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Is it effective? The state of sexual health education for adolescent students with intellectual disabilities in British Columbia

by

Sari Glavin

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We accept this Thesis as conforming to

the required Standard.

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Dr. Amanda McKerracher, Thesis Faculty Supervisor April 27th, 2018
Faculty of Education,
Vancouver Island University

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Dr. David Paterson, Dean, Faculty of Education April 30th, 2018
Vancouver Island University

Abstract

A review of available literature indicates that sexual health outcomes for adolescent students with intellectual disabilities (ID) have been understudied in British Columbia. The research available indicates that adolescent students with ID experience a number of significant sexual health inequalities in comparison with their neurotypical peers including, unplanned pregnancy, sexually transmitted infection (STI) rates, and prevalence of sexual abuse. This study seeks to examine if there is a relationship between these inequalities and the relationship between the type of sexual health education students with ID are receiving in British Columbia. Specifically, this study asks, what the breadth and the depth of sexual health education is for students with ID in British Columbia and what specific challenges special educators face when trying to teach their students sexual health and how they try to overcome these challenges.

Both quantitative and qualitative data were collected through an online survey and were analyzed using a mixed methods research design. Based on the analysis, students with ID, in British Columbia, have limited access to learning sexual health education topics and sexual health education delivery methods, specifically evidence based practices, are inconsistent for students with ID. Challenges to teaching sexual health for adolescent students with ID include, lack of support from colleagues, administration, and parents in addition to a lack of professional development. Solutions include, professional development, specifically in sexual health education for students with ID, for classroom teachers, specialist teachers, parents and administration, in addition to improvement in communication between education assistants, classroom teachers and specialist teachers.

Keywords: Intellectual disability, sexual health education, teacher practices

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Chapter 1

Overview

Background

In British Columbia's elementary, middle, and high school curricula, there are components of Sexual Health Education in the Provincial Core Competencies. In the elementary years, the focus is on the student knowing and understanding their bodies and what healthy choices they can make to maintain a healthy body. As a student ages, the themes of the sexual health curriculum expand and become more focused on knowledge of specific health topics that assist students in understanding their growth and development such as: understanding social, physical, and emotional changes in adolescents, understanding personal boundaries, healthy sexual decision-making, and learning how to prevent HIV/AIDS and other sexually-transmitted infections. There are many opportunities for students graduating with their high school diploma (Dogwood Certificate) to understand concepts of the sexual health curriculum. In fact, unless parents/guardians stipulate that they do not want their children to partake in the sexual health syllabus, these topics are mandated curriculum competencies that a student must undertake in order to graduate. But how do these sexual health core competencies and learning outcomes, mandated for students educated in the Dogwood Diploma stream, translate to students who are on a different of graduation track?

What is an intellectual disability?

The Ministry of Education (2016) in the Province of British Columbia, divides intellectual disability into two categories: (1) Mild Intellectual Disability and (2) Moderate to Profound Intellectual Disability.

> A student with a mild intellectual disability has intellectual functioning that is 2 or more standard deviations below the mean on an individually administered Level C assessment instrument of intellectual functioning, and has limitations of similar degree in adaptive functioning in at least two skill areas appropriate to the student's age […] A student with a moderate to profound intellectual disability has intellectual functioning that is 3 or more standard deviations below the mean on an individually administered Level C assessment instrument of intellectual functioning, and has limitations of similar degree in adaptive functioning in at least two skill areas appropriate to the student's age (p.41).

Students with an intellectual disability, whether mild or moderate to profound, may show needs in the areas of adaptive behavior, usually experiencing significant delay in social-emotional development in addition to possible gross and fine motor skill deficits, communication deficits, social reasoning limitations, difficulties with memory, difficulties with problem solving, and difficulties with conceptual skill acquisition.

Individual Education Plan

The Ministry of Education (2016) in the Province of British Columbia defines an Individual Education Plan (IEP) as the following:

> An IEP is a documented plan developed for a student with special needs that describes individualized goals, adaptations, modifications, the services to be provided, and includes measures for tracking achievement […] Some students require small adaptations and minimum levels of support; other students with more complex needs may require detailed planning for educational modifications, adaptive technologies, or

> health care plans. The IEP will reflect the complexity of the student's need and, accordingly, can be brief or more detailed and lengthy (p. 16).

A modification is defined as, “instructional and assessment-related decisions made to accommodate a student’s educational needs that consist of individualized learning goals and outcomes which are different than learning outcomes of a course or subject” (Ministry of Education, 2016, p. VI). An adaptation is defined as, “teaching and assessment strategies especially designed to accommodate a student’s needs so he or she can achieve the learning outcomes of the subject or course and to demonstrate mastery of concepts” (Ministry of Education, 2016, p V). The IEP does not have to report every detail of a student’s education program. However, modifications or adaptations employed to teach the student should be referenced in the IEP (Ministry of Education, 2016, p. 17).

The Ministry of Education (2016) describes best teaching practices for educating students with Mild Intellectual Disabilities and those students with Moderate to Profound Intellectual Disabilities:

> While individual needs may differ, many students with mild intellectual disabilities will require specific instruction for the acquisition of academic skills, personal independence, social responsibility and life skills, as well as with reasoning skills, memory, problem solving and conceptualizing skills […] The older the student or the more severe the disability, the greater is the need for functional educational objectives. Since the skills taught should be those that afford many opportunities for practice, and since teaching should be in preparation for adult life in the community, the student will need an increasing degree of educational instruction in community environments (p. 44).

Thus, educational opportunities for students with intellectual disabilities must be specific and have occasions for repetition and practice.

Adolescence

The World Health Organization defines adolescence as, "…those people between 10 and 19 years of age" (World Health Organization, n.d.). In British Columbia students who are between the ages of ten to nineteen fall typically between grades four to twelve.

Statement of the problem

Students with intellectual disabilities experience similar physical growth and development patterns as their neurotypical peers. However, there is no specified educational requirement for sexual health education for students on an Individual Education Program (IEP). Coco and Harper (2002) state that,

> [p]olicy changes, especially those related to community integration and inclusion, have dramatically altered the lives of people with mental retardation over the past 30 years…[this] has resulted in multiple benefits for people with mental retardation, including increased opportunities and better integration of their participation in the community (p. 35).

Yet, along with this opportunity for increased interaction with peers and connection with people in their community, are a myriad of safety concerns. Utley, Reddy, Delquadri and Greenwood (2001) state that,

> Prevention instruction and making children aware of risks in their environment are important issues, it becomes essential for students with developmental disabilities to have a curriculum that teaches good health habits, an awareness of dangerous situations encountered at home and school, and the teaching of safety facts (p. 2).

The Ministry of Education states that:

> British Columbia promotes an inclusive education system in which students with special needs are fully participating members of a community of learners. Inclusion describes the principle that all students are entitled to equitable access to learning, achievement and the pursuit of excellence in all aspects of their educational programs. The practice of inclusion is not necessarily synonymous with full integration in regular classrooms, and goes beyond placement to include meaningful participation and the promotion of interaction with others (Ministry of Education, 2017).

Students on an IEP are not necessarily beholden to the same curriculum as the peers in their inclusive classroom. Thus, it is entirely possible to create meaningful goals in an IEP for a student with intellectual disabilities (ID) that would teach them about risks in their environment and how to make health living choices.

Students with intellectual disabilities, like their neurotypical peers, may be exposed to similar peer pressures of substance abuse and sexual activity. Yet, there is no mandated health curriculum geared to the learning needs of students with intellectual disabilities that teaches students, how to make safe choices. While students with intellectual disabilities can take sexual health education with their peers, these students require their learning in sexual health to be delivered in a specific and measured way in order for it to be effective (Blanchett & Wolf, 2002). Greenwood and Wisconsin (2013) hypothesize that "a lack of biological and health knowledge may correlate to a lack of practical knowledge (i.e., how to properly put on a condom) that may put adults with ID at increased risk of negative sequelae of sexual activity" (p. 2).

If students with intellectual disabilities do not receive sexual health education in a format that meets their learning needs, they are disadvantaged in understanding how to take care of their bodies, how to have safe sex, and how to protect themselves from unwanted sexual attention.

McDaniels and Flemming (2016) state the following:

> Sexual education is an important part of the development of every adolescent. Considerable challenges exist in providing effective and appropriate sexuality education for adolescents with intellectual disabilities (ID); including lack of training of school personnel and lack of adequate materials suitable to meeting the special needs of students. As children begin to mature and progress through the stages of puberty, they begin to experiences new feelings and desires that need to be acknowledged and addressed (p. 220).

Ramage (2015) reported that adolescents with intellectual disabilities have a limited knowledge about their sexual health education and, without effective information and education, there can persist a lack of sexual health education that negatively impacts them not only in their adolescence but also into their adulthood. Their lack of knowledge impacts their understanding of healthy relationships, and healthy bodies that can, in turn, translate into an inability to recognize sexually transmitted infections, to maintain hygiene, and to recognize when personal boundaries have been violated. "Youth with a disability are particular vulnerable to abuse. Students who report having a limited health condition or disability were more than twice as likely to as their peers to report being physically abused and were three times more likely to report both physical and sexual abuse" (Smith, A, Stewart, D, Peeled, M, Poon, C Seawye, E and the McCreary Centre Society (2009, p. 42). In addition, adolescents

and adults with ID have a greater risk at contracting a sexually transmitted disease and are 50 percent more likely than their peers to become pregnant (Cheng and Udry, 2005).

Practice and the Literature

Jeda (based on an amalgamation of students represented in the literature and practice) is a girl in the last years of high school. Jeda has a moderate ID. She is a very quiet person and has difficulty with expressive and receptive language. Jeda fits in well with her peers. She dresses in the same style of clothes and she has learned to mirror the body language of the different groups with which she associates. If she does not talk, it is very difficult to identify that she has an ID. She has taken Physical Health Education (PHE) 10 with a sexual health component with her peers. In the PHE 10 class, there were learning opportunities concerning staying safe online and how to react to unwanted sexual attention.

Jeda has one female friend that she has had since elementary school. Staff have noticed that Jeda is spending less and less time with her friend. Jeda lives with her mother but does not stay at home very often, preferring to hang out by the local coffee shop. Various staff members who live in the community have reported seeing Jeda hanging out with a male in his thirties after school and into the evenings. Despite having had PHE 10 Jeda does not recognize the dangers that associating with this new "friend" may pose for her.

In a study by Frawley and Nathan (2016) young people with ID living in Australia were interviewed regarding their sex health education. Girls reported that they had received information on topics of hygiene and menstruation both at school and at home. However, on topics such as sexual intercourse and relationships, the girls reported that they had received little information and reported that what they received at school was not useful. Sources such as films in mainstream classes were mentioned. These women chose to access the internet for

sexual health information, citing that they had little information on "how to have sex and how to control sexual relationships" (p. 480). Boys reported that while they had had "some" sexual education at school, they sought out family, particularly siblings, for further information. Most of the men interviewed stated that they received most of their information from movies, pornography, and talking to friends. Topics they were interested in learning about included masturbation, how to socialize with girls, and how to have a girlfriend.

Statement of need

There is little research regarding sexual health education for students with ID in British Columbia. Questions such as *Who is teaching sexual health to students with ID?* And *How is it being taught to students with ID?* are unanswered. Because educational programming for students with ID is laid out in their IEP goals and objectives, unless sexual health topics are stipulated in the IEP, they are not legally mandated to be taught. This is a significant divergence from expectations for students on a Dogwood Diploma track, who must take sexual health as part of their graduation requirements. Because students with ID often develop physically as quickly as their non-disabled peers, and because they are more likely to engage in risky sexual behaviour or be targets of abuse, it is imperative that they are taught sexual health topics. Are educators providing a sexual health curriculum to students with ID that explores the skills and knowledge in a developmentally appropriate manner? Giulio (2003) states that, "… teachers must equip themselves with the necessary knowledge and skills to provide comprehensive and appropriate sexuality education" (p.7). This study seeks to uncover what the level of professional development teachers have to teach/modify/adapt sexual health education programs to their students with ID. It also seeks to uncover what the educational environments are that support students with ID obtaining sexual health programs

and identify any barriers that may exist to prevent successful, empirically validated sexual health programs from being taught.

Research questions

What is the breadth and depth of sexual health education that students with ID are receiving in province of British Columbia? What are the challenges that educators experience when implementing sexual health education for their students with ID?

Contributions

This mixed method study seeks to add to the understanding of the breadth and the depth of sexual health curricula delivered to students with ID in selected school districts in the province of British Columbia. By beginning to identify the gaps in consistency of sexual health curricula delivery to students with ID, it is hoped that educators can begin to remedy the problem. An online survey was used to acquire data from ten school districts across British Columbia. Survey responses provided much needed data regarding the type of sexual health education that British Columbia's ID students are receiving. Data outcomes revealed gaps in curriculum content, methods for delivering sexual health content, areas for professional development for teachers delivering sexual health curriculum, barriers to curriculum delivery address by teachers, and successful teaching methods based on information provided by teachers.

Chapter 2

Literature Review

Introduction

This Literature review begins in the past. The history of education, and attitudes towards people with ID is explored and reveals a potential explanation for the lack of sexual health education for adolescents with ID today. A definition of sexual health, provided by the Ministry of Education of British Columbia, and the IEP process, are explained. We then explore a theoretical framework employed by this study, which provides information about how a lack of sexual health information affects people with ID, followed by understandings about sexual health knowledge for people with ID. We then look to people with ID and their parents to explore their perspective about sexual health education. Theories of sexual health topics that are important for adolescents with ID to learn are examined and effective teaching strategies to teach those topics are revealed. The final section concludes the literature review with common barriers that teachers face when teaching sexual health curriculum to students with ID. It should be noted that there is significant gap in the research about sexual health curriculum within Canada. The lack of Canadian research in this review is a reflection of the lack of peer reviewed data and Canadian content regarding sexual health and people with ID.

History of education for people with Intellectual Disabilities

From approximately 1878 until as recently as 1996, people with ID were housed and received some schooling in segregated institutions in British Columbia (Inclusion BC, 2017). Institution settings were seen as the right environment to educate and care for people with disabilities in a way that families and communities could not. Parents of children with disabilities were encouraged by the medical community to bring their children to these

institutions where it was thought they would receive the care they needed. This institutionalization was fraught with abuse of people with disabilities. People with disabilities lived in these institutions and were separated from their families and their communities. Some people were separated from their families for their lifetime (L'Arche, 2014, p. 5).

As early as the 1950's parent advocacy groups began to lobby the government to provide different housing, education, and community access for their children with disabilities. In 1975, the United Nations adopted the Declaration of Rights for Disabled Persons. In 1982 The Canadian Charter of Rights and Freedoms declared physical or mental disability as a prohibited reason for discrimination (Inclusion British Columbia, 2017). Because of parent advocacy and shift in government policy, students with disabilities have moved from being schooled in segregated settings, to being in separate classrooms in their community schools, to recently receiving education in classrooms with their neuro-typical peers (Inclusion BC, 2017).

History of sexual health education for individuals with Intellectual Disabilities

Historically, Individuals with intellectual disabilities have been denied access to sexual health education and the opportunity for sexual decision making. Povilatiene and Radzeviciene (2010) write that, "[s]ociety believes that persons with intellectual disabilities are considered to be eternal children, non-sexual and lifelong virgins" (p.108). In 1933, the Sexual Sterilization Act of BC allowed any guardian of a person with an intellectual disability to sterilize their child/adult without the child's/adult's consent. There has also been, and continues to be, an assumption that people with intellectual disabilities are asexual and thus their needs for sexual health education are ignored (Murphy &Elias, 2006). Milligan and

Neufeld (2001) state that that misinformation can result in a, "self-fulfilling prophesy, leading people with disabilities to retreat from intimacy and sexuality" (p. 102).

Definition of sexual health

The Ministry of Education of British Columbia (2017) describes the following as a rationale for Physical and Health Education:

> Physical and Health Education (PHE) is designed to develop educated citizens who have the knowledge, skills, and understandings they need to be safe, active, and healthy citizens throughout their lives. PHE (Physical Health Education) curriculum focuses on competencies that support life-long learning—competencies that can contribute to personal lives and career aspirations.
>
> PHE emerges from two areas of learning, physical education and health education, that are brought together in order to promote and develop all aspects of well-being. The PHE curriculum is strongly linked to the personal awareness and responsibility core competency. The personal awareness and responsibility competency addresses the skills, strategies and dispositions that help students to stay healthy and active, set goals, monitor progress, regulate emotions, respect their own rights and the rights of others, manage stress and persevere in difficult situations (Ministry of Education Government of British Columbia).

The curriculum for Health Education is broad and spans core competency knowledge (i.e., understandings that must be achieved in order to move to the next competency). Topics include, but are not limited to: identifying body parts, hygiene, inappropriate and appropriate touching, substance abuse, sexually transmitted diseases, and healthy sexual decision making.

All students who graduate from grade twelve in British Columbia with a Dogwood Diploma must take PHE as a graduation requirement unless parents or guardians express concerns.

The IEP process in British Columbia

For students with disabilities who are unable or unsuited to meet the requirements of a Dogwood Diploma (high school diploma) in British Columbia's public school system, an Individualized Education Plan (IEP) is developed for the student by a team of professionals in consultation with their parent or guardian. Students on an IEP who are unable to meet the Dogwood graduation requirements typically graduate with an Evergreen Diploma, which represents a school completion certificate rather than formal high school graduation. In order to leave grade 12 with an Evergreen Diploma, students must obtain the following:

> For students pursuing an Evergreen Certificate, their education program should enable them to meet their individual learning goals. Accordingly, they should have an Individual Education Plan (IEP) that indicates their personal education goals, how the goals will be achieved, and on-going monitoring and assessment to know when the goals have been met and an Evergreen Certificate should be issued (Ministry of Education 2017).

Students with ID technically do have access to the PHE curriculum through inclusion. Some of the difficulty to sexual health education access, for students with ID, lies in its delivery and content topics. Ramage states that, "…limited sexual health education has been offered to them. Existing programs are rarely specific to the needs of this population. Specifically, research has shown that individuals with intellectual disabilities receive less sex education than their non-disabled peers" (2015, p. 8). The information is presented in a way that is focused on students without learning concerns. Unless a sexual health learning goal is

stipulated in a child's IEP there is no focused evaluation of a student's knowledge of sexual health curriculum content. For our student Jeda, there is an immediate need for her to focus on the topics of, personal boundaries and the concepts of friendship and consent.

Theoretical frameworks and sexual health education for students with Intellectual Disabilities

Finding theoretical frameworks for delivery of sexual health education for students with ID is problematic. Sexual theory is grounded in Masters and Johnson's (as cited in Giulio, 2003, p. 2) Sexual Response Model, which categorises sexual response as a physiological staged sequenced, linear-based model of sexual health function. Giulio (2003) states that "[p]hysiological, linear based models of sexual response, such as that adopted by the DSM (Diagnostic and Statistical Manual of Mental disorders-IV-TR) can be problematic in terms of their suitability for addressing the sexual health issues of people with disabilities" (p.54). A disabled person's healthy (i.e. functional) sexual response may be more variable and adaptive to his or her particular needs and circumstances than is the case with non-disabled individuals. This is a similar sentiment put forth by Dukes and McGuire (2009) who believe that a sexual health curriculum is effectively delivered on a one-on-one basis and addresses, "targeted gaps in knowledge for each participant" (p. 728). Similarly, Blanchett and Wolf (2002) suggest adaptations that can be made to existing sexual health curricula to meet the need of diverse learners. Thus, one specific framework for delivery of an effective sexual health curriculum does not meet the varying needs for sexual health education for students with ID; instead framework for delivery is flexible and considers individual need.

Understandings about Sexual Health knowledge for people with Intellectual Disabilities

Dukes and McGuire (2009) implemented a sexual health program for four students with moderate intellectual delay. The study adopted a single subject design, using multiple baseline method with four adults with moderate ID. Findings included that sexual knowledge before implementation of curricula is lower in students with ID than those in the general population. This finding is consistent with Murphy and O'Callaghan (2004), who examined 60 adults with ID, to assess for their sexual knowledge and vulnerability to abuse. Their findings indicate that people with ID have challenges in the area of sexuality that might differ from the challenges their non-disabled peers face. For example, people with ID tend to be less informed about sexuality, have fewer sexual experiences, have more negative attitudes towards sexual activities, and have more experiences with sexual abuse than those without intellectual disabilities.

Poor sexual health education places adolescents with ID at risk. Cheng and Udry (2005) examined a longitudinal study of adolescent health. They identified 422 adolescents with low cognitive abilities. Through interviews and other data sources, they determined that in addition to fewer sexual experiences than their non-disabled peers, these students had difficulty understanding their own romantic and sexual preferences. If adolescents with ID do have sex, they do not often practice birth control and are more likely to become infected with Sexually Transmitted Infections (STIs). Eight percent of boys with ID have STIs, compared with only three percent their neurotypical peers. Girls are even more at risk, with twenty six percent of girls with ID having an STI, compared with only ten percent of neurotypical girls. If adolescents with ID do have sex, the girls are more likely to become pregnant. The rates for pregnancy for adolescents with ID are at forty percent compared with eighteen percent of pregnancy for neurotypical adolescents (Cheng & Udry, 2005). This trend is made more

problematic by Guilio's (2003) findings that, "people with disabilities often have known risk factors for HIV infection" (p. 53). She notes that people with disabilities tend to be at a disadvantage for negotiating safer sex, particularly if they are with a partner willing to exploit their vulnerabilities (p. 56). This points to the need for sexual health education and for social skill education in sexual health programs for adolescents with ID. Gigliotti (as cited in Giulio, 2003, p.60) states "statistics vary, but generally indicate that about 80 to 90% of persons with disabilities are victims of some type of abuse at some point in their lives." Simpson and Best (1991) estimate that 83% of women with disabilities in Canada will be assaulted, sexually assaulted or abused in their lifetime.

What adolescents with Intellectual Disabilities and parents who have children with Intellectual Disabilities say about sexual health education

Frawley and Wilson (2016) interviewed 25 adults with ID between ages 17 and 20 in Australia. Interviews were conducted to determine their perceptions about that was missing from sexual health curricula. Findings indicated that, "young people knew facts and rules but not the 'how to' of relationships and sex, access to information was limited and mediated by risk averse informants, and young people were full of unanswered questions-they wanted to know more and do more" (p. 469). The young people in the study, particularly the young women, reported that they did ask their friends and felt comfortable talking to other young people with disabilities. A lack of peer-reviewed Canadian research in this area makes it difficult to determine what adolescents with ID in Canada believe about their knowledge base in sexual health.

Betz (1994) reports that parents of children with ID state that they may withhold information from their mentally disabled children due to fear for their children's vulnerability

to sexual abuse. Parents also report that they rarely talk to their children about healthy sexual relationships and how to protect themselves from harmful sexual behavior. While this study is over 22 years old, it corroborates Frawley & Wilson's (2016) findings that, "[the] evidence strongly suggests that the values, attitudes and actions of these 'mediators' are conservative and risk averse, leading to restrictive approaches that limit the young person's access to information, education and opportunities to develop their own social and sexual identity" (p. 469).

Topics of an effective sexual health curriculum for adolescents with Intellectual Disabilities

It is clear from the review of literature, up to this point, that people with Intellectual disabilities should have access to sexual health education programs. Important topics for such programs include: social interaction skills, self-protection skills, specific information about intercourse, knowledge about STIs and reproduction, sexual preferences and developing a healthy attitude about sexuality. Dukes and McGuire (2009) write that, "people with intellectual disabilities lack in knowledge and experience with their sexuality, dating, and intimacy, and have less of a chance to learn those topics" (p. 728). Jobling & Cuskelly (2006) interviewed 38 adults with Down Syndrome regarding health and hygiene. They showed that most aspects of health assessed, hygiene practices, exercise, appropriate substance use, healthy eating habits, "was poor and pointed to a gap in the preparation of young people for independent living" (p. 210). Thus, the topic of health and hygiene also appears to be a necessary addition to a sexual health curriculum.

Instructional strategies of an effective sexual health curriculum for adolescents with Intellectual Disabilities

In order for a sexual health program to be effective for adolescents with ID, Walker-Hirsch (2007) recommends that the pace of instruction and the emphasis of the discussions are designed to meet the needs for adolescents with ID. Wolfe and Blanchett (2002) determined that sexual education curricula should contain a variety of instructional media (e.g., books, videos, and models), various instructional strategies (e.g., lecture, role-play and demonstration), and provide a means of evaluating student progress (e.g. tests, surveys, and concept identification). They further recommend that prior knowledge be assessed as information, preconceptions, myths and fears may affect student understanding of topics. The others also note that verbal cues be present with discussions, "to elicit appropriate responses and participation" (p. 53).

If students with ID are to be provided with a sexual health program that meets their needs, Utley, et al. (2001) suggest that,

> [f]or a health education curriculum to be successfully implemented, it must be tailored to the cognitive, learning and behavioural characteristics of students with developmental disabilities (DD) (e.g., slow learning rates, failure to identify relevant features of task, difficulty responding to newly learned material, and difficulty generalizing learned skills to new and unfamiliar situations (p. 2).

This idea is also supported by Schaafsma, Kok, Stooffelen & Curfs (2015), who state that, "knowledge alone does not change behaviour and that the necessary skill to perform the appropriate behaviour are also important" (p. 414).

Evaluation methods to determine if learning has occurred are also seen as an important component of a valid and effective sexual health program. Schaafsma et al. (2015) argue that a successful sexual health program cites specific defined goals that are essential for

measuring the true effectiveness of sex education materials or programs. They note that out of the 20 articles they reviewed for identifying effective methods for teaching sexual education to individuals with ID, the only articles that described specific goals were ones investigating self-protection skill training (e.g., Lumley et al., 1998). The authors determine that the maintenance of knowledge and skills is required for a program to be effective and valid. Therefore, long term review of topics is important for student understanding.

Attitudes and professional preparedness of teachers

Howard-Barr, Rienzo, Morgan, and James (2005) conducted a study in Florida that included 494 special educators, examining their beliefs and professional preparation regarding teaching sexual health education to their students. Findings included a strong belief that topics of sexual health should be taught to students. Topics of families, friendships, values, decision making, communication and finding help were taught by at least 75% of respondents. Topics related to sexual behaviour such as shared sexual behaviour, human sexual response, contraception, abortion, sexually transmitted infections, sexual abuse and reproductive health were taught by fewer than 1 in 10 special educators polled. Of the respondents, 19% reported that they had received some sort of sexuality education course in college, while 38.9 reported that they had received some sort of sexual health development program through staff development.

Blanchett (2001) notes that in terms of transition training for adolescents leaving high school to in Pennsylvania, providing education around sexual health was regarded as being a less important competency to teach by 30% of 98 special educator respondents. Money management and job preparedness were deemed most important by 98% of those polled. Blanchett (2001) states that, “transition planning is only concerned with training in skills

associated with work" (p. 10). She further argues that given the lack of sexual knowledge in the areas of, "birth control and sexually transmitted diseases may place individuals with disabilities at risk of unwanted pregnancies and HIV infection. Therefore, persons responsible for transition planning must be prepared to provide sexuality training to their students with disabilities" (p. 10).

Ramage (2015) reports that there is a lack of Canadian–specific research regarding what strategies and methods for sexual health education are appropriate and effective for Canadian adolescents' with ID (p. 24). Embedded within the overarching topics of "strategies" and "methods" is the person who delivers the curriculum, the teacher and their knowledge base and beliefs about sexual health education. Barr et al. (2005) noted that most of the Florida educators they surveyed reported that it was of value to teach "educable mentally disabled students" but that "…most did not consider their professional preparedness adequate" (p. 103).

In British Columbia, the IEP is coordinated by a specialist teacher/case manager. Specialist teachers in British Columbia have different roles. Some case manage students and their IEPs, while others do direct teaching of students with ID in a classroom, while still others do a combination of both. Specialist teachers are responsible for writing and implementing the IEP in conjunction with the classroom teacher and in some cases the education assistant. The education assistant (EA) in conjunction with the classroom teacher and the case manager, assists in the implementation of the IEP, and reports to the classroom teacher and the case manager (Ministry of Education, 2016).

> The teacher responsible for a student with special needs is responsible for designing, supervising and assessing the educational program for that student. Where the student

> requires specialized instruction, this is best done in consultation with resource personnel available, with the parents and with the student. Where the student's program involves specialized instruction by someone other than the classroom teacher, collaborative processes are required to make best use of the expertise of the specialists available to assist and to ensure a co-ordinated approach. (Ministry of Education, 2016 p.9).

Collaborative consultation between EA, classroom teacher and specialist teacher are necessary in order for all parties to be aware of a student's progress with their IEP goals.

The goal of this research is to begin to fill the literature gap about teacher beliefs and professional preparedness of special educators in British Columbia to teach sexual health education to students with ID.

Chapter 3:

Methodology

Overview of research

This study explored the breadth and the depth of sexual health curricula utilized by special educators throughout British Columbia. Specifically, the focus was on how special educators support learning topics related sexual health for students with ID, as well as the challenges that they experience when implementing sexual health education for their students. To achieve this, an online questionnaire was designed and offered to practicing special educators who were currently teaching or case managing adolescent students with ID in schools in British Columbia. Both qualitative and quantitative data was gathered based on the completed questionnaire, and conclusions were drawn based on the accumulated data. The following details the design of the research/methodological framework, the sample population, the instrument used and the procedures followed. The validity of the study and analysis process will also be discussed.

Methodological Framework

This study employs a mixed methods research framework. Creswell et al. (2011) define a mixed methods study as: "the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involves integration of the data at one or more stages in the process of research" (p. 212).

Morgan (2007) contends that a pragmatic philosophical understanding be employed when conducting mixed methods research. Thus, this methodology will "facilitate human problem solving" (Powell, 2001, p. 884), as researcher and participants seek to understand

and construct what makes an effective sexual health program for students with ID and what are the challenges that prevent it from being effectively implemented to adolescents with ID in the public school system in British Columbia.

Creswell et al. (2011) identify six major mixed method research designs: convergent parallel, explanatory sequential, exploratory sequential, embedded, transformative, and multiphase designs. This study employs a parallel mixed design. Creswell (2009) defines this particular type of study: "The researcher converges or merges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem. In this design, the investigator collects both forms of data at the same time and then integrates the information in the interpretation of the overall results" (p. 14).

The primary reason that a parallel mixed design method was used for this study is that the literature review uncovered little information regarding the breadth and the depth of sexual health topics taught to students with ID in British Columbia or Canada. There was also little existing peer-reviewed literature regarding the challenges that specialist teachers face in British Columbia or Canada. Thus, the quantitative questions on the questionnaire were based on information obtained from peer-reviewed literature from the United States of America, Australia, Ireland, Netherlands, England, in addition to a single study from Saskatchewan, to determine whether the information in other parts of Canada or the western world correlated with findings from this study.

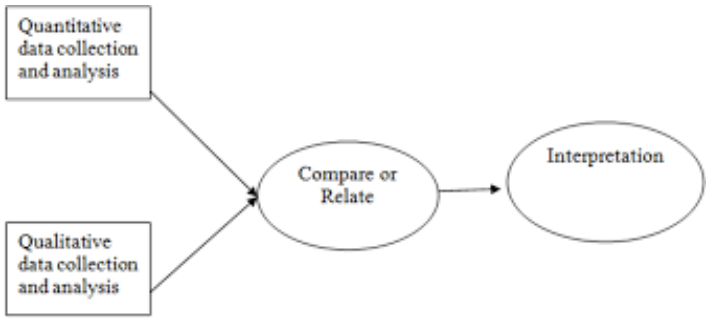


Figure 1. Parallel Mixed Design (http://pubs.sciepub.com/education/4/7/10/figure/1)

The sample population

Characteristics:

Participants in this study are special education teachers working with adolescent (10 through 19 year old) students with ID. Participants may teach students with ID directly or case manage students. The case management involves, but is not limited to, working collaboratively with the student and the student's family to implement and evaluate a student's IEP, adapt and/or modify course work as is necessary, and work with itinerant professionals and community professionals who service the needs of the student. Participants may work in an elementary, middle, or high school setting.

Recruitment:

Permission was sought from ten school districts across British Columbia in order to send an online survey link to specialist teachers within those school districts. The researcher made contact with ten school districts via e-mail (Appendix A), specifically with administrators in charge of special education. All school districts received information via e-mail and follow up telephone contact was attempted. The researcher received no responses from three of the school districts. Two of the school districts responded to the initial information contact via e-mail however, the request was denied. Formal individualized school

district applications to conduct research were requested by four separate school districts. One formal school district application was denied and three formal school district applications were approved. From those three school districts, links to the survey (Appendix C) were sent directly to teachers via directors of Special Education or through principals (Appendix B) and in turn to specialist teachers. As all research in Social Sciences is governed by protocols outlined and governed by the Research Ethics Board (REB) research ethics for teacher participants and individual school board approval was considered for each application and during data collection.

Storage and Security Information

Prior to completing the online questionnaire, informed consent was obtained from each participant (Appendix C). Consent to participate in the survey was sought from each participant and was the only mandatory question on the questionnaire (Appendix C). All participants and school districts were assured of anonymity and confidentiality.

Data collection

Data collection for this study incorporates a thirteen-part questionnaire. The questionnaire was posted on a social media site shared with teachers via email. Instructions were provided to teachers through district e-mail. The survey was designed to be anonymous for respondents and their school districts and could be completed in approximately 10-15 minutes.

Instrument

A 13 part, 93 item instrument was developed to determine the sexual health curriculum topics teachers are teaching to their students with ID, as well as the challenges teachers are experiencing when teaching these topics. The first section of the instrument is a

consent to participate and is the only mandatory question on the survey. The second section is quantitative in nature. Likert-like questions are used to gather data. The question topics were based on the instrument for collecting attitudes, professional preparedness and teacher beliefs by Howard-Barr, Rienzo, Pigg & James (2005). Curriculum topics chosen by Howard-Barr et al (2005) are based on the recommendations by Sexuality Information and Education Council of the United States (1993). In addition, the questionnaire is also based on the work of Ramage (2015) for the Saskatchewan Prevention Institute, and her recommendation of the topics of: abuse prevention, individualized programming and healthy relationships have been added to the question.

In the second section of the instrument teachers identify topics they teach to their students out of a possible choice of 48 topics provided. Using a Likert-like scale teachers identify the importance of the topic based on 1 (strongly disagree) to 5 (strongly agree) and how to professionally prepared teachers feel in order to teach those topics on a Likert-like scale of 1 (poor) to 5 (excellent).

On the third section participants indicate whether they teach any of the 48 sexual health topics identified on the questionnaire. In addition, the third section asks participant teachers to determine the frequency of teaching the 48 sexual health topics; whether they are taught daily, weekly, bi-annually or annually, and has a section for comments.

The fourth section has participants quantify how many years they have been teaching and the fifth sections asks how many years participants have taught students with ID. The sixth section asks for a formal level of education. The seventh section asks participants for grade of students that they are teaching or managing caseload for.

The eighth section asks participants to choose how aware they are of the sexual health education that their students are receiving. Choices to this question include: I am fully aware, I am fully aware and they are part of my students' IEP, I teach sexual health topics to my students, I adapt/modify sexual health topics for the students on my case load, I know that my students are receiving sexual health content but I do not know the topics, I do not know if my students are receiving sexual health curriculum, my students are not receiving sexual health curriculum at school. In addition, there is an anecdotal section for participants to name sexual health topics found in their students IEPs.

The ninth section asks participants to identify with yes or no if the following are challenges to their teaching/adapting/modifying sexual health curriculum: time, personal comfort level, Support (parents, colleagues, administration, district administration), professional understandings and applications. There is also an area for participants to anecdotally comment on this section.

The tenth section of the questionnaire asks participants to make anecdotal comments on any challenges that may prevent them from teaching/modifying/adapting sexual health curriculum to their students with ID. The eleventh section asks for anecdotal comments on successful instructional strategies, material, or outside agencies that they may use to teach their students with intellectual disabilities sexual health topics.

The twelfth section asks if participants teach their students based on: age range, range of ID, teach in small groups or teach curriculum individually. Instructional groupings chosen for the questionnaire were based on the work of Mc Daniels & Fleming (2016), Dukes & McGuire (2009), Galea et al. (2012), and Wolfe & Blanchett (2002).

The final section asks for anecdotal information regarding participant identification of changes that would enhance access for students with ID to receive meaningful sexual health education.

Data interpretation

The survey collected quantitative data, through close questions regarding specialist teacher training in sexual health and attitudes towards specific sexual health topic curricula they deem necessary for their students. The data collected examined causal relationship regarding attitudes, awareness of sexual health education students were receiving, length of teaching students with ID, and specific training, and the effect that had on the breadth and depth of sexual health education topics delivered to students with ID. Breadth of sexual health was determined based on how many of the provided topics on the questionnaire, of sexual health topics, were taught by participants to their students or determined as important. Topics for the questionnaire were provided by Sexuality Information and Education Council of the United States (1993) and Ramage (2015). Depth of sexual health education was defined by the frequency of topics taught and the types of groupings of students (Dukes and McGuire 2009, Lumley et al. 1998, Ramage 2015, Schafsma et al. 2015). Topics taught in British Columbia, identified by this study's participants, were cross referenced with literature from other Canadian provinces and other countries to determine similarities and differences in what sexual health topics participants deem important for students with ID to learn in British Columbia.

The study further examined specific challenges teachers experienced when teaching sexual health to students with ID. Quantitative data and qualitative data were amalgamated to create a frequency table of challenges that teachers in British Columbia are experiencing

when attempting to implement or support students with ID, sexual health curriculum. This information is important as it will enable the researcher to identify specific challenges that exist for teachers in British Columbia when it comes to teaching students with ID sexual health education. By identifying challenges solutions can be determined by school districts. Anecdotal information regarding solutions to challenges or successful programs that teachers have incorporated into their teaching of sexual health were identified to determine what solutions and programs most teachers are finding useful when supporting or teaching sexual health students to students with ID.

Collins, Onwuegbuzie and Sutton (2006) state that mixed methods research can inform 'treatment integrity'. Outcome of teacher beliefs, level of training, self-identified challenges and successful strategies for teaching sexual health will enable this researcher to identify solutions to barriers and correlate them with identified peer reviewed solutions in the literature and peer identified qualitative comments on the survey.

Limitations

Mixed methods research will be achieved by combining both quantitative and qualitative strands of data. Creswell and Planko Clark (2011) define validity in mixed methods research as "employing strategies that address potential issues in data collection, data analysis, and the interpretations that might compromise the merging or connecting of the quantitative and qualitative strands of the study and the conclusion drawn from the combination" (p. 239). Validity of this study may be compromised by a failure of the researcher to successfully identify how to merge both quantitative (attitudes of teachers) with qualitative (experiences of teachers). Issues that may further affect data validity could be bias in the wording of questions on both the survey and in the interview.

While this research begins to identify the curriculum topics that students with ID are receiving and challenges that teachers face when teaching/modifying/adapting sexual health curriculum across British Columbia more research is required in order to get a larger sample of the population of teachers teaching sexual health education across British Columbia.

Significance

This research is intended to identify the breadth and the depth of sexual health education being provided to adolescent students with intellectual disabilities in British Columbia, to provide a scope of what students with ID are learning and how they are being taught. In addition, identification of the challenges of teacher attitudes, professional education, access to materials, support of colleagues and parents will be identified and then quantified. Solutions based on peer reviewed literature will be correlated to identified challenges to attempt to provide teachers with solutions to overcome barriers.

By determining the challenges faced by teachers regarding sexual health curriculum delivery for students with ID, and identifying sexual health topics being taught to students with ID in British Columbia, in addition to identifying the frequency that those topics are being taught, we can begin to fill the huge void of data regarding what kind of sexual health education students with ID are receiving in British Columbia. It is the hope that teachers and school districts can use this data to advocate for effective policy for students with ID so that these students can receive effective sexual health education that meets their needs.

Chapter 4

Results

This chapter presents the research findings as summarized after data was collected. The general purpose of this study was to determine the breadth and the depth of sexual health education for students with ID in British Columbia, what specific challenges special educators face when trying to teach their students sexual health, and how they try to overcome these challenges. The study was guided by the following research questions: a) demographic data of the level of education, years of experience teaching students with ID, and the grade levels, that participants currently teach/modify and/or adapt for, b) the special educator's perception of the value of various sexual health education topics for students with ID to learn in school, c) how professionally prepared participants feel to teach particular sexual health topics to students with ID, d) the sexual health education topics taught/modified and/or adapted by the special educator to teach sexual health to their adolescent students with ID and the frequency with which they are taught, e) the types of teaching methods being employed by specialist teachers to teach/modify and/or adapt sexual health education, f) special educators' awareness of the type of sexual health education that their students with ID are receiving in their inclusive classrooms, g) what challenges specialist teachers face when teaching sexual health to, or case managing sexual health for, adolescents with ID and how do they overcome them, g) are there any common strategies or resources used by special educators to teach/case manage students with ID sexual health?

From the above research questions the following themes were developed: (1) participants' education level and experience teaching students with ID and a possible relationship to students with ID receiving sexual health education, (2) the breadth of sexual

health topics adolescent students with ID are currently receiving in school and the relationship to participant awareness of the importance of sexual health topics, (3) depth of sexual health topics adolescent students with ID are currently receiving in school, (4) challenges faced by specialist teachers with regards to sexual health education when teaching or case managing adolescent students with ID, as a determinant for students with ID receiving sexual health education, (5) strategies employed by specialist teachers to provide sexual health education to their students and suggested solutions to make access to sexual health education easier for their students with ID.

Demographic data

A total of 30 participants from British Columbia responded to the survey. The following tables reveal the years of teaching experience of participants and levels of their education.

Table 1: Teaching Experience Distribution

Groupings of Years Taught	Years of Teaching Experience		Years of Teaching/Case Managing Students with ID	
	n	%	n	%
0-5 years	6	20	19	63
6-10 years	12	40	8	27
11-15 years	0	0	1	3
16-20 years	7	23	0	0

21 plus years	5	17	2	7

Note: Frequency of Respondents 30

Table 2: Level of Education Distribution

Level of Education of Participants	n	%
Bachelor Degree	10	33
Post Baccalaureate Diploma	12	40
Masters	8	27

Note: Frequency of Respondents 30

The majority of respondents (40%) have had 6-10 years of total teaching experience. In terms of teaching or case managing students with ID the majority of participants (63%) in the survey reported having 0-5 years of experience. The majority (40 %) of participants reported having post baccalaureate diplomas.

Data from question 7 of the survey revealed that out of the 29 respondents who answered the question, close to 70 percent of respondents reported working in the kindergarten to grade seven range, close to 20 percent work in the high school range, and close to 10 percent work with students from kindergarten through to grade twelve.

Importance of sexual health education topics as determined by participants

Participants were asked to provide a value 1 (Strongly Disagree) – 5 (Strongly Agree) on 37 sexual health topics for students with ID to learn as part of a sexual health education curriculum. The following is a hierarchy of sexual health topics, for student with ID to understand, as determined by participants. Hierarchy was determined by identifying the topic given the highest percentage by participants in the "Strongly Agree" category and in each descending number for the category.

Table 3: Sexual Health Topics Reported as Being Important to Teach to Students with Intellectual Disabilities

1 (Strongly Disagree) -5 (Strongly Agree).

Sexual Health Topics	1	2	3	4	5
Looking for Help	3.45 %	0.00%	0.00%	6.90%	89.66%
Consent	3.33%	3.33%	3.33%	3.33%	86.67%
Decision Making	3.33%	3.33%	3.33%	10.00%	80.00%
Sexual Abuse	6.67%	3.33%	3.33%	6.67%	80.00%
Communication	3.33%	0.00%	0.00%	20.00%	76.67%
Friendships	3.33%	0.00%	6.67%	13.33%	76.67%
Sexually Transmitted Infections and HIV	6.67%	3.33%	3.33%	10.00%	76.00%

Puberty	10.00%	3.33%	3.33%	10.00%	73.33%
Contraception	10.34%	3.45%	10.34%	3.45%	72.41%
Families	3.33%	3.33%	6.67%	16.67%	70.00%
Love	6.67	0.00%	10.00%	13.33%	70.00%
Sexuality and Social Media	6.67%	3.33%	6.67%	13.33%	70.00%
Assertiveness	10.34%	0.00%	3.45%	20.69%	65.52%
Reproduction	6.90%	0.00%	10.34%	17.24%	65.52%
Reproductive Anatomy and Physiology	10.00%	3.33%	13.33%	13.33%	60.00%
Values	13.33%	0.00%	16.67%	10.00%	60.00%
Body Image	10.34%	0.00%	6.90%	24.14%	58.62%
Dating	13.33%	0.00%	10.00%	20.00%	56.67%
Marriage and Lifetime Commitments	10.00%	3.33%	23.33%	6.67%	56.67%
Reproductive Health	6.90%	0.00%	17.24%	20.69%	55.17%
Sexuality and Orientation	10.00%	3.33%	10.00%	23.33%	53.33%

Sexuality and the Law	13.33%	6.67%	10.00%	20.00%	50.00%
Sexuality and the Media	13.33%	6.67%	13.33%	16.67%	50.00%
Sexuality and Society	13.33%	10.00%	10.00%	20.00%	46.67%
Masturbation	10.34%	3.45%	17.24%	24.14%	44.83%
Sexuality Through the Lifespan	13.79%	3.45%	17.24%	20.67%	44.83%
Abstinence	7.14%	21.43%	10.71%	21.43%	39.29%
Abortion	10.34%	6.90%	13.79%	31.03%	37.93%
Human Sexual Response	10.34%	24.14%	10.34%	17.24%	37.93%
Gender and Gender Identification	13.33%	6.67%	16.67%	26.67%	36.67%
Negotiation	6.67%	3.33%	16.67%	40.00%	33.33%
Shared Sexual Behaviour	17.24%	3.45%	20.69%	27.59%	31.03%
Sexual Dysfunction	14.29%	10.71%	39.29%	14.29%	21.43%
Fantasy	13.79%	17.24%	31.03%	17.24%	20.69%
Sexuality and Religion	30.00%	6.67%	26.67%	20.00%	16.67%
Sexuality and the Arts	23.33%	16.67%	36.67%	23.33%	0.00%

Note: *(Frequency of Respondents 30)*

In combining the "agree" and "strongly agree" categories of numbers four and five in the table an ordered ranking was established. Educators chose the topics of, Communication (96.67%), Looking for Help (96.56), Consent (90%), Friendships (90%), Decision Making (90%), Sexual Abuse (86.67%), Families (86.67%), Sexually Transmitted Infections and HIV (86%), Assertiveness (86.21%), and Puberty (83.33%), as the ten most valuable topics to teach to students with ID. The high percentages of value given to these topics by participants indicate that educators in British Columbia, who work with students with ID have a strong belief that some sexual health education topics are highly valuable for their students to learn.

Professional preparedness to teach sexual health topics as determined by participants

Participants were presented with 37 sexual health topics and were asked to determine how professionally prepared they were to teach/modify and/or adapt for these sexual health topics. Topics were the same as in the above question for determining the importance of sexual health topics for students with ID. Ratings ranged from 1 (Poor) – 5 (Excellent). The following is a list of topics in descending order of sexual health topics and how professionally prepared participants felt to teach them. Hierarchy was determined by identifying the topic with the highest percentage of participants in the "Excellent" category and in each descending number in the category.

Table 4: Sexual Health Topics and Professional Preparedness by Participants

1 (Poor) -5 (Excellent).

Sexual Health Topics	1	2	3	4	5
Friendships	0.00%	10.00%	10.00%	33.33%	46.67%
Raising Children	13.33%	16.67%	16.67%	20.00%	33.33%

Decision Making	6.67%	10.00%	16.67%	36.67%	30.00%
Communication	0.00%	10.00%	30.00%	30.00%	30.00%
Sexual Abuse	10.00%	36.67%	6.67%	16.67%	30.00%
Looking for Help	3.45%	10.34%	27.59%	31.03%	27.59%
Sexually Transmitted Infections and HIV	10.34%	13.79%	24.14%	24.14%	27.59%
Families	3.33%	3.33%	36.67%	30.00%	26.67%
Love	10.00%	13.33%	30.00%	20.00%	26.67%
Puberty	3.45%	10.34%	24.14%	37.93%	24.14%
Consent	6.90%	17.24%	24.14%	27.59%	24.14%
Values	13.33%	13.33%	16.67%	33.33%	23.33%
Sexuality and Orientation	6.90%	10.34%	34.48%	27.59%	20.69%
Contraception	10.34%	17.24%	27.59%	24.14%	20.69%
Assertiveness	3.33%	23.33%	33.33%	20.00%	20.00%
Body Image	3.33%	10.00%	36.67%	33.33%	16.67%
Reproduction	3.33%	23.33%	26.67%	30.00%	16.67%
Gender and Gender Identification	26.67%	13.33%	26.67%	16.67%	16.67%
Negotiation	6.90%	31.03%	27.59%	20.69%	13.79%
Abstinence	24.14%	13.79%	27.59%	20.69%	13.79%
Abortion	13.79%	27.59%	24.14%	20.69%	

					13.79
Dating	13.33%	13.33%	33.33%	26.67%	13.33%
Sexuality and Society	20.00%	23.33%	23.33%	20.00%	13.33%
Sexuality and the Media	23.33%	23.33%	26.67%	13.33%	13.33%
Reproductive Health	3.33%	20.00%	40.00%	26.67%	10.00%
Sexuality and Social Media	10.00%	36.67%	20.00%	23.33%	10.00%
Masturbation	34.48%	24.14%	13.79%	20.69%	6.90%
Sexuality Through the lifespan	20.69%	31.03%	24.14%	17.24%	6.90%
Shared Sexual Behaviour	31.03%	24.14%	20.69%	17.24%	6.90%
Human Sexual Response	20.69%	24.14%	37.93%	10.34%	6.90%
Fantasy	34.48%	27.59%	20.69%	10.34%	6.90%
Sexuality and the Arts	46.67%	20.00%	13.33%	13.33%	6.67%
Sexuality and Religion	46.67%	16.67%	23.33%	6.67%	6.67%

Sexual Dysfunction	41.38%	24.14%	24.14%	6.90%	3.45%
Sexuality and the law	30.00%	23.33%	20.00%	23.33%	3.33%
Note: Frequency of Respondents 30					

The following is a list of self-rated participant professional preparedness of sexual health topics. The percentages were determined by combining level four and five (excellent and high excellence) on the self-rated scale in question two of the survey.

- Friendships
  80%
- Raising Children
  70%
- Decision Making
  66.67%
- Puberty
  62.07%
- Communication
  60.00%
- Looking for Help
  58.62%
- Families
  56.67%
- Values
  56.66%
- Consent
  51.73%
- Sexually Transmitted Infections and HIV
  51.73%

- Body Image
  50.00%
- Sexual Abuse
  46.67%
- Love
  46.67%
- Sexuality and
  Orientation
  48.28%
- Contraception
  44.83%
- Assertiveness
  40.00%
- Dating
  40.00%
- Reproduction
  46.67%
- Reproductive Health
  36.67%
- Negotiation
  34.48%
- Abstinence
  34.48%
- Abortion
  34.02%
- Gender and
  Gender Identity
  33.34%
- Sexuality and Society
  33.33%

- Sexuality and the Media
  26.66%

- Masturbation
  27.59%

- Sexuality and the Law
  26.66%

- Sexuality Throughout

  The Lifespan
  24.14

- Shared Sexual
  Behaviour
  24.14%

- Sexuality and the Arts
  20.00%

- Human Sexual Response
  17.24%

- Fantasy
  17.24%

- Sexuality and Religion
  13.34%

- Sexual Dysfunction
  10.35%

The top ten topics that participants felt they were at the low to high "Excellent" range to teach in terms of professional preparedness were: Friendship (80%), Raising Children (70%), Decision Making (66.67%), Puberty (62.07%), Communication (60.00%), Looking for Help (58.62%), Families (56.67%), Values (56.66%), Consent (51.73%), and Sexually Transmitted Infections and HIV (51.73%).

Topics participants teach/modify and/or adapt

Participants were asked to determine if they taught any of the sexual health topics from a list of topics provided on the survey. The following is a list of the most frequently taught sexual health topics, in descending order, determined by the participants, and the frequency with which the topics were taught.

Table 5: The Most Frequently Taught Sexual Health Topics as Determined by Survey Participants and the Frequency with which They are Taught.

Sexual Health Topics	Percentage of Participants Who Taught/Modified/Adapted this Topic	Daily	Monthly	Bi Annually	Annually
Communication	86.67%	66.67%	13.33%	0.00%	6.67%
Friendship	76.67%	43.33%	16.67%	6.67%	10.00%
Looking for Help	73.34%	46.67%	10.00%	10.00%	6.67%
Decision Making	73.33%	53.33%	10.00%	0.00%	10.00%
Values	70.00%	30.00%	26.67%	3.33%	10.00%
Families	62.07%	13.79%	27.59%	3.45%	17.24%
Assertiveness	58.02%	31.03%	20.69%	3.45%	3.45%
Negotiation	46.67%	20.00%	10.00%	6.67%	10.00%
Dating	43.33%	3.33%	20.00%	3.33%	6.67%

Love	43.33%	10.00%	20.00%	10.00%	3.33%
Consent	33.33%	3.33%	10.00%	3.33%	16.67%
Raising Children	30%	6.67%	13.33%	0.00%	10.00%
Sexual Abuse	30%	0.00%	10.00%	13.33%	6.67%
Puberty	30%	0.00%	10.00%	13.33%	6.67%
Masturbation	26.67%	3.33%	6.67%	10.00%	6.67%
Marriage and Lifetime Commitments	26.67%	0.00%	10.00%	10.00%	10.00%
Sexually Transmitted Infection and HIV	26.67%	0.00%	6.67%	10.00%	10.00%
Reproductive Anatomy and Physiology	26%	3.33%	3.33%	13.33%	6.67%
Contraception	24.14%	0.00%	6.90%	10.34%	6.90%
Sexuality and Social Media	23.34%	6.67%	10.00%	6.67%	0.00%
Reproductive Health	23.33%	0.00%	3.33%	10.00%	10.00%
Human Sexual Reproduction	23.33%	0.00%	3.33%	6.67%	13.33%

Sexuality and the Media	20%	3.33%	10.00%	6.67%	0.00%
Abstinence	16.67%	0.00%	6.67%	6.67%	3.33%
Gender and Gender Identification	16.67%	0.00%	6.67%	3.33%	6.67%
Sexuality and Society	16.67%	0.00%	6.67%	3.33%	6.67%
Shared Sexual Behaviour	13.80%	0.00%	3.45%	6.90%	3.45%
Abortion	13.33%	0.00%	3.33%	3.33%	6.67%
Sexuality and the Arts	10.00%	3.33%	6.67%	0.00%	0.00%
Sexuality and Religion	10.00%	0.00%	6.67%	3.33%	0.00%
Note: Frequency of Respondents 30					

Specialist teachers are teaching/modifying and/or adapting some sexual health topics with some frequency and regularity. Communication Skills is taught/modified and/or adapted by 86% of participants with 66.67% of them focusing on the topic daily. Just under 50% of participants are teaching/modifying and/or adapting, Friendship and Looking for Help Skills, with just under 50% engaging in this daily. Decision Making is taught/modified and/or adapted by 77.33% of participants with over 50% teaching this skill to their students with ID daily. Values is taught/modified and/or adapted by 70% of respondents and 30% of respondents report that they teach it daily while 26.67% of respondents report teaching it

monthly. Families is taught/modified/adapted by 62.07% of respondents with the majority reporting that they teach the topic monthly. The skill of Assertiveness was reported as being taught/modified and/or adapted to adolescent students with ID by 52.08% of respondents with 31.03% of respondents reporting that instruction occurs daily and 20.69% of respondents reporting instruction occurs monthly. The topic of Sexuality in Private vs. Public Places was anecdotally named by one respondent as a separate topic to include on the sexual health topics list.

There are twenty-six of the listed sexual health topics that are not being taught/modified and/or adapted by at least 50% of participants. Less than 50% of the respondents teach/modify and/or adapt Negotiation, Dating or Love. With 20%, 3.33% and 10% respectively teaching it daily. Consent, Raising Children, Sexual Abuse, and Puberty was taught by close to 30 %. The frequency of teaching/adapting and/or modifying Consent was, 3.33% daily, 10.00% monthly and 16.67% annually. While Raising Children skills were taught 6.67% daily and 13.33% monthly. In contrast, the topic of Sexual Abuse was taught 0.00% daily, 10.00 monthly and 13.33% biannually and Puberty instruction occurred 0.00% daily, 10.00% monthly and 13.33% biannually.

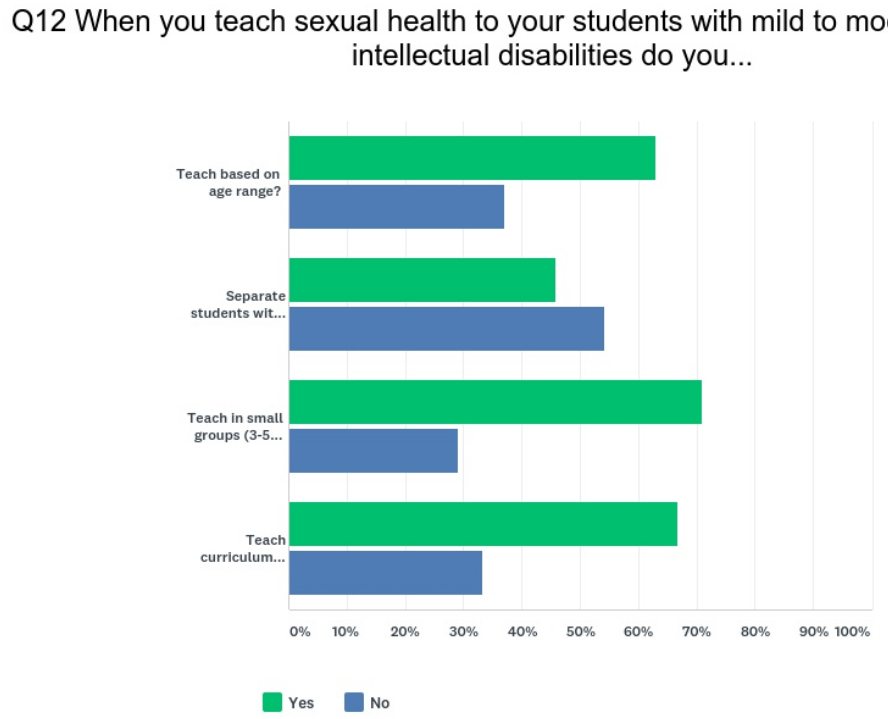
The following topics are taught by less than 27% of participants: Masturbation, Marriage and Lifetime Commitments, Sexually Transmitted Infection and HIV, Reproductive Anatomy and Physiology, Contraception, Sexuality and Social Media, Reproductive health, Human Sexual Reproduction. Masturbation was taught/adapted/modified 3.33% daily, 6.67% monthly and 10% biannually, Marriage and Lifetime Commitments skills were taught 0.00% daily 10% monthly, 10% biannually and 10% annually. The topic of Sexually Transmitted Infection and HIV, 0.00% daily and 6.67% monthly. Although 10% taught/adapted and/or

modified the topic biannually and annually. Reproductive Anatomy was taught/adapted and/or modified 3.33% daily and monthly respectfully with 13.33% teaching it biannually. Contraception was taught 0.00% daily, 6.67% monthly and 10.34% biannually. Sexuality and Social Media skills were taught by 6.67% daily and 10.00% monthly and Human Sexual Reproduction was taught/adapted and/or modified: 0.00% daily, 3.33% monthly and 13.33% annually.

The following topics were taught/adapted and/or modified by 16% or less of participants: Abstinence, Gender and Gender Identification, Sexuality and Society, Shared Sexual Behaviour, and Abortion. Abstinence was taught/adapted/modified 0.00% daily, and 6.67% monthly, Gender and Gender Identification was taught/adapted/modified 0.00% daily, and 6.67% monthly. Sexuality and Society was taught/adapted and/or modified by 0.00% daily and 6.67% monthly. Shared Sexual Behaviour was taught/adapted and/or modified 0.00% daily and 3.45% monthly and Abortion was taught/adapted and/or modified by 0.00% and 3.33% monthly. Sexuality and the Arts, and Sexuality and Religion was taught/adapted and/or modified by 10 percent of participants with less than 4% teaching/adapting and/or modifying the topics daily and 6.67% monthly.

Classroom groupings for teaching sexual health

Table 6: Groupings of Students Taught

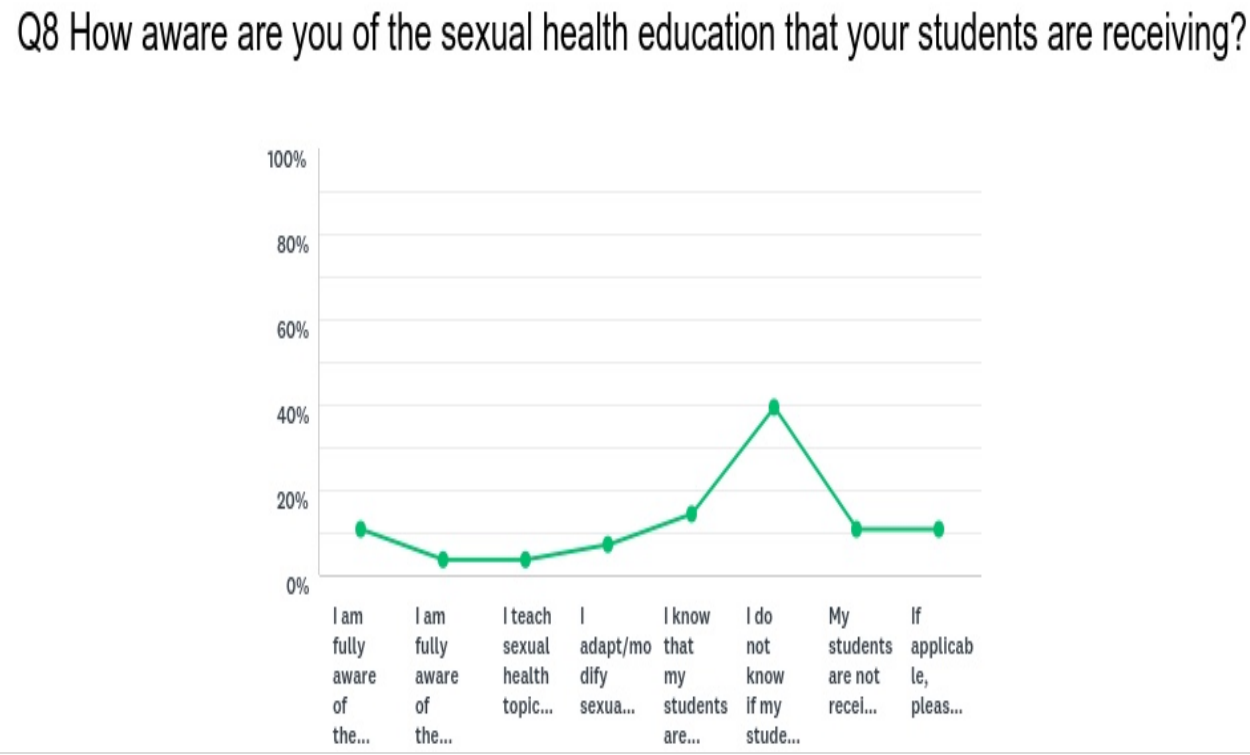


Note: Frequency of respondents 30

When asked if participants taught in specific groupings for teaching sexual health to their students with ID, 70.83% reported that they teach in small groups (3-5 students). When asked if they taught sexual health on an individual basis 66.67% of respondents reported, "yes". Respondents also reported that 62.96% taught based on age range and 45.83% reported that they separate students with mild intellectual disabilities from the students with moderate/profound ID.

Participant awareness of sexual health education of students with ID

Table 7: Specialist Teacher Awareness of Sexual Health Education that Students are Receiving in the Student's Classrooms



Note: Frequency of Respondents 28

Participants reported that 10.71% of them were fully aware of the sexual health topics that their students were learning. Participants reported that 3.57% were fully aware of the sexual health topics that their students were learning and they were part of their students IEP. Teaching students sexual health was executed by 3.57% of participants. Adapting and modifying sexual health topics was reported by 7.14% of the participants. Participants that knew that their students were receiving sexual health but did not know the topics students were receiving were 14.29%. 39.29% of the participants reported they did not know if their students were receiving sexual health curriculum. Further reported 10.71% of participants stated that their students do not receive sexual health curriculum at school. While 10.71% named sexual health topics found in their students IEP (this will be elaborated on after Table 9).

Table 8: Level of Education and Awareness of Students Sexual Health

Education

Awareness	Bachelor of Education	Post Grad Diploma	Masters
Fully Aware	1		
Fully Aware and on IEP	3	2	1
Teach Sexual Health to students	1		
I adapt/modify	1	1	
Know they are receiving but I do not know the topics	1	3	
I do not know if my students are receiving sexual health curriculum	5	3	5
My students do not receive sexual health curriculum	2	1	

Awareness	0-5 yrs.	6-10 yrs.	11-15 yrs.	15-20 yrs.	21 plus yrs.
Fully Aware		3			

Fully Aware and on IEP	2	1		1	
Teach Sexual Health to students	1				
I adapt/modify	2				
Know they are receiving but I do not know the topics	2	1			1
I do not know if my students are receiving sexual health curriculum	10	1			
My students do not receive sexual health curriculum	1	2			
Note: Frequency of Respondents 30					

The data reveals, that when correlating level of academic education and years of teaching students with ID, with the level of awareness of sexual health education that their students receive, there appears to be no increase in level of awareness of sexual health education for students with ID the higher the education level of the teacher nor the years of teaching experience.

Table 9: Level of Grade Groupings and Awareness of Sexual Health Education of Students

with ID

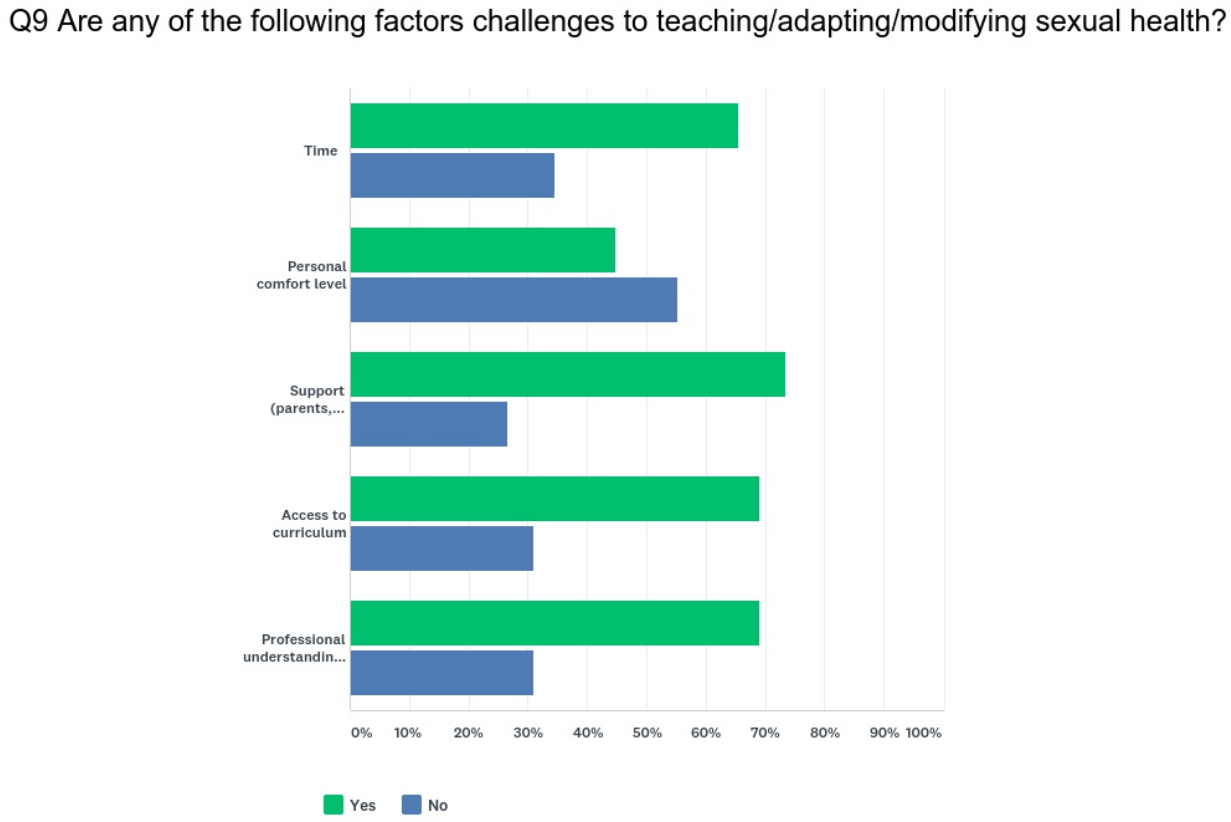
	K-7	8-12	K-12
Fully Aware	3	1	
Fully Aware and on IEP	2	1	
Teach Sexual Health to students		1	
I adapt/modify	1		1
Know they are receiving but I do not know the topics	3	1	
I do not know if my students are receiving sexual health curriculum	10		1
My students do not receive sexual health curriculum		1	1

Note: Frequency of Respondents 27

Anecdotal comments were provided by participants on the survey regarding the sexual health topics on their students' IEPs. One participant who taught in the grade 8-12 range named the topics of: Relationships, Friendships, Appropriate Touching, Planning a Family and Marriage Plans. Another participant identified Mensuration and another participant identified Touching as topics in their student's IEP. One participant stated, "no parents have discussed that they need or want this so I don't do it", as a reason no sexual health education was provided to their student.

Challenges

Table 10: Challenges



Note: Frequency of Respondents 30

Factors that participants found challenged their ability to teach/adapt and/or modify sexual health were numerous. Question 9 (note Table 10) provided a list of options to choose from for the question,

"Are any of the following factors challenges to teaching/adapting/modifying sexual health? From that question, 73.33% reported that parents, colleagues, administration or district support was a challenge to implementing sexual health for their student. In the anecdotal comments section of this table respondent #28 wrote, "Fear of saying something that may

offend students/parents/teachers/admin…job protection". While respondent # 12 wrote, "unwilling staff" was a barrier to implementing sexual health.

Access to sexual health curriculum and professional understandings were tied at 68.97% as challenges that impeded participants from administering sexual health curriculum. Time was also a deterrent to providing sexual health curriculum for their students and was rated by 65.38% of the respondents. In addition, personal comfort level was rated by 44.83% as a challenge to implementing sexual health curriculum for their student.

Table 11: Anecdotal Data Provided by Participants Regarding Challenges to Implementing Sexual Health Curriculum

Challenges	Number of Anecdotal Responses out of 30 responses
Parents	2
Unsupportive School Environments/Stigma	6
Student Comprehension	1
Time	2
Materials	6
Professional Preparedness	9
Classroom Composition	2
EA Communication	3
Access to Classroom Curriculum	1

Notes: Frequency of Respondents 29

Anecdotal reporting by participants reiterated previous quantitative accountings of: a lack of parental support, a lack of classroom teacher support, a lack of EA support, materials, time, unsupportive school environments, and professional preparedness as challenges to implementing sexual health education for their students. New topics of challenges to implementing sexual health education for students with ID also emerged. Student understanding, stigma, students not being able to access the sexual health curriculum taught in their classrooms due to the format it is taught in, and a lack of EA communication with teachers was also revealed. Respondent #19 commented that challenges included: "Climate and culture of the school. Parents wanting to keep their children acting their psychological age instead of their physical age". Respondent #15 reported that, "EAs are uncomfortable working with students on this topic, and teachers [classroom] typically run this as a reading comprehension unit and my students can't access it". Respondent #12 reported that, "Many teachers don't teach it, or teach it once". Respondent #10 stated that, "Perhaps a lack of material, some teachers or EAs may not think their student with intellectual disabilities would benefit or understand the content of sexual health, which is unfortunate, so the student isn't in the classroom at the time". Respondent #7 stated, "The belief that students with ID do not need to know "this stuff" and "knowing exactly what is needed to meet their needs and keep them safe".

Successful strategies for teaching sexual health as peported by participants

Participants anecdotally reported many successful strategies, materials or outside agencies that they use. The following is a recording of the information provided.

Strategies:

- Social Stories ™
- Social Narratives
- Videos
- Books
- YouTube
- CDs
- Visual Matching

Materials

- James Stanfield: Circles Curriculum: Teaches Social Boundaries
- Always Hygiene Program for Girls, https://always.com/en-us
- Kids in the Know: The program engages students with interactive activities to help build skills that increase their personal safety and reduce their risk of victimization online and in the real world. https://www.kidsintheknow.ca/app/en/
- Talk Sex Today: Seleema Noon

Guest Speakers

- Seleema Noon**:** Sexual Health Educators http://www.saleemanoon.com/
- OPT Options for Sexual Health https://www.optionsforsexualhealth.org

Suggestions for changes that would enhance access for students with Intellectual Disabilities

Table 12: Anecdotal Suggestions to Enhance Access to Sexual Health Education for Students with Intellectual Disabilities

Topics	Number of People	Participant Number and Some of the Anecdotal Comments Pertaining to Category
Materials	6	#2 “Special Ed teachers to make up materials that are mature looking but low language and appropriate content level”. #3“A resource about the basics written to their level of understanding”. #6 “Resources” #8 “Lesson plans in the curriculum”. #15 “We need resources that are ability based”.
Strategies	5	#4 “Too much information just confuses them, for instance no need to teach girls about periods until it is physically about to happen to them”. #9 “It should be inclusive to all students”.

		#11 “Require it to be an IEP goal”. #12 “It should almost be mandatory as part of the life skills programming for these kids”. #14 “Changes in policies”
Access to helping teachers, outside agencies or district support	1	#6 “In Service” … “Someone identified in the district to go to”
Funding	1	
Professional Development	5	
Parent Communication/Education	2	#18 “Provide information sessions for the parent”.
School Communication	1	#13“It is a conversation that needs to be had more in schools”
Test Sample	1	#19 “Test Sample”
Note: Frequency of Respondents 19		

Anecdotal information reveals that access to sexual health education for students with ID would be enhanced by: access to materials designed specifically for students with ID, access to professional development, incorporating strategies that include making sexual health mandatory in specialized classes for students with ID or mandating IEP goals that concern sexual health education. In addition, specialist teachers also reported being able to access a district professional or outside agencies as helpful. Parent communication and school communication, that included education for those particular individuals, about sexual health and ID, was also noted. A participant also noted that having a test sample of students with ID, who studied sexual health would be of value.

Chapter 5

Conclusions

Summary

This mixed methods research project was conducted to identify what the breadth and the depth of sexual health education is for students with ID in British Columbia. Secondly, the current study aimed to determine what specific challenges special educators face when trying to teach their students sexual health curriculum and how they try to overcome these challenges.

The participants in the study were 30 specialist teachers who case manage or teach adolescent students with ID from three different school districts in British Columbia. The experience of these teachers ranged from the majority (63%) teaching students with ID from 1-5 years to 21 plus years (7%). The education level of this group consists of the majority (40%) of respondents having a Post Baccalaureate Diploma, with the next largest group having their Bachelor Degree (33%) followed by the final group with their Masters Degree (27%). Three out of a possible ten school districts this researcher applied to agreed to take part in this study. Districts and participants were promised anonymity in the reporting of findings.

The procedure employed for the current study was an online survey (Appendix C) in which respondents were asked thirteen questions regarding their experience with teaching/modifying/ and/or adapting for sexual health curriculum for students with ID. Questions could be answered quantitatively with an opportunity for qualitative comments and seven of the questions asked for qualitative data alone.

Discussion of findings

The revealed themes of the findings of this study, will be discussed under the following topics: (1) the value that specialist teachers hold with regards to their students learning sexual health topics and how that compares with sexual health topics actually being taught to students with ID, (2) the awareness of sexual health education that specialist teachers have with regards to the sexual health education their students are receiving, (3) the depth with which sexual health topics are being taught and the instruction methods teachers are using, (4) the challenges specialist teachers face with teaching/modifying and/or adapting sexual health curriculum for adolescent students with ID and how it relates to sexual health delivery, and (5) suggestions from specialist teachers to increase student access to sexual health curriculum will be discussed.

Sexual health education: Value and topics taught

Interesting themes were discovered when examining the number (breadth) of sexual health topics that students with ID are studying at school in British Columbia. The first theme is that teachers are teaching/modifying and/or adapting some sexual health topics at a higher rate and some at a lower rate than some of the literature indicates. For example, according to the study by Howard Barr et. Al. 2005, sexual health topics of: Communication, Families, Friendships, Values and Decision Making were taught/adapted and/or modified by 75% of their participants. In this study, while the topic of Communication rated high at 86% and Friendship at 76.67%, Looking for Help was ranked at 73.34%, Decision Making at 73.33% and Families at 62.07%.

A theme to note is the fact that although educators rate sexual health education for students with ID of high importance, their ratings do not reflect their practice. There are many reasons for this which will be discussed later in this chapter. Consent, which was rated by

90% of respondents as being valuable to learn, was taught/modified/and/or adapted by 33.33%. Sexual abuse was rated by 86.67% of participants as important for students with ID to learn yet it is being taught/modified/and/or adapted by 33.33% of the respondents. Puberty, rated at 83.33% of value to teach to students with ID, is being taught by only 30% of participants. Of notable mention is the fact that we know that adolescent students with ID are independently seeking out much of their sexual health education through the media, in particular boys, as outlined by Frawley and Nathan 2016. Yet, there appears to be a strong disconnect as 83.33% of participants reported it as being of value to teach, yet only 23.34% of participants are actually teaching it. This places students with ID at extreme risk. Not only are they at risk of receiving misinformation about sexual health education through inaccurate online sites but to further exacerbate this issue is the question of who are these students communicating with when they are online and what kind of information are they sharing with strangers? Without focused lessons on online safety how will students know how to make safe choices when looking for sexual health information online?

Awareness

Specialist teachers work in many environments and are not always in classrooms with the students on their caseload. A question about awareness of the sexual health education that their students were receiving was embedded into the study to determine how sexual health education ranks as a subject of importance for specialist teachers to monitor in the inclusive classroom curriculum. Of the respondents, 39.0% reported that they did not know if their students were receiving sexual health curriculum and 14.29% knew that their students were receiving sexual health education but were unaware of the topics. This means that over 50% of respondents are not aware of the sexual health education their students are receiving or if

they are receiving sexual health education at all. Another 10% state that their students do not receive any sexual health education. As outlined by Utley et al. (2001) while inclusion offers unprecedented benefits for students with and without disabilities, it does little to formally address health and safety concerns that being in an inclusive environment may entail for students with ID.

Anecdotal evidence points to a lack of communication between specialist teachers and classroom teachers as a reason for the lack of awareness specialist teachers have regarding their students' sexual health education. Just under 25% of respondents named areas of poor communication in their reporting.

Depth of topics taught and empirically based approaches

Students with ID learn best with repetition of information and information being taught in different environments to increase generalization (Utley, et al. 2001). The depth, or the frequency, of the teaching of most sexual health topics appears to be sporadic. The most frequently taught sexual health topics are Communication (66.67% daily) and Decision Making (53.33% daily). Friendship and Looking for Help, all topics that are deemed by respondents, to be very important for students with ID to learn, are taught by less than 47% daily. Topics such as puberty and sexual abuse are at most taught bi-annually by 13.33% of respondents, Reproductive Health biannually at 10% both biannually and annually, and Reproductive Anatomy and Physiology are taught most frequently biannually at 13.33%. With infrequent teaching of these topics students are not learning about health, hygiene, changes to their bodies and how to look after themselves in order to stay healthy or how to notice changes that could indicate health concerns. This finding is supported by Jobling & Cuskelly's (2006) Australian study that demonstrated that most aspects of health assessed,

hygiene practices, exercise, appropriate substance use, healthy eating habits, "was poor and pointed to a gap in the preparation of young people for independent living" (p.210).

When respondents teach sexual health topics to students with ID there appears to be a sufficient knowledge base of effective and empirically based teaching methods used for students with ID amongst specialist teachers. When asked if sexual health was taught and what strategies for student groupings specialist teachers used, 70.83% stated small groups and 66.67% stated that they taught sexual health topics individually. This is in line with Blanchett and Wolf (2002), who suggest one specific framework for delivery of an effective sexual health curriculum does not meet the varying needs for sexual health education for students with ID; instead framework for delivery is flexible and considers individual need. Participants also used empirically based methods for teaching such as video modelling, matching, social narratives, and Social Stories ™ (Wolf & Blanchett 2002). However, we know that 50% of respondents do not know what type of sexual health education their students are receiving and that 10% are not getting any education at all. This reveals that 60% of respondents are not using, or are not involved in working with classroom teachers, in implementing empirically based methods for teaching sexual health even if they know what they are. Anecdotal reporting suggests a large gap in the delivery of empirically based methods being used to teach sexual health to students with ID. For example, Respondent # 24 commented, "If the whole class is not appropriate, I tailor the materials to the individual needs of the student and level of understanding". While Respondent # 4 commented, "It all sounds good but I don't do it." Anecdotal information, in combination with quantitative data, points to gap in the consistency of evidence based teaching practices used by specialist teachers with students

with ID when teaching/adapting and/or modifying sexual health education in British Columbia.

Challenges

The biggest challenge for teachers implementing sexual health for students with ID is lack of support. Specialist teachers revealed that 73.33% of them felt unsupported by parents, colleagues, administration and/or the district. Over 40% of the anecdotal responses mentioned school environments, and staff, as unsupportive for students with disabilities to access to this curriculum. “Teachers typically run it as a reading comprehension unit and my students can’t access it,” “Some teachers and EAs think that their student with intellectual disabilities would not benefit or understand the content of sexual health, which is so unfortunate, so the student is not in the classroom at the time.” It appears that professional development may be necessary for teachers, as a whole, to remove the stigma that creates this unsupportive learning environment.

There appear to be many areas of sexual health education delivery affected by a lack of professional preparedness related to students with ID receiving sexual health. When examining professional preparedness of sexual health topics and comparing those topics with the graph, Topics You Teach/Modify and/or Adapt, there appears to be a correlation between a lack of professional development in sexual health education and the delivery of the teaching the topics of sexual health for students with ID amongst specialist teachers. In addition, over 68% of respondents commented of Professional Development as a challenge that prevents them from teaching/adapting and/or modifying sexual health topics for their students. Of particular note, was a lack of familiarity with sexual health as curricula and that it is an inclusive topic and a part of the mandated curriculum for all students in British Columbia.

This study found no correlation between the number of years of experience, nor level of post-secondary education and participant awareness of sexual health education being taught to their students with ID. Nor did there appear to be more sexual health being taught/adapted and/or modified in high school vs. elementary school. Therefore, because knowledge with sexual health curriculum is not founded in level of education or experience, all specialist teachers would benefit from sexual health education. However, because the sample size in this study is small, a larger sample size of participants may indicate different results of correlation between education level and experience and delivery of sexual health education.

Further areas noted by specialist teachers as challenges that affect sexual health education delivery were: a lack of time, a lack of parent support, a lack of comfort level with the subject and a lack of materials and resources specific for students with ID. With exception of a lack of time, professional development for parents, teachers and district staff, may be of help in lessening challenges. If districts understand the need for sexual health education for students with ID then they may be more willing to purchase materials specific for that purpose and to fund professional development.

Anecdotal suggestions by specialist teachers

Of all the anecdotal suggestions to increase student access to sexual health education, professional development was the suggestion made by over 50% of participants. This included professional development for parents as well as teachers. Materials that were "mature looking but low language and appropriate content and level" were described by just under 30%. Of interest is that just over 20% of the comments regarded making sexual health a "mandatory part of curriculum," or "IEP specific," to ensure that sexual health education occurs.

Conclusions

Six major conclusions were drawn from this study.

- Students with ID in British Columbia are not receiving the sexual health education that they need in order to make informed decisions regarding their sexual health and their safety.
- Sexual health education delivery methods, specifically evidence based practices, are inconsistent for students with ID.
- Specialist teachers' knowledge base regarding sexual health education for students with ID is inconsistent.
- Specialist teachers require materials/curriculum specific to sexual health education delivery for students with ID.
- There is a need for increased communication between classroom teachers, EAs, and specialist teachers regarding what sexual health education students are receiving in the classroom.
- The stigma that sexual health is not a necessity for students with ID is prevalent in school culture.

Limitations

This study has a very small sample size of specialist teachers in the province of British Columbia. In order to have more accurate data, regarding the entire province of British Columbia, a much larger sample size is needed. This study invited ten different school districts to take part in this survey and three gave their permission. This means that there is a low response rate of 30%. Permission for the survey to take place was provided to each of the ten individual school districts. The low response rate may be indicative of the sensitive nature

of the topic for the study. Although great lengths were taken by the researcher to assure confidentiality, districts may not have felt safe exposing their circumstances. For further studies, it is recommended that researchers go directly through teachers' organizations or to professional development events to gather their data.

Further limitations were the wording of the question regarding challenges. Administration, district, parent and colleague support were grouped into one answer for determining challenges that teachers faced with regards to sexual health education. For future studies separating out these choices into separate possible answers would provide more specific data.

Recommendations

Further research in the area of sexual health education and specialist teachers' and classroom teachers' comfort level would be beneficial to determine whether it is teaching students with disabilities sexual health education or teaching sexual health education in general that causes teachers to feel uncomfortable. In addition, information regarding if it is a lack of professional development that is the cause of comfort level or if it is the nature of the topic that causes discomfort would be useful when planning a sexual health curriculum for students with ID. A study of relevant sexual health education materials specifically for students with ID, that are available in British Columbia, would also be beneficial.

If school districts and the province want to create meaningful opportunities for students with ID to learn about sexual health topics, then they must place some value on providing professional development learning opportunities for all staff. This includes improving staff access to relevant materials to teach students with ID about sexual health in a

meaningful way and providing staff with time and opportunities to teach their students sexual health over a sustained period of time.

The following is a list of recommended areas for professional development in sexual health education:

1. For all staff, including, education assistants, specialist teachers, classroom teachers and administers, to become familiar with the provincial sexual health curriculum.
2. Staff understanding, including, education assistants, specialist teachers, classroom teachers and administers that there is the same need for students with ID to learn about sexual health as their neurotypical peers.
3. How to teach students with ID sexual health using evidence based practice methods.
4. Advocacy and how professionals can discuss the benefits of sexual health education for students with ID in order to advocate for student sexual health education needs with parents, classroom teachers, EAs, administration and their districts.

It is the hope that with professional development available to all teachers and administrators who teach and/or case manage students with ID, the importance of sexual health education for students with ID will be understood by all. The outcome of district focus on the topic of Sexual Health Education for Students with ID will be that sexual health programming will be relevant and meaningful for all students in British Columbia.

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Appendix A

Is it Effective? The State of Sexual Health Education for Students with Intellectual Disabilities in British Columbia.

Principal Investigator
Sari Glavin, Student
Master of Education
Vancouver Island University
Glavin_s@surreyschools.ca

Student Supervisor
Amanda McKerracher, PhD.
Department of Education
Vancouver Island University
Amanda.McKerracher@viu.ca

Attention: Director of Instruction
Dear

I am a student in the Master of Education in Special Education at Vancouver Island University (VIU). My research, entitled "*Is it Effective? The State of Sexual Health Education for Adolescent Students with Intellectual Disabilities in British Columbia,"* aims to identify the breadth and depth of sexual health content that high school students with Intellectual Disabilities on an Individual Education Plan (IEP) are receiving in British Columbia. Students on an IEP who are in inclusive public school settings have no curricular requirement for sexual health education during their school years, unlike their typically developing peers. Studies show that students with intellectual disabilities are at an increased risk for sexual assault, pregnancy, contracting sexually transmitted disease, compared to their typically developing peers (Government of Canada, 2004 Cheng and Udry, 2005). The results generated from this study will help teachers develop an effective sexual health education program for students with intellectual disabilities in British Columbia.

Research Procedures

Upon approval from your district, principals of schools of your recommendation, will be provided an informational letter, which is also included in this package for your review. As part of that letter, an attachment is included for principals to forward to teachers who manage the IEPs of, or who teach functional skills to adolescent students with intellectual disabilities. The school district and the teachers' participation is completely voluntary. Potential participants are asked to complete an online questionnaire. If teachers agree, they would be asked questions regarding their experiences teaching sexual health education to students with intellectual disabilities; what topics they teach or provide adapted and modified curriculum for, how frequently topics were taught, what curricula they used, and whether they encountered any challenges teaching sexual health to this group. Teachers' participation would require approximately 10- 15 minutes of their time.

Statement of Risks

There is the possibility that the topic of sexual health for students with disabilities may cause discomfort for some participants. The design of the questionnaire allows participants to skip any question that may cause them discomfort and teachers may choose to withdraw from the study up until they perform the action of submitting their questionnaire. At no time is personal information requested that could identify individual students or participants. As participation is anonymous and teachers may choose which questions to answer, there is little possibility that the information that participants provide could cause loss of social status and/or embarrassment.

Upon request, you and/or the participant will be provided a copy of the study results. Electronic data will be stored on a password-protected computer. Signed consent forms and paper copies of questionnaires will be stored in a locked file cabinet in my home. Data will be deleted and shredded at the end of the project, approximately July 31, 2018.

The results of this study will be published in my Masters thesis, and may also be used for conference publications, presentations, and published in peer-reviewed journals.

I will comply with any study approval process that your district may require for educational studies to take place in your school district.

If you have any concerns about this study, please contact me at 604-833-4006 or at glavin_s@surreyschools.ca If you would like a copy of the study upon completion please feel free to contact me and I would be happy to provide you with a copy.

Sincerely,

Sari Glavin, B.A.
Inclusion Support Teacher
Surrey School District

If you have any concerns about your treatment as a research participant in this study, please contact the VIU Research Ethics Board by telephone at 250-740-6631 or by email at reb@viu.ca.

Appendix B

VANCOUVER ISLAND UNIVERSITY

Is it Effective? The State of Sexual Health Education for Students with Intellectual Disabilities in British Columbia.

Principal Investigator
Sari Glavin, Student
Master of Education
Vancouver Island University
Glavin_s@surreyschools.ca

Student Supervisor
Amanda McKerracher, PhD.
Department of Education
Vancouver Island University
Amanda.McKerracher@viu.ca

December 6, 2017

Attention: Principal of _____

To Whom It May Concern:

I am a student in the Master of Education in Special Education at Vancouver Island University (VIU). My research, entitled "*Is it Effective? The State of Sexual Health Education for Students with Intellectual Disabilities in British Columbia,"* aims to identify the breadth and depth of sexual health content that high school students with intellectual disabilities, on an Individual Education Plan (IEP), are receiving in British Columbia. Students on an IEP, who are in inclusive public school settings, have no curricula requirement for sexual health education during their school years, unlike their neuro-typical peers. Studies show that students with intellectual disabilities are at an increased risk for: sexual assault, pregnancy, contracting sexually transmitted disease, compared to their neuro-typical peers. My hope is that master of education students, teachers and school districts can use the result generated from this study to investigate and develop an effective sexual health education program for students with intellectual disabilities in British Columbia.

I have approval from your school district to be able to conduct my study within your district. It would be greatly appreciated if you would forward the bottom portion of this letter to the special education teacher(s) who manage the IEPs of students with moderate to mild intellectual disabilities or who teach functional skills to students with mild to moderate intellectual disabilities from grades ___ to ___, in your school.

I would like to provide you with some information about this study. The school district and the teacher's participation is completely voluntary. The online questionnaire that the study participants will be completing contains questions concerning their personal experiences of teaching sexual health education to students with intellectual disabilities; what

topics they taught, the frequency of topics taught, to name curricula programs that they may have used, and any barriers that they have experienced teaching sexual health. Teachers participation requires approximately 10-15 minutes of their time. Participation will be anonymous. Participants may withdraw from the study at any time, and the nature of the online questionnaire allows participants to only answer questions they feel comfortable answering. However, because the study is anonymous withdrawal is only possible up to the point of questionnaire submission.

There is the possibility that the topic of sexual health pertaining to students with disabilities may cause discomfort for some participants. Volunteering for this study is optional. The design of the questionnaire allows participants to skip any question that may cause them discomfort and teachers may choose to withdraw from the study up until they perform the action of submitting their questionnaire. At no time is there information requested to identify individual students. As participation is anonymous and teachers may choose which questions to answer, there is little possibility that the information that participants provide might cause loss of social status and/or embarrassment.

Upon request you, and or the participant, will be provided a copy of the study. Electronic data will be stored on a password-protected computer. Signed consent forms and paper copies of questionnaires will be stored in a locked file cabinet in my home. Data will be deleted and shredded at the end of the project, approximately July 31, 2018.

The results of this study will be published in my Masters thesis, and may also be used for conference publications, presentations, and published in peer-reviewed journals.

If you have any concerns about this study, please contact me at 604-833-4006 or at glavin_s@surreyschool.ca If you would like a copy of the study upon completion please feel free to contact me and I would be happy to provide you with a copy.

Sincerely,

Sari Glavin, B.A.
Inclusion Support Teacher
Surrey School District

Appendix C

Participant Consent with Survey

Dear Participant,

You are being invited to participate in a research study on what curriculum topics you use, and level of confidence you feel, about implementing a sexual health curriculum to your students in public high school with mild to moderate intellectual disabilities. In particular, we are interested in what sexual health content you teach your students, your knowledge base about teaching students with mild to moderate intellectual disabilities sexual health curriculum, and any self-identified barriers that exist for you that hinder or prevent you from teaching sexual health to your students.

This research will require about 10-15 minutes of your time. During this time, you will be asked to fill out a survey questionnaire about your experiences with teaching students with intellectual disabilities sexual health topics.

You may find the questionnaire to be very enjoyable and rewarding, as teachers are seldom asked their perceptions about the curriculum that they teach. By participating in this research, you may also benefit teachers at large as we seek to define the type of support that teachers require in order to feel confident to teach sexual health to their students.

Participation is anonymous and voluntary. The nature of the online questionnaire allows participants to only answer questions they feel comfortable answering. However, because the study is anonymous withdrawal is only possible up to the point of questionnaire submission.

There is the possibility that the topic of sexual health pertaining to students with disabilities may cause discomfort for some participants. The

design of the questionnaire allows participants to skip any question that may cause them discomfort and teachers may choose to withdraw from the study up until they perform the action of submitting their questionnaire.

Several steps will be taken to protect your anonymity and identity. The questionnaire is anonymous. Printed questionnaires will be kept in a locked filing cabinet at my home, and only myself and my supervisor (sworn to confidentiality) will have access to the interviews. All printed information will be destroyed in 30 weeks time.

The results from this study will be presented in a written thesis read by professionals, to help them better understand effective strategies to support teachers to teach sexual health curriculum and gain a better understanding of the sexual health topics deemed important by teachers for their students with mild to moderate intellectual disabilities. The information may also be used for conference publications, presentations, and published in peer-reviewed journals and may also be presented in person to thesis advisors and or interested students. Any anecdotal information that you provide would be indirectly quoted in the study. At no time will any place names or identifying information, that you may provide, be used in the study. Because the study is anonymous, at no time will your name be used. If you wish to receive a copy of the results from this study, you may contact this researcher at the telephone number or e-mail provided below.

If you require any information about this study, or would like to speak to the researcher, please contact Sari Glavin at 604-833-4006 or sariglavin@hotmail.com. If you have any other questions regarding your rights as a participant in this research, you may also contact the Office of Research Services at the University of Vancouver Island University at https://www2.viu.ca/research/aboutresearchatVIU/ .

Please connect with the attached link if you would like to participate in this study.

https://www.surveymonkey.com/r/YTFYCPV

Thank you for your consideration of participation in this study.

Sincerely,

Sari Glavin

Consent

Dear Participant,

You are being invited to participate in a research study on what curriculum topics you use, and level of confidence you feel, about implementing a sexual health curriculum to your students in public high school/late elementary school, with mild to moderate/profound intellectual disabilities (ID). In particular, we are interested in what sexual health content you teach (or assist teachers to modify/adapt curriculum) your students, your knowledge base about teaching students with mild to moderate intellectual disabilities sexual health curriculum, and any self-identified challenges that exist for you that hinder or prevent you from teaching sexual health to your students.

This research will require about 10 minutes of your time. During this time, you will be asked to fill out a survey questionnaire about your experiences with teaching students with intellectual disabilities sexual health topics.

You may find the questionnaire to be very enjoyable and rewarding, as teachers are seldom asked their perceptions about the curriculum that they teach. By participating in this research, you may also benefit teachers at large as we seek to define the type of support that teachers require in order to feel confident to teach sexual health to their students.

Participation is anonymous and voluntary. The nature of the online questionnaire allows participants to only answer questions they feel comfortable answering. However, because the study is anonymous withdrawal is only possible up to the point of questionnaire submission.

There is the possibility that the topic of sexual health pertaining to students with disabilities may cause discomfort for some participants. The design of the questionnaire allows participants to skip any question that may cause them discomfort and teachers may choose to withdraw from the study up until they perform the action of submitting their questionnaire.

Several steps will be taken to protect your anonymity and identity. The questionnaire

is anonymous. Printed questionnaires will be kept in a locked filing cabinet at my home, and only myself and my supervisor (sworn to confidentiality) will have access to the interviews. All printed information will be destroyed in 30 weeks time.

The results from this study will be presented in a written thesis read by professionals, to help them better understand effective strategies to support teachers to teach sexual health curriculum and gain a better understanding of the sexual health topics deemed important by teachers for their students with mild to moderate intellectual disabilities. The information may also be used for conference publications, presentations, and published in peer-reviewed journals and may also be presented in person to thesis advisors and or interested students. Any anecdotal information that you provide would be indirectly quoted in the study. At no time will any place names or identifying information, that you may provide, be used in the study. Because the study is anonymous, at no time will your name be used. If you wish to receive a copy of the results from this study, you may contact this researcher at the telephone number or e-mail provided below.

If you require any information about this study, or would like to speak to the researcher, please contact Sari Glavin at 604-833-4006 or sariglavin@hotmail.com. If you have any other questions regarding your rights as a participant in this research, you may also contact the Office of Research Services at the University of Vancouver Island University at https://www2.viu.ca/research/aboutresearchatVIU/ .

Thank you for your participation in this

study. Sincerely,

Sari Glavin

1. Consent:

I have read (or have been read) the above information regarding this research study and consent to participate in this study.

Yes

No

2. Curriculum Topics

	Is this topic Important for your students with ID to learn? 1 (Strongly Disagree) 5 (Strongly Agree)	How professionally prepared do you feel to teach/modify adapt these topics? 1 (Poor) 5 (Excellent)
Reproductive Anatomy and Physiology		
Consent		
Reproduction		
Puberty		
Body Image		
Sexuality and Orientation		
Families		

	Is this topic Important for your students with ID to learn? 1 (Strongly Disagree) 5 (Strongly Agree)	How professionally prepared do you feel to teach/modify adapt these topics? 1 (Poor) 5 (Excellent)
Friendships		
Love		
Dating		
Marriage and Lifetime Commitments		
Raising Children		
Values		
Decision Making		
Communication		
Assertiveness		
Negotiation		
Looking for Help		
Sexuality Throughout the Lifespan		
Masturbation		
Shared Sexual Behaviour		
Abstinence		
Human Sexual Response		
Fantasy		
Sexual Dysfunction		
Contraception		
Abortion		
Sexually Transmitted Infections and HIV		
Sexual Abuse		
Reproductive Health		

	Is this topic Important for your students with ID to learn? 1 (Strongly Disagree) 5 (Strongly Agree)	How professionally prepared do you feel to teach/modify adapt these topics? 1 (Poor) 5 (Excellent)
Sexuality and Society		
Gender and Gender Identification		
Sexuality and the Law		
Sexuality and Religion		
Sexuality and the Arts		
Sexuality and the Media		
Sexuality and Social Media		

3. Topics You Teach/Modify/Adapt

	No	Yes Daily	Yes Monthly	Yes Bi Annually	Yes Annually
Reproductive Anatomy and Physiology					
Consent					
Sexuality and Orientation					
Families					
Friendships					
Love Dating					
Marriage and Lifetime Commitments					
Raising Children					
Values					
Decision Making					
Communication					
Assertiveness					
Negotiation Looking for Help					
Sexuality Throughout the Lifespan					

	No	Yes Daily	Yes Monthly	Yes Bi Annually	Yes Annually
Masturbation					
Shared Sexual Behaviour					
Abstinence					
Human Sexual Reproduction					
Fantasy					
Sexual Dysfunction					
Contraception Abortion					
Sexually Transmitted Infection and HIV Sexual					
Abuse Reproductive					
Health Sexuality and					
Society					
Gender and Gender Identification					
Sexuality and the Law Sexuality					
and Religion Sexuality and the					
Arts Sexuality and the Media					
Sexuality and Social Media					
Other (please specify)					

4. How many years have you been teaching?

5. How many years have you been a teacher for students with intellectual disabilities?

6. What is your level of formal education?

7. What grade levels have you taught and what grade level(s) are you currently teaching? If you do not do direct teaching, what is the age range of the students on your caseload?

8. How aware are you of the sexual health education that your students are receiving?

- I am fully aware of the sexual health topics my students are learning.
- I am fully aware of the sexual health topics my students are learning and they are part of my students' IEP Goals/Objectives. I
- teach sexual health topics to my students.
- I adapt/modify sexual health topics for the students on my caseload.
- If applicable, please name the sexual health topic(s) found in your students' IEPs.
- I know that my students are receiving sexual health content but I do not know the topics.
- I do not know if my students are receiving sexual health curriculum.
- My students are not receiving sexual health curriculum at school.

9. Are any of the following factors challenges to teaching/adapting/modifying sexual health?

	Yes	No
Time	○	○
Personal comfort level	○	○
Support (parents, colleagues, admin, district)	○	○
Access to curriculum	○	○
Professional understandings and applications	○	○

Other (please specify)

10. Please comment on any challenges that may prevent you from teaching/modifying/adapting sexual health to your students with intellectual disabilities.

11. What are some successful teaching strategies, material, or outside agencies, that you may use to teach your students with intellectual disabilities sexual health topics?

12. When you teach sexual health to your students with mild to moderate/profound intellectual disabilities do you...

	Yes	No
Teach based on age range?		
Separate students with mild intellectual disabilities from moderate/profound intellectual disability?		
Teach in small groups (3-5 students)?		
Teach curriculum individually?		
Other (please specify)		

13. Do you have any suggestions for changes that would enhance access for student's, with mild to moderate/profound intellectual disabilities?