



THE EXPERIENCES OF NEW YORK CITY  
FOSTER CHILDREN IN HIV/AIDS  
CLINICAL TRIALS

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with

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## Executive Summary

At the request of New York City's Administration for Children's Services, beginning in 2005 the Vera Institute of Justice undertook an in-depth examination of issues related to the enrollment and monitoring of New York City foster children in clinical trials related to the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). The request was prompted by allegations that African American and Latino children were inappropriately removed from their families and placed in foster care to facilitate their enrollment in dangerous and unnecessary medical experiments. Other concerns included whether children suffered unnecessarily as a result of their participation, whether children in trials were HIV infected, whether trial researchers properly obtained informed consent, and whether the child welfare system adequately monitored the children in their care.

The Vera Institute agreed to conduct the review under a number of conditions. First, that Children's Services search its files for children who might have participated in the trials and also provide Vera staff complete access to its files and records and the full cooperation of its staff. Second, that Vera retain full editorial control over the final report. Third, that work on the project be overseen by Vera's own advisory board. Dr. Richard G. Dudley, a Vera trustee, a psychiatrist in private practice, and a founding member of the National Black Leadership Commission on AIDS, agreed to chair Vera's Clinical Trials Advisory Board. Children's Services appointed its own advisory board of community advocates and service providers to advise it on issues related to the controversy, to assist the agency in developing a new clinical trial policy, and to facilitate dialogue between Children's Services and the communities it serves.

To conduct the study, Vera reviewers examined the child welfare files of 796 children who might have participated in HIV/AIDS clinical trials. Vera staff also reviewed policy documents and correspondence, clinical trial protocols, published reports about the clinical trials, federal and state regulations, and material from the National Institutes of Health and the federal Office of Human Research Protections obtained through the Freedom of Information Act. Staff also interviewed dozens of people with experience and perspectives on this controversy, including community advocates, clinical trial researchers, foster care agency staff, and child welfare agency personnel.

For each child whose files were reviewed, project staff sought to document the family circumstances that prompted the child to enter and leave foster care, the child's medical problems and medical treatment, and the child's participation in clinical trials. For every child who participated in clinical trials Vera reviewers also documented the consent process, whether the child had adverse consequences or medical benefits from the trial, and the medical care provided throughout the child's stay in foster care.

Vera reviewers found a significant amount of medical information in the child welfare files. However, citing confidentiality laws, the New York State Department of Health (NYSDOH) refused multiple requests from Children's Services that it use its supervisory authority to allow

staff from Vera or Children’s Services to review clinical trial research or medical records. This limited Vera’s review in several ways, including the ability to fully document the frequency and severity of toxicity (side effects), the individual outcomes of trial participation for the children in the review, and the existence of valid, signed informed consent documents.

## **Background**

The first cases of HIV/AIDS in children were reported in New York City in 1982. Between 1977 and 2006, 3,895 children in New York City were born with HIV infection.

## **Findings**

Vera’s review of the child welfare files identified 532 New York City foster children who participated in 88 clinical trials and observational studies between 1985 and 2005. Of the 88 clinical trials and observational studies, 65 involved trials of new medications for HIV or its associated conditions. Forty-four of the 65 trials involved antiretroviral drugs.

*Vera reviewers found little or no evidence in the information examined for some of the concerns that prompted Children’s Services to initiate this study.*

1. Many children—inside and outside of foster care and clinical trials—died because of complications of HIV/AIDS during the late 1980s and 1990s. Eighty of the 532 children who participated in clinical trials or observational studies died while in foster care; 25 of them died while enrolled in a medication trial. Vera medical staff did not find, however, that any child’s death was caused directly by clinical trial medication.
2. An examination of data from the New York City Department of Health and Mental Hygiene, though not conclusive, suggests that HIV-positive foster children who were enrolled in clinical trials and/or observational research studies did not experience an increased risk of death from their enrollment in clinical trials.
3. The child welfare files contained information indicating that some children experienced serious toxicities, or side effects, from trial medications, such as reduced liver function or severe anemia. These toxicities were consistent with toxicities described in published articles about the trials. Vera reviewers found many instances where a physician made adjustments to a child’s treatment in light of these problems as required by the clinical trial protocol.
4. Where documentation allowed reviewers to make a determination, children in foster care met age, HIV status, and disease stage criteria for inclusion in the specific trials in which they were enrolled as described in the trial protocol. Reviewers found that two of the 532 children met exclusion criteria for the medication trials in which they were enrolled.
5. Of the children who participated in trials, Vera identified two who were HIV exposed, but for whom there was evidence suggesting they *might* not have been infected with HIV. Vera project leaders informed Children’s Services about these two cases. Children’s Services

subsequently responded that inquiries to state and local agencies had confirmed a diagnosis that made it appropriate for one of the children to participate in the clinical trial. Children's Services has not provided additional information on the second child, who died of causes unrelated to clinical trials participation.

6. In 1988, when city officials first considered the participation of foster children in clinical trials, the child welfare agency conducted a lengthy review of state and federal research regulations. The social services commissioner and his staff were aware of concerns about the participation of African American and Latino children in medical research and they consulted with several medical experts, including the National Medical Association (an organization of African American physicians). The standard the agency developed for approving trials—that every child in foster care enrolled in a trial have the possibility of benefiting from that trial—exceeded that of federal regulations. The policy also required that researchers obtain informed consent from a birth parent when parental rights remained intact.
7. In response to physicians' and some advocates' requests for faster trial approvals, the child welfare agency changed its policy in 1991. The new policy called for a medical advisory panel (MAP) of physicians to review and make a recommendation to the commissioner on whether a trial met the agency's standards for approval. Seventy-six percent of foster child enrollments in medication trials that took place after this policy change were in 15 trials recommended by the MAP and approved by the commissioner. Researchers and child welfare staff often followed Children's Services' policy to obtain permission for a child to enroll in a trial.
8. Many files document medical researchers' discussions of the risks and potential benefits of trial enrollment with a birth parent and the parent's subsequent permission to enroll the child. In several cases, parents did not want their children in a clinical trial and the child did not participate in the trial.
9. Children in foster care appeared to participate in trials at rates that suggest they were not specially targeted for enrollment into HIV/AIDS clinical trials. Foster children made up 30 percent of all New York City enrollments in 16 trials of medical interventions for which city-level data were available. Thirteen percent of these enrollments occurred *prior* to the child's entry into foster care, with participation extending into the period they were in foster care.
10. Children in foster care who participated in HIV/AIDS clinical trials were predominantly African American and Latino (64 percent African American and 30 percent Latino). This demographic profile paralleled the demographics of children with HIV infection in New York City (58 percent African American, 35 percent Latino).
11. There was no evidence in the child welfare files of children being removed from their families by Children's Services because a parent refused to consent to a child's participation in a clinical trial. Three-quarters of the children entered foster care before age one year and more than half entered directly from a hospital after birth. Families faced many issues such as substance use, unemployment, and poverty that were exacerbated by the medical needs of children and parents with HIV/AIDS.

12. Several files documented differences of opinion between child welfare staff and both birth and foster parents concerning antiretroviral medications prescribed *outside of clinical trials* and *after the approval* of the medication by the U.S. Food and Drug Administration (FDA). These differences were resolved on a case-by-case basis. Sometimes this involved continued monitoring and alternative treatments; in other cases it resulted in removal from parents or legal guardians or the transfer of a child to a new foster home.
13. Vera reviewers found no evidence in the child welfare files, clinical trial protocols, or interviews that children, parents, foster parents, foster care agencies or staff, or child welfare agencies or staff received incentive payments for children to participate in clinical trials. Vera's study of this issue was limited to information in child welfare, policy files, and public information from the NIH on the funding of their clinical trials.

*The Vera review also found evidence that supported some concerns about the participation of foster children and their families in clinical trials. This evidence includes violations of state regulations, Children's Services' own policies for clinical trial review and enrollment, and federal regulations for protecting human subjects.*

1. Child welfare agency policy after 1991 called for a review of clinical trials by a Medical Advisory Panel and approval by the commissioner. However,
  - Twenty-one children participated in three medication trials that the MAP reviewed and did *not* recommend and the commissioner did not approve. Thirteen of these enrollments took place before the children entered foster care.
  - Thirteen children participated in four medication trials that the MAP had reviewed but for which no recommendation had been forwarded to the commissioner. Two of these enrollments took place before the children entered foster care.
  - Sixty-four children participated in 30 medication trials that were not reviewed by the MAP. Thirteen of these enrollments took place before the children entered foster care.
2. Regulations and policy required the child welfare agency to retain signed informed consent forms, commissioner approval documents, and other documentation for each trial and each enrollment. For 21 percent of enrollments in medication trials that took place while the children were in foster care, signed informed consent forms were not found in the child welfare files.
3. Trials sponsored by the National Institutes of Health were monitored by an organization charged with ensuring that an informed consent document was present in the research records for each enrolled child. Without access to clinical trial research records, Vera cannot say whether or not a valid informed consent document existed in every case.
4. In at least 16 cases, Vera staff found that children in foster care appeared to have been enrolled in trials prior to the commissioner's approval of the trial. In some instances, HRA/ACS took several months to approve a trial.

5. In at least seven enrollments, the person who signed an informed consent form was not legally authorized to do so. Kinship foster parents, parents without parental rights, and child welfare staff signed the consents in these cases.
6. Federal regulations required informed consent forms to be written in accessible language. Many informed consent forms contained technical language difficult for people without a medical background to understand.
7. The role and requirements of the independent advocate described in federal research regulations were not well understood by clinical trials researchers and, in some cases, child welfare staff. In at least six instances where Vera reviewers found that an independent advocate had been appointed, the person appointed had relationships to the institution conducting the trial or a child welfare agency that the federal regulations specifically bar.
8. In several situations, child welfare files described deviations from the processes required by federal regulations and Children's Services policy. These include handwritten notes for informed consent in lieu of official documents, consent accepted over the phone, and consent sought or obtained from parents who may not have been competent to provide it. In at least two instances, the files indicate that parents' wishes were ignored. In other situations, consent was requested in ways that parents might have perceived as coercive.
9. Although state regulations mandated that Children's Services ensure the retention of most of the child welfare files that Vera was asked to review, for 30 percent of the children, some part of the child welfare file was lost, destroyed, or otherwise unavailable.
10. Available records often did not contain documentation required by state regulations.
11. Though required to collect information related to HIV testing, HIV-related medical care, and clinical trials enrollment, the records of the Pediatric AIDS Unit (PAU) were incomplete, especially after 1995. Problems with the PAU's record keeping after 1995, including defects in the unit's electronic database, were noted in the unit's quarterly reports to supervisors and state officials, including the AIDS Institute.
12. Foster care agency staff approved at least 14 enrollments of children who were in the joint guardianship of the commissioner and the foster care agency. Although conforming to the technical requirements of the policy, this resulted in the enrollment of several foster children in trials the commissioner had not approved. Three of these children were enrolled in a phase I clinical trial even though Children's Services' policy barred participation in phase I trials.

*Results of Clinical Trials in which New York City Foster Children Participated.* There are presently 15 medications approved by the FDA for the treatment of pediatric HIV. The FDA approved these medications after it reviewed data from clinical trials and determined that the data showed the drugs were safe and effective for widespread use by children living with HIV. Five antiretroviral medications and three HIV vaccines tested in clinical trials in which foster children participated have not been approved by the FDA for pediatric use. All five of the antiretrovirals (but not the vaccines) have been approved by the FDA for use in adults.

## Recommendations

There is a continuum of situations in which children might be considered for clinical trials. Each point on this continuum contains a different set of risks and potential benefits. For children in foster care there are additional concerns. These include the effect enrollment in a trial will have on placement stability and how close a child is to entering a permanent home where adoptive parents can assume decision-making responsibility.

Some people feel that child welfare agencies should not allow children in foster care to participate in any clinical trials. In support of their position, they often cite the history of medical research involving African American and Latinos and the vulnerability of foster children. Others feel that children in foster care, including African American and Latino children, should have the same chance to participate in the development of new treatments as other children and that they should not be denied access to a promising new medication because they are no longer in their parents' care. It is not the Vera Institute's role to take a position in this debate: elected and appointed officials, in consultation with community and professional representatives, are charged with making clinical trials policy for foster children.

The knowledge gathered in this study does, however, provide a basis for Vera and its Clinical Trials Advisory Board to make recommendations for those policymakers who do decide to allow foster children to participate in clinical trials. The recommendations presented here are aimed, in part, at remedying the problems that this report identifies. Children's Services has developed a new clinical trials policy. The recommendations below can be seen as a set of benchmarks that child welfare staff, elected representatives, and community advocates can use to measure progress in addressing the concerns this report raises.

### 1. Respect Parental Decision Making

*Concern:* Parental rights were not respected in every case.

*Recommendation:* Only researchers and their staff, not foster care agency staff, should obtain permission for a foster child's participation in a clinical trial.

*Recommendation:* In cases where the parents cannot be engaged and the child welfare commissioner feels it is imperative that a child enroll in a clinical trial, a person representing the child's interest and not connected to either the foster care agency or the medical institution, such as a law guardian or family court judge, should provide a written determination that participation in the clinical trial is in the child's best interest.

### 2. Make Detailed Policy

*Concern:* New York City's clinical trials policy in the 1980s and 1990s did not detail procedures for how to handle many issues. The policy documents Vera reviewed did not anticipate several frequently occurring situations, leaving staff to improvise in a pressured environment that involved legally and ethically complex decisions.

*Recommendation:* Children's Services should create detailed policy guidelines that can apply across a range of child welfare and medical/public health circumstances.

### **3. Ensure That Staff Understand and Agree to Abide by the Rules**

*Concern:* Vera staff found that not all child welfare and clinical trial research staff knew the regulations and policies regarding the participation of foster children in clinical trials.

*Recommendation:* Require staff involved in the participation of foster children in clinical trials—within child welfare and at medical institutions—to have a regularly updated certification indicating that they understand and agree to follow the applicable rules and regulations.

### **4. Increase Transparency and Community Involvement**

*Concern:* The policy that allowed the participation of foster children in HIV/AIDS clinical trials was discussed publicly and disseminated to physicians, foster care agency staff, and staff in New York City's child welfare agency. Child welfare officials received input from many medical experts and child welfare professionals. However, there is little evidence that community constituents, including parent and child advocacy organizations, were involved.

*Recommendations:* Given community concerns about medical research and specifically about the participation of foster children in medical research, Children's Services should take steps to ensure that clinical trials policy development and oversight involve child and community advocates and representatives of African American, Latino, and other constituencies as well as medical and child welfare professionals.

### **5. Maintain Commissioner Control of Trial Enrollments for Children in Guardianship**

*Concern:* For a period in the 1990s, foster care agencies approved enrollments of foster children in joint guardianship.

*Recommendation:* Only the commissioner of Children's Services should have the right to approve or reject trial enrollments for foster children who are in the sole or joint guardianship of the commissioner.

### **6. Document Activities**

*Concern:* Many of the clinical trials examined in this report were conducted during a difficult period for New York City and its child welfare agency. Nonetheless, the violations of regulations and policy concerning file documentation and retention prevented officials from providing required information about the participation of foster children in HIV/AIDS clinical trials.

*Recommendations:* Children's Services should provide public reports that demonstrate that the agency is ensuring that regulations regarding record keeping for all foster children are being followed. Government must ensure that child welfare personnel have the resources to adequately staff operations to accomplish this work.

### **7. The New York State Department of Health Should Authorize the Review of Medical Records**

*Concern:* The New York City Law Department determined that only the New York State Department of Health has the right to conduct or authorize a review of medical and clinical trial records of foster children who participated in HIV/AIDS trials—even when hospitals agree to have the files reviewed. Children’s Services asked NYSDOH to exercise this supervisory authority on several occasions and in several ways. The NYSDOH declined these requests.

*Recommendation:* The NYSDOH should either authorize Children’s Services to obtain copies of the informed consent forms used to permit children to enroll in the clinical trials and other relevant information that Children’s Services may request or conduct its own investigation.

### **8. Actively Manage Clinical Trials Issues**

*Concern:* In the late 1980s and early 1990s, HRA put considerable resources into increasing the number of employees of the PAU and hired staff with strong credentials. The performance of the PAU declined, however, after 1995.

*Recommendations:* Children’s Services should manage clinical trials issues actively. In addition to providing sufficient staff and resources, Children’s Services should also consider conducting regular reviews of clinical trials policy during times of increased participation.

### **9. Use High Standards for Clinical Trial Enrollment**

*Concern:* Children’s Services policy used the standard that a trial must offer a potential treatment benefit to *every* foster child who might enroll in a trial.

*Recommendations:* For each foster child who might enroll in a clinical trial, Children’s Services should ensure that the anticipated benefits outweigh the risks of harm. In addition, Vera urges Children’s Services to restrict foster child enrollment to trials in which the individual child has the possibility of receiving a clinical benefit not available outside the clinical trial.

### **10. Manage Conflicts of Interest**

*Concern:* By relying on external pediatric HIV/AIDS experts to help implement its clinical trials policy and response to the onset of pediatric HIV, Children’s Services had little choice but to draw from a small circle of people who shared professional relationships. In some situations, this created real or apparent conflicts of interest.

*Recommendations:* Children’s Services should adopt a conflict of interest policy relating to clinical trials research.

For nearly five decades, the Vera Institute of Justice has provided stakeholders and the general public with information and recommendations aimed at reforming and improving public policy. The authors of this report and their advisors have sought to stay true to this tradition. It is our hope that the information presented here will inform the debates that are sure to follow, and lead ultimately to improvements in the services that people rely on for safety and justice.