August 20, 2012

The Honorable Kathleen Sebelius  
Secretary of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  

Jerry Menikoff, M.D., J.D.  
Director Office for Human Research Protections  
U.S. Department of Health and Human Services  
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Dear Ms. Sebelius and Dr. Menikoff,  

On behalf of the Society for Research in Child Development (SRCD) we are pleased to provide comments on the implications of the Advanced Notice of Rulemaking (ANPRM) to the responsible conduct of biomedical and social-behavioral research involving infants, children and adolescents. The Society is a multidisciplinary professional association with a membership of approximately 5,500 researchers, practitioners, and human development professionals from over 50 countries. Since 1933, SRCD has been committed to fostering research on development from infancy through adolescence and encouraging the application of findings to policies that work for the betterment of society's children and families. Our comments reflect a view of human subjects research as a moral endeavor that requires an optimal balance between scientific integrity and participant protections to advance children’s welfare. Drawing on the Belmont Principles of beneficence, respect and justice, SRCD provides the following comments to ensure that the welfare and privacy rights of infant, preschool, child and adolescent research participants are adequately protected and that such protections do not prevent them from equitable sharing of the burdens and benefits of research.  

We strongly support the aims of the project to revise the Common Rule to enhance participant protections and reduce institutional review board (IRB) and investigator burden, delay and ambivalence. Our primary aim is to highlight significant implications of the ANPRM to the interpretation and application of 45CFR46 Subpart D, Additional Protections for Children Involved as Subjects in Research and offer recommendations for revisions that would enhance the responsible conduct of research involving children from infancy through adolescence.  

GENERAL COMMENTS  

The Common Rule (45CFR46 Subpart A) provides foundational rules for the interpretation of regulations in Subpart D. For example, the Common Rule definition of “minimal risk” is a key concept for determining IRB approval for each regulation under Subpart D. In addition, definitions of expedited (§46.110) and exempt (§46.101) research as well as general requirements for informed consent (§46.116, §46.117) appear only in Subpart A and rules relevant to waiver of parental permission under §46.408 are linked to §46.116. Yet, the rationale provided in the ANRPM does not address the relevance of changes to protection of child and adolescent research participants.
We believe it is essential to the success of the rule-change process that clear and specific consideration be given to how the proposed changes will affect implementation of Subpart D, *Additional Protections for Children Involved as Subjects in Research.*

In sections on changing and expanding the exempt/excused category, the ANPRM restricts its recommendations to apply to research involving “competent adults”.

We endorse the recommendation in SACHRP’s letter to Secretary Sebelius that all references to *competent adults* be removed throughout the ANPRM because “inclusion of this qualifying language is more restrictive than the current regulations and would introduce numerous unintended consequences.”

While there are many proposed changes in the ANPRM that we believe have implications for research involving children and adolescents, at this time our comments are focused on four aspects of the ANPRM that have major implications for the responsible conduct of pediatric and developmental science.

### 1. STRENGTHENING DATA PROTECTIONS TO MINIMIZE INFORMATION RISKS

We applaud the ANPRM’s recommendation to distinguish procedures to provide and evaluate security protections independent of the evaluation of other research related risks and benefits. SRCD does not, however, support the recommendation to remove data protection evaluations from the purview of the IRB. The ANPRM is vague and ambiguous in its description of the oversight mechanisms that will ensure investigator knowledge of and adherence to data security protections. The HIPAA analogy within the ANPRM, which places primary responsibility on the investigator’s knowledge of up-to-date security rules, fails to recognize that researchers, unlike health practitioners, are not uniformly subject to forms of data protection and ethics training (accreditation rules requiring comprehensive ethics graduate education) or oversight and continuing education requirements (state licensing boards) outside the IRB.

SRCD believes that IRB review provides the critical third-party oversight needed to ensure that investigators are aware of and implement best practices for data protection.

We further recommend that any form of third-party oversight must include members with expertise in developmental differences in the nature of information risks and the confidentiality protections appropriate for research participants from infancy through adolescence.

We agree with the ANPRM that IRBs (especially when reviewing protocols that include adolescents) fail to take into account the investigator’s proposed privacy protection procedures, and instead incorporate the potential for privacy risks outside such procedures as a basis for categorizing research as greater than minimal risk.

SRCD recommends that changes to the Common Rule (a) include a separate section on IRB evaluation of information risk akin to the separate sections on informed consent and risk-benefit evaluation and (b) link this section to a list of common and acceptable categories of age-appropriate protections for calibrated levels of information risk (similar to the current and proposed expansion of categories for expedited review).

In developing a new section on information risk protections, SRCD supports the proposal that security protections should be calibrated to level of informational risk. We believe such calibrations should be empirically informed by age relevant research to ensure that low probability and low magnitude risks are not over-protected, a consequence that would lead to depriving children of the potential benefits of research generated knowledge. In addition the list of exemplar categories described should include examples from infant, child and adolescent research.
Identifiable information is a dynamic category that changes with increasing knowledge and emerging technologies. For example, future technology may allow identification of individuals participating in basic research on brain functioning. Data protection guidance should keep track of these technologies and recommend changes as they emerge. This is especially important for the use of new technologies (e.g., social media) in child and adolescent research. We recognize that informational risk may change over time with advancing technologies and agree that a committee should be appointed to periodically re-assess and provide guidance on informational risk and security procedures.

In some instances, even when information is de-identified, participants in a study involving a small, unique sample can be identified through a description of demographic variables (e.g., children with a rare developmental disorder or specific environmental risk living in a small distinct community). Security and data protection rules should be developed for de-identified data that have risk of such “deductive” disclosures.

SRCD agrees with the ANPRM proposal that a standing committee be established to review and update current and new forms of information risk and risk protections as they emerge. We further recommend that this standing committee include members with expertise in biomedical and social-behavior science research with infants, children and adolescents as well as members with expertise on how these age groups utilize new and emerging technologies. We believe it is critical that OHRP establish specific and continually updated developmentally informed guidance on information risk protection for IRBs and investigators.

We agree with other organizations that have voiced rejection of adoption or adaptation of HIPAA security regulations. In particular, although required guardian access to a minor’s medical records may be appropriate to secure suitable child medical treatment, this requirement is not relevant for information collected solely for research purposes and that is not intended to be entered into a child’s personal medical record.

Caution is needed when considering whether investigators who collect biospecimens from child participants should necessarily share with parents and adolescents information regarding possible developmental or adult onset risk. Under most circumstances, biospecimen information collected for non-clinical research purposes should not be shared because the concurrent and predictive validity and clinical utility of such data are questionable.

Finally, research involving children is often subject to state laws on reporting child abuse, maltreatment and neglect. These reporting requirements are included in the informed assent and guardian permission documents. In addition, researchers may sometimes come across strong indications that a child or adolescent might be in danger of seriously harming themselves or others of which other adults are unaware. Investigators involved in research with the potential to elicit such information normally develop specific procedures, described in the IRB protocol, to minimize the possibility of such harms if they arise and such procedures often involve disclosure to a guardian, school counselor or health professional.

On this basis SRCD recommends that information security rules should include guidance on explaining to prospective participants the investigator’s legal reporting responsibilities (i.e. mandated child abuse reporting, Tarasoff-type state laws) as well as other forms of disclosures the investigator and IRB have decided are necessary to protect the participant or others from serious harm. In addition, all such disclosure procedures should be described in the informed consent, parental permission and child assent materials subject to IRB review.

2. Ensuring Risk Based Protections: Minimal Risk

Reference to the Common Rule definition of “minimal risk” in §46.102 is included in each of the nine
regulations specific to Subpart D, Additional Protections for Children Involved as Participants in Research. We applaud the ANPRM recommendations to establish a “general population” index for assessing minimal risk. The general population standard is a particularly welcome protection for child and adolescent participants. We agree with recommendations by previous federally appointed committees such as NRPHAC, the IOM Committee, and the SACHRP Research Involving Children’s Subcommittee that there are compelling reasons to adopt a general (uniform) standard. In particular, the general standard when applied to Subpart D § 46.404 “Research not involving greater than minimal risk”, ensures that children with health problems or living in unsafe environments are not unjustly permitted to be exposed to higher levels of risk than healthy children living in safe environments simply because their daily lives are filled with greater risk.

In addition, research involving children and adolescents is often conducted in or for schools. For such research the reference to routine psychological examinations or tests in the current minimal risk definition does not provide sufficient guidance for use of educational tests.

For these reasons SRCD recommends that Federal regulations adopt the definition of minimal risk recommended by SACHRP in its letter to Secretary Sebelius:

*Minimal Risk means that the probability and magnitude of harm or discomfort introduced solely by the research are not greater in and of themselves than those familiar and routine experiences ordinarily encountered in the daily life of the general population or during the performance of routine medical, dental, psychological, or educational examinations or tests.*

We endorse the NRPHAC, IOM and SACHRP Subcommittee on Research Involving Children (SRIC) previous recommendations that interpretations of routine medical, dental, psychological or educational examinations and tests draw upon the routine age-graded well-child or adolescent health-care visits and age-graded tests, observations and interview procedures for routine psychological or educational screening. We offer some examples in Appendix A of this comment.

SRCD also recommends that evaluation of minimal risk for social-behavioral components of research involving preschoolers, children and adolescents as well as adults should not be based solely on the content area covered by an examination or test (e.g., sexual behavior), but on whether the content and the method and language of inquiry is age appropriate and whether the investigator has the developmental training required to treat participants with sensitivity and respect.

SRCD believes that guidance should address which mechanisms for risk mitigation may be considered by IRBs when determining that proposed research is minimal risk. Specifying mechanisms is particularly important if assessments of information risks are to be separated from assessments of other research risks. However, we would amend the SACHRP recommendation to include the following language “Age appropriate risk mitigation mechanisms should be considered by IRBs when determining that proposed research is minimal risk.”

We believe that Subpart D, Additional Protections for Children Involved as Subjects in Research includes sufficient provisions for protecting the rights and welfare of child populations and additional consideration of their status as “vulnerable” in the Common Rule can lead to over-protective requirements or a diminishment of the application of Subpart D.

SRCD recommends that language in the Common Rule remove the inclusion of “children” in its description of vulnerable populations or clearly state that children, especially adolescents, as a class should not by default be considered “vulnerable” populations outside the Subpart D regulations. As with adults, IRBs should define vulnerability in terms of children with special needs (e.g., medical illness or physical, emotional or intellectual disability) or living in unsafe environments (e.g., homeless children and adolescents, those living in war torn countries). This is consistent with the SRIC
recommendation that a general, age-indexed definition of minimal risk should represent the upper not lower limits of risk to which children with unique vulnerabilities can be exposed.

3. Ensuring Risk-Based Protections: Expedited Review and Moving Away from the Concept of Exempt

Expedited Review

SRCD applauds the ANPRM proposed expansion of the expedited category list. More often than not, IRBs do not apply the current general categories to children’s research despite the regulatory language in part B of the Categories of Research that states that “The categories in this list apply regardless of the age of subjects, except as noted.” We also strongly favor the establishment of a standing committee to review, expand and modify the categories on a regular basis.

SRCD strongly recommends that the expedited categories (a) include specific examples for biomedical and social-behavioral research from infancy through adolescence; (b) that these examples be age-graded and (c) based on empirical evidence that can reduce the possibility of over-or under-estimating risk. A standing committee charged with reviewing, expanding and modifying these categories should include members with expertise in the application of human subjects protections to biomedical and social-behavior research involving infants, children and adolescents.

We also support recommendations that the types of research listed in the expedited category be examples rather than an explicit and exhaustive list of a limited set of procedures. An introduction to the expedited categories list should make clear that IRBs and investigators should utilize the expedited research as exemplars to guide decisions on whether various types of research meet expedited criteria. These decisions should evaluate the risk equivalence of proposed procedures to those listed in terms of risk magnitude and probability, duration, cumulative effect, transience and reversibility of harm, within the context of relevant participant characteristics (including but not limited to their age).

We believe the current language in expedited Research Categories is not sufficiently protective of child participants and may lead to precipitous decisions that some drugs and mechanical devices not yet approved for children, and which may present unknown harms would be considered minimal risk. Drugs and medical devices that received an investigative new drug category for adults should not be presumed by default to be safe and of minimal risk for research involving children.

SRCD recommends that HHS modify language in Expedited Category 1(a) so that it excludes pediatric research testing a drug or medical device approved solely for use with adults when there is no animal or clinical evidence for calibration of harm or discomfort of these drugs for children; We also recommend adding a further restriction to this category such that pediatric research involving unregulated vitamins and nutrients should not by default be considered expedited if there is no animal or clinical evidence for calibration of harm or discomfort to children. Finally, we suggest that Expedited Category 1(b) clarify that “(ii) the medical device is cleared/approved for marketing with children and the medical device is being used in accordance with its cleared/approved labeling for children.

Exempt/Excused/Registered Research

Subpart D does not include a specific section on exempt research. Rather §46.401 states that exemptions at §46.101 of the Common Rule are applicable to Subpart D. Therefore, any modifications to this category must consider the consequences for pediatric research. We applaud the ANPRM’s recommendation to streamline the process and clarify the categories of research that qualify for exempt review. SRCD does not, however, support the recommendation to remove the exempt decision from the purview of the IRB. The ANPRM is vague in its description of the oversight mechanisms that will ensure investigator knowledge of
and compliance with criteria for exempt status; and as articulated by several other commentators the proposed excused/registered category would not protect participants from decisions contaminated by investigator conflict of interest.

SRCD believes that maintaining the IRB’s current responsibility to approve research as meeting exempt criteria provides the critical third-party over-site necessary to ensure participant protections. We therefore reject any proposed change in terminology that indicates that such research is “excused” from IRB review.

As described in section 1 of this commentary, SRCD endorses the ANPRM proposal to distinguish information risks from other research related risks, as long as the IRB retains appropriate oversight to ensure that protocols meet age-graded security protections. We take a similar position on the role of the IRB in ensuring that exempt research meets data security standards. If as suggested in section 1 of this commentary, age-graded and information risk-calibrated categories and procedures are created and updated by a standing committee. This would enable investigators applying for exempt classification to simply need note the level of approved information protections that would be applied.

SRCD also agrees that the approval procedure for exempt research must be streamlined. We support the recommendation to address the ambiguity that currently surrounds regulatory language on exempt categories. For example, currently there is great IRB variability and investigator confusion over application of exempt categories described in §46.101b(1) and 101b(2) for research involving children conducted in “established or commonly accepted educational settings, involving normal educational practices…” and “involving the use of employing educational tests.”

SRCD strongly recommends that federal regulations include a description of “categories of exempt research” similar to the modifications recommended for the current categories of research for expedited review and that this category (a) include specific examples for biomedical and social-behavioral research involving children and adolescents; (b) that these examples are age-graded and (c) based on empirical evidence that can reduce the possibility of over- or under inclusion of research involving infants, children and adolescents in the exempt category. A standing committee charged with reviewing, expanding and modifying these categories should include members with expertise in application of research protections to biomedical and social-behavior research from infancy through adolescence.

4. IMPROVING INFORMED CONSENT

Under Subpart D §46.402 “Children are persons who have not attained the legal age for consent to treatment or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted.” The Subpart D definition refers to state regulated definitions of “mature” and “emancipated minors” or other permissive state laws. However, in many instances IRBs will erroneously apply Subpart D rather than the Common Rule for research involving adolescents who do not meet the federal definition of “children” and needlessly require guardian permission or waiver of guardian permission for their involvement in clinical trials or research using surveys, interviews, or tests related to treatment and procedures for which they have obtained legal adult status. This deprives adolescents of their full rights and protections as “adult” participants under Subpart A. For example, an adolescent who by state law has the right to seek, consent to and obtain reproductive and sexual health medical care without parental permission should also have the right to autonomously consent to clinical trials research on the effectiveness of such treatments as well as research exploring the cognitive, social-behavioral, psychological, and attitudinal factors associated with adolescent reproductive and sexual health.

SRCD recommends that the Common Rule include language clarifying that Subpart A should be applied to research involving adolescents who by their statutory classification as “mature” or “emancipated” minors or who can otherwise by law give effective consent for health care treatments.
entitles them to be accorded the same status when they participate in research on biomedical, social or behavioral factors related to treatments and procedures for which they are legally entitled to provide autonomous consent.

Informed Consent to Longitudinal Research, National Surveys, Data Sharing and Data Repositories

Longitudinal research is an essential method of developmental science. Following children and families through infancy, childhood and adolescence generates critical knowledge of individual differences in emotional, cognitive, behavioral, social and other aspects of human development. Longitudinal studies allow for tests of continuity and change in developmental processes and the influence of genetic, social and environmental contexts over time. Longitudinal studies are essential for assessing the lifelong consequences of medical, educational, clinical, or other interventions. By definition, longitudinal studies require collection and maintenance of identifiable information. In addition, annual or periodic large longitudinal and cross-sectional national surveys of children and youth (e.g., the National Children’s Study, the Youth Risk Behavior Survey) have and will continue to make significant contributions to informed policies on child health and welfare. Whether data in longitudinal studies or national surveys are identifiable or de-identified, their contribution to society is greatly enhanced by secondary analysis by investigators over different periods of time. Finally, developmental scientists are increasingly conducting inter-disciplinary research that requires the collection of biospecimens to contribute to further understanding, prevention and amelioration of childhood and adult onset disorders. The extent to which a biospecimen in and of itself is a personal identifier will present increasing challenges for data security as the technology develops. For all these reasons new rules governing data security will have a significant impact on the nature of developmental science research.

We agree that there is no need for re-consent for future use of de-identified information, because future analysis of de-identified data by the original investigator or secondary analysis of de-identified data by other investigators poses no informational risk, with one caveat: Emerging software and biomedical technologies may make original data security protections obsolete. SRCD thus recommends when children or their parents provide permission for future use of data, the consent form indicates that all investigators who will have access to data in the future will be bound by best practices in data and confidentiality protections and new protections as they emerge.

We agree with ANPRM that identifiable information for which parental permission was obtained should be considered as default permission for continuation of use of data after the child has reached the age of majority as long as appropriate security protections are in place and updated as may be required by evolving federal standards.

Protection of child and adolescent privacy rights require that when an investigator wishes to link archival identifiable data with collection of new data, informed assent or consent (if the child has reached the age of majority) and guardian permission must occur. However, the consent should be for the new data collection and linking to the archival data set, not for access to the contact information of individuals who participated in the original study. Rather, access to participant contact information should be permitted to occur with a signed letter of agreement between institutions that security and confidentiality rules will be followed.

Waiver of Consent

Under Subpart D regulation §46.408 (c) Requirements for permission by parents or guardians and for assent by children, IRBs may waive the requirement for parental permission if conditions meet the “provisions for waiver contained in Subpart A regulations §46.116 Informed Consent.” The only provision for guardian waiver specifically provided in Subpart D is for conditions in which “parental or guardian permission is not a reasonable requirement to protect subjects (for example, neglected or abuse children).”
SRCD recommends that adequate regulatory language in and application of Common Rule §46.116 is essential to ensure that guardian permission waivers unrelated to potential harm appropriately protect the rights and welfare of children and at the same time do not deprive them of participation in research that can contribute to child health and wellbeing.

Under Common Rule §46.116 the reluctance of any adult or child subject [or guardian] population to provide consent [or guardian permission] is antithetical to the Belmont principle of respect and should not in itself a legitimate reason to waive consent (or guardian permission) and is. This happens all too frequently when investigators find it difficult to obtain parental permission from historically marginalized populations that are distrustful of research. When a significant proportion of the research population [or their guardians] refuse to agree to research participation, investigators and IRBs should consider the reasons for the reluctance and use such knowledge to increase the population sensitivity of the research, recruitment and consent procedures.

Regulations should be clear that consent, assent and guardian permission should never be waived for convenience or solely for reasons of cost or speed or other expedient measures if doing so weakens protection of subjects’ rights and welfare.

Waiver of consent under §46.116 has four criteria. In Appendix B we list the criteria and comment on the relevance of current and possible future regulatory or OHRP guidance language to protection of child and adolescent research participant rights and welfare.

Excessive Length and Complexity of Consent Forms

Subpart D §46.408 (b) also refers to §46.116 Subpart A for general rules regarding information that must be provided for guardian permission for a child or adolescent’s participation in research and by default §46.116 must be considered when developing guardian permission and child assent procedures. SRCD agrees with the ANPRM recommendations to improve consent forms in ways that enhance prospective participant [and guardian] understanding of their research rights and procedures. We support shortening the length to 2 pages and providing additional information in an appendix.

We also appreciate the ANRPM’s willingness to address the problem of over-inclusion of institutional liability clauses in informed consent. We agree with current regulation §46.116 a(6) that consent forms for research involving greater than minimal risk should include explanations regarding compensation for research related risk and medical treatment. However, for minimal risk social-behavioral research SRCD believes that statements regarding an institution’s lack of legal liability refers to risks outside of the research procedures themselves (e.g., falling while walking down the hall) and thus do not belong in the informed consent. In addition, liability waivers included in an informed consent document clearly violate the regulatory language in §46.116, which states that no informed consent “may include any exculpatory language through which the subject or representative is made to waive or appear to waive any of the subject’s legal rights or appears to release the investigator, the sponsor, the institution or its agents from liability for negligence.”

Thus, SRCD recommends that (a) institutional liability statements be removed from informed consent documents for research participation and (b) institutions that wish to notify prospective participants or their guardians about limits to the institution’s legal liability do so in a separate document.

SRCD appreciates the ANPRM’s inquiry into ethical justification for exclusion of some of the informed consent components listed in §46.116. For minimal risk research, too often IRBs require investigators to name in the informed consent the possibility of risks that are low in magnitude and probability. For example, a common IRB requirement is to include in consent documents for minimal risk research the statement: “you may find these questions stressful” or “your child may become upset” even when the study addresses a topic for which there is no empirical or clinical evidence to support claims of potential stress or discomfort (e.g., questions about children’s food preferences).
SRCD believes that in many research contexts a default requirement to include a specific type of risk in the informed consent when the probability and magnitude of such a risk is small can be deceptive and threaten scientific validity by unduly create an expectation of distress or harm. We recommend that when there is no evidence of specific risk, the default “risk” statement for minimal risk research should be: “This research presents minimal risks no greater than those of daily life or routine medical, dental, psychological or educational examinations or tests.”

Oral Consent and Oral Documentation of Consent

We appreciate ANPRM’s questions regarding justification for oral consent and oral documentation. Informed consent is more than a document. It is a process that whether oral or written provides a prospective participant or their guardian with sufficient information to make an informed decision about participation and provides the opportunity to ask questions. SRCD believes that in most cases persons benefit from the availability of an informed consent information sheet that they can refer to as they consider whether to participate and to refer to during their participation.

SRCD recommends that the default position on informed consent is (a) except in situations in which it is culturally inappropriate, where a written document may jeopardize participant safety, or research is conducted solely through telephone contact, and (b) whether or not information is discussed orally with the prospective participant, whenever feasible adults, adolescents and guardians be provided with an information sheet (whether on paper or via the Internet) that includes the critical elements of informed consent.

Similarly, to facilitate oversight, written confirmation of agreement to participate should be the default position except: (a) when it is culturally inappropriate; (b) would place a participant in danger; or (c) consent or guardian permission is obtained via written survey or electronic media where agreement to continue to answer questions is sufficient to document consent.

For young children with limited reading ability, presentation of assent information orally as well as waiver of written consent may be age-appropriate and should be permissible.

On behalf of the members of the Society for Research in Child Development, thank you for this opportunity to share the ideas and concerns expressed above. Should you require any additional information or have any questions please contact Celia B. Fisher, Chair SRCD Common Rule Task Force at (718) 817-3793, fisher@fordham.edu.

Sincerely,

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APPENDIX A

Age-Graded Examples of Minimal Risks Research: Common Rule Definition §46.102i

There is no independent definition of minimal risk in Subpart D, Additional Protections for Children Involved as Participants in Research. Reference to §46.102i, the Common Rule definition of “minimal risk”, is included in each of the nine Subpart D regulations. SRCD applauds the ANPRM recommendations to establish a “general population” index for assessing minimal risk. A Common Rule general standard when applied to Subpart D §46.404 “Research not involving greater than minimal risk”, will ensure that children with health problems or living in unsafe environments are not unjustly permitted to be exposed to higher levels of risk than healthy children living in safe environments simply because their daily lives are filled with greater risk.

Research involving children and adolescents is often conducted in or for schools. For such research the reference to routine psychological examinations or tests in the current minimal risk definition does not provide sufficient guidance for use of educational tests. For these reasons SRCD recommends that Federal regulations adopt the definition of minimal risk recommended by SACHRP in its letter to Secretary Sebelius:

Minimal Risk means that the probability and magnitude of harm or discomfort introduced solely by the research are not greater in and of themselves than those familiar and routine experiences ordinarily encountered in the daily life of the general population or during the performance of routine medical, dental, psychological, or educational examinations or tests.

SRCD endorses the NRPHAC, IOM and SACHRP Subcommittee on Research Involving Children (SRIC) previous recommendations that interpretations of routine medical, dental, psychological or educational examinations and tests draw upon the routine age-graded well-child or adolescent healthcare visits and age-graded tests, observations and interview procedures for routine psychological or educational screening.

The following examples illustrate the breadth and inclusive nature of information routinely collected from infants, children and adolescents:

a. During the first three years of life such routine procedures might include single blood draws, collection of voided urine, hearing and vision tests measurement of heat rate, testing of fine motor skills, intelligence tests, school readiness, observation of child behaviors or parent-child interactions, parenting education, and medical and psychological history.

b. For preschool and school age children routine procedures also include class-room observations; questions about physical or mental health relevant parent-child and peer interactions, assessment of obesity with skin-fold clippers, evaluation of modest changes in diet; a review of documented history of abuse or neglect; and tests to assess cognitive, adaptive, social, academic and emotional development.

c. In early and later adolescence routine collection of information involves examinations and tests related to pubertal development, sexual orientation, sexual knowledge and practice, substance use or abuse and screening for other adolescent and early adult onset psychological disorders.

SRCD also recommends that evaluation of minimal risk for social-behavioral components of research involving preschoolers, children and adolescents as well as adults should not be based solely on the content area covered by an examination or test (e.g., sexual behavior), but on whether the content and the method and language of inquiry is age appropriate and whether the investigator has the developmental training required to treat participants with sensitivity and respect.
APPENDIX B

Waiver of Consent §46.116 Subpart A

Under Subpart D regulation §46.408 (c) Requirements for permission by parents or guardians and for assent by children, IRBs may waive the requirement for parental permission if conditions meet the “provisions for waiver contained in §46.116 Subpart A, Informed Consent.

SRCD recommends that adequate regulatory language in and application of Common Rule §46.116 is essential to ensure that guardian permission waivers unrelated to potential harm appropriately protect the rights and welfare of children and at the same time do not deprive them of participation in research that can contribute to child health and wellbeing.

Waiver of consent under §46.116 has four criteria. In Appendix B we list the criteria and comment on the relevance of current and possible future regulatory or OHRP guidance language to protection of child and adolescent research participant rights and welfare.

§46.116 (1) The research involves no more than minimal risk to the subjects.

SRCD endorses SACHRP’s recommendation to modifications in the definition of “minimal risk”

Minimal Risk means that the probability and magnitude of harm or discomfort introduced solely by the research are not greater in and of themselves than those familiar and routine experiences ordinarily encountered in the daily life of the general population or during the performance of routine medical, dental, psychological, or educational examinations or tests.

§46.116 (2) The waiver or alteration will not adversely affect the rights and welfare of the subjects.

Procedures to ensure that guardian waiver does not adversely affect participant rights in pediatric research should be age graded and fitted to the research context. First, irrespective of other procedures, child assent materials must be developmentally appropriate in content, language and presentation. A significant body of empirical data on children’s and adolescents’ understanding of their research rights and research procedures has been generated and should provide the basis for obtaining child assent. Second, there is a growing literature on methods to enhance children’s understanding of research procedures and to encourage children and adolescents to assert their right to refuse or withdraw from participation. When feasible, such consent enhancement procedures should be incorporated into the child and adolescent assent process. Finally, for some child or adolescent populations the first two alternatives will not be sufficient. In these situations an independent participant advocate should be appointed to ensure informed and voluntary participation.

§46.116 (3) The research could not practicably be carried out without the waiver or alteration.

A number of organizations have recommended criteria IRBs might use to evaluate whether a request for waiver would meet the “practically” requirement. Below we draw and expand upon these comments to recommend 4 criteria for determining whether research could not practicably be carried out without the waiver.

a. The investigator must provide a reasonable argument that the scientific validity of the study would be compromised if consent [parental permission] was required. For example, waiver of parental permission might be necessary to guard against sampling bias and to ensure the validity of a minimal risk study on the effect of environmental noise on children’s academic performance that requires collecting data from large samples of children randomly selected from schools across a large number of geographically distinct regions.
b. The waiver [of parental permission] is justified by the study’s significant prospective scientific, educational, or applied value. Some research may be scientifically valid but knowledge generated may have little potential to significantly contribute to science or society. In such cases, IRBs should question whether scientific validity should have privileged status over participant autonomy to consent [or the additional protections provided by guardian permission].

c. The investigator provides a reasonable argument that alternative methods to obtain consent [parent/guardian permission] are not feasible. As an example, a study designed to evaluate the adequacy of mental health services provided to incarcerated youth had only a 3-day window of opportunity to conduct assessments while juveniles were waiting in detention for permanent placement. In many instances the adolescents were never visited by their parents and despite attempts many parents could not be contacted by telephone. By the time a letter to parents could arrive the juvenile would have left the detention center.

d. Neither consent nor guardian permission should be waived for convenience or solely for reasons of cost or speed or other expedient measures if doing so weakens protection of subjects’ rights and welfare. The reluctance of a subject [or parent] population to provide consent [or guardian permission] is not a legitimate reason and is antithetical to the principle of respect. This happens all too frequently when investigators find it difficult to obtain parental permission from historically marginalized populations that are distrustful of research. When a significant proportion of the research population’s [or their guardians] refuse to agree to research participation, investigators and IRBs should consider the reasons for the reluctance and use such knowledge to increase the population sensitivity of the research, recruitment and consent procedures.

§46.116 (4). Whenever appropriate, the subjects [or their parents] will be provided with additional pertinent information after participation. In the example of a juvenile detention center study described above, this requirement could be met by sending descriptions of the study and the investigators’ contact information to parents whose addresses were available and whose children had agreed to participate in the research.