing healthcare.

### Alaskan Laws about Minor Consent to Medical Treatment

#### AS 25.20.025. Examination and Treatment of Minors.

In Alaska, a minor may give consent for their medical treatment if:

- ▶ They are living apart from their parents or legal guardians and manage their own finances
- ▶ If the minor's parents cannot be contacted or are contacted and they are unwilling to grant or withhold consent, the healthcare provider should counsel the minor to consider their interests and their parent or guardian's interest in making a decision.
- ▶ A minor who is the parent of a child may give consent for themselves
- ▶ A minor who is a parent may give consent for their child
- ▶ A minor may give consent for diagnosis, prevention and treatment of pregnancy.
- ▶ A minor may give consent for diagnosis and treatment of sexually transmitted infections

For the full law see:

<http://www.touchngo.com/lglcntr/akstats/Statutes/Title25/Chapter20/Section025.htm>

#### AS 18.16.020. Consent Required Before Minor's Abortion.

In the state of Alaska, an abortion may not be performed on a minor who is pregnant, unmarried, under 17 years of age, and **unemancipated** unless:

- ▶ The minor's parent or guardian has consented in writing
- ▶ There is a court order in place

For the full law:

<http://www.touchngo.com/lglcntr/akstats/Statutes/Title18/Chapter18/Section020.htm>

### Mandatory Reporting

Healthcare providers are mandatory reporters and if there is any suspicion of neglect or any type of abuse it should be reported to the Office of Children's Services per your clinic's policy.

*Report Child Abuse in Alaska:*  
1-800-478-4444

For more information:

<http://dhss.alaska.gov/ocs/Pages/publications/reportingchildabuse.aspx>



### Appendix C

These were retrieved on April 15<sup>th</sup>, 2016. The laws should be reviewed frequently for amendments.

#### **Alaska Stat. § 25.20.025. Examination and Treatment of Minors.**

(a) Except as prohibited under AS 18.16.010 (a)(3),

(1) a minor who is living apart from the minor's parents or legal guardian and who is managing the minor's own financial affairs, regardless of the source or extent of income, may give consent for medical and dental services for the minor;

(2) a minor may give consent for medical and dental services if the parent or legal guardian of the minor cannot be contacted or, if contacted, is unwilling either to grant or withhold consent; however, where the parent or legal guardian cannot be contacted or, if contacted, is unwilling either to grant or to withhold consent, the provider of medical or dental services shall counsel the minor keeping in mind not only the valid interests of the minor but also the valid interests of the parent or guardian and the family unit as best the provider presumes them;

(3) a minor who is the parent of a child may give consent to medical and dental services for the minor or the child;

(4) a minor may give consent for diagnosis, prevention or treatment of pregnancy, and for diagnosis and treatment of venereal disease;

(5) the parent or guardian of the minor is relieved of all financial obligation to the provider of the service under this section.

(b) The consent of a minor who represents that the minor may give consent under this section is considered valid if the person rendering the medical or dental service relied in good faith upon the representations of the minor.

(c) Nothing in this section may be construed to remove liability of the person performing the examination or treatment for failure to meet the standards of care common throughout the health professions in the state or for intentional misconduct.

**AS 18.16.020. Consent Required Before Minor's Abortion.**

A person may not knowingly perform or induce an abortion upon a minor who is known to the person to be pregnant, unmarried, under 17 years of age, and unemancipated unless, before the abortion, at least one of the following applies:

- (1) one of the minor's parents or the minor's guardian or custodian has consented in writing to the performance or inducement of the abortion;
- (2) a court issues an order under AS 18.16.030 authorizing the minor to consent to the abortion without consent of a parent, guardian, or custodian, and the minor consents to the abortion; or
- (3) a court, by its inaction under AS 18.16.030 , constructively has authorized the minor to consent to the abortion without consent of a parent, guardian, or custodian, and the minor consents to the abortion.