Purpose

To provide an overview of the effectiveness of data collection efforts related to passive versus active consent.

Background

Passive consent, also known as “opt out,” allows for a student to take surveys and answer questions not related to the setting they are in i.e. school without parental consent for each data gathering effort. This time of consent allows a parent or subject to “opt out” of taking the survey(s) at a prescribed time or at the time of collection. Active consent or “opt in” requires a parent and or subject to actively agree to participation in data collection efforts at a prescribed time or at the time of data collection.

Over the years, many states, communities and schools have employed a variety of consent measures. The parameters of consent have been implemented for different reasons including ease of data collection, informed consent, participant protection and other community contextual factors. As locations of data collection have moved from a less restrictive level of consent to a more restrictive level, studies have been done to determine the extent and consequences of this changing practice.

Research Findings

Five studies were reviewed including a case study done in Hudson County New Jersey for this review. In general each of the peer-reviewed articles indicated a significant variance of participation related to active versus passive consent (60%-80%), with a low of 30% participation for active consent and a high of 100% participation for passive consent (Tigges, 2003). Additionally, the parents of individuals who are more likely to have mental health or substance abuse concerns are less likely to participate in surveys, reinforcing existing disparities in access to mental health services (Chartier, Stoep et al, 2008). Furthermore, active consents create a selection bias that allows for a lower-than-actual reporting of cannabis and ecstasy use substance-using behaviors (White & Hill, Effendi, 2004). Lastly, the cost of data collection significantly increases when using active consent procedures, an additional $20-$25 per student (Chartier, Stoep et al, 2008). The results of a single county’s experience with active consent in 2012, yielded significantly divergent response rates (10%-80%) resulting in an inability to generalize findings for various schools due to a sample error greater than 95% (Dzierzawski, 2012).

Recent research investigated how to increase participation, with active consent which could result in improved response rates. The study used 3 methods to obtain active consent; these were based on school principals' suggestions. In method 1, the consent request was sent to the students' home with the report card, which required parental signatures. In method 2, the school sent consent requests to the students' home. The parents were required to sign and return the form. In the final method (3) the consent forms were sent to the students homes with self-addressed stamped postcard to be returned with parents' signatures. In this study method 1 was the most successful requiring little staff follow-up and a return rate of 85%. Method two required some staff follow-up and yielded return rates of 55% to 82%. Method three required more follow-up than the rest and the return rate was only 33%. (Pokorny, 2016)

Conclusions

The intent of active consent is to provide appropriate levels of protection for individuals involved in data collection efforts. Research and on the ground experience demonstrates that this practice significantly reduces the validity and reliability of the data and increases selection bias. This leads to the potential of under reporting, enhancing existing misperceptions, and increasing the likelihood of misallocation of resources.

Decisions regarding the use of active versus passive student are complex. A consideration of norms in the community, IRB guidelines, and the funding infrastructure should be helpful. These can lead to passive consent implementation within these considered guidelines that yield the same protection results that active consent provides.

References

Chartier, M., Vander Stoep, A., McCauley, E., Herting, J. R., Tracy, M., & Lymp, J. (2008). Passive Versus Active Parental Consent: Implications for the Ability of School-based Depression Screening to Reach Youth at Risk. Journal of School Health, 2008 March 78(3): 157-186.

Courser, M., W., Shamblen, S. R., Lavrakas, P. J., Collins, D., & Ditterline, P. (2009) The impact of active consent procedures on nonresponse and nonresponse error in youth survey data: evidence from a new experiment. Evaluation Review, 07/2009; 33(4):370-95.

Dzierzawski, D. 2012. Drug use in Hudson County N.J.

Pokorny, S. B., Jason, L. A., Schoeny, M. E., Townsend, S. E. & Curie, C. J. (2001). Do participation rates change when active consent procedures replace passive consent. Evaluation Review, Evaluation Review, 11/2001; 25(5): 567-80.

Pokorny, S.B. (2016, July 18). Active vs passive consent. 3C Institute: Where Research and Practice Come Together. Retrieved from http://www.3cisd.com/active-vs-passive-parental-consent?p=1702

Tigges, B. B. (2003). Parental consent and adolescent risk behavior research. Journal of Nursing Scholarship. 2003: 35(3): 283-89.

White, V. M., Hill D. J., & Effendi, Y. (2004). How does active parental consent influence the findings of drug-use surveys in schools?. Evaluation Review. 06/2004; 28: 246-260.