



Kansas School

Nurse Organization

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Position Statement

Adolescent Risk Behavior Related Curriculum – Opt-out Preferable over Opt-in

SUMMARY

The National Health Education Standards provide guidance to locally developed health curriculum, and the Kansas State Department of Education requires teaching of human sexuality at both the elementary and secondary levels in Kansas public schools. Ideally, the development of health curriculum is done in partnership with teachers, school nurses, counselors, administrators, parents, and local healthcare providers with consideration of the development level of the students and the adolescent behaviors of concern in the individual community. Schools should offer opportunities for parents to review the curriculum and resources in advance of the lessons annually and encourage parent participation in the teaching process. Process for Opt-out should be in place for parents, who after review, do not desire their student to participate, but Opt-in procedures, which require every parent to sign a permission form are difficult to manage time-wise and have the potential for an increased number of students missing instruction in an area that addresses adolescent risk behaviors of importance to the individual student, their family, and society as a whole. It is the position of the Kansas School Nurse Organization (KSNO) that Opt-out procedures are preferable to Opt-in procedures for obtaining parental consent for student participation in adolescent risk health education lessons such as human growth and reproduction, human sexuality, and sexually transmitted infections.

HISTORY

Human sexuality education is recommended to be a part of a planned, sequential, K-12 locally-adopted curriculum that addresses the physical, mental, emotional, and social dimensions of health. The Kansas State

Department of Education Regulation #91-31-32, requires as part of the *performance and quality criteria* schools provide “**programs and services to support student learning and growth at both the elementary and secondary levels, including the following: . . . (G) physical education, which shall include instruction in health and human sexuality; . . .**” (p. 57). In truth, sexuality education is a lifelong process and includes learning not only about reproduction, anatomy, and hormonal changes, but also includes the development of relationships, intimacy, parenting, menopause, and changes that occur with aging (Selekman & Kahn, 2013). Ideally, the home and the school complement each other when providing instruction and guidance in this area.

As stated above, health curriculum in Kansas is written and adopted locally according to individual school policies and procedures and must contain instruction in health and human sexuality at both the elementary and secondary levels. The National Health Education Standards (NHES)(<https://www.cdc.gov/healthyschools/sher/standards/index.htm>) provide guidance for curriculum goals and objectives and also provide research surrounding the characteristics of an effective health education curriculum (see <https://www.cdc.gov/healthyschools/sher/characteristics/index.htm>) (CDC, 2015). Effective curriculum is designed not only to educate students about health, but to also motivate and assist students to maintain and improve their health. In addition to knowledge, students are taught skills and advocacy in the areas of health promotion and disease prevention.

With a desire to partner with parents in teaching human sexuality, schools typically rely on one of two ways for obtaining participation consent: passive consent (i.e., opt-out) or active consent (i.e., opt-in). Passive consent or opt-out provisions require a parent or guardian to notify the school district if they do not want their child to participate in sexuality education instruction. Otherwise, the student will receive instruction. Conversely, opt-in consent requires a signed or verbal consent be received from every student’s parent in order for them to participate in the lesson. Thirty-six states and the District of Columbia have opt-out provisions, and only 3 states required opt-in consent (Guttmacher Institute, nd). Specifically, according to the most recent information obtained from the Guttmacher Institute:

- 38 states and the District of Columbia require school districts to involve parents in sex education, HIV education or both.
 - 22 states and the District of Columbia require that parents be notified that sex education or HIV education will be provided.
 - 3 states require parental consent for students to participate in sex education or HIV education.
 - 36 states and the District of Columbia allow parents to remove their children from instruction.

The National Conference of State Legislators (2016) provides additional information regarding the state policies on sex education in schools at this link: <http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx>

DESCRIPTION OF ISSUE

High-risk behaviors have long been associated with adolescents, and historically the behaviors of concern were in the following areas: engaging in sexual activity, drinking alcohol, using illegal drugs, smoking tobacco, and risk taking behaviors such as unsafe driving. More recently behaviors of concern have expanded to include “body modification, use of anabolic steroids, abuse of prescription drugs, tanning, gambling, and carrying firearms” (Selekman & Kahn, 2013, p. 1118). Every two years, the Centers for Disease Control and Prevention (CDC) conducts a Youth Risk Behavior Survey (YRBS) for students grades 9 through 12. A recent report on the national adolescent trends in the prevalence of sexual behaviors from 1991 – 2015 from the YRBS included among its report:

- 41.2% of students **have ever had sexual intercourse** (down from 54.1% in 1991),
- 3.9% of student **had sexual intercourse before age 13 years** (down from 10.2% in 1991),
- 11.5% of students **had sexual intercourse with four or more persons** (down from 18.7% in 1991),

- 30.1% of students **were currently sexually active (defined as within 3 months of the survey)** (down from 37.5% in 1991),
- 56.9% of the **students reporting being sexually active used a condom during the last sexual intercourse** (considered unchanged over the years), and
- 13.8% of the **students reporting being sexually active did not use any method to prevent pregnancy** (considered unchanged over the years) (CDC, 2016a).

It is important to note that Kansas participated in the survey, but insufficiently to be considered “weighted.” Thus, the results obtained in Kansas cannot be applied across the state (2016b).

The National Conference of State Legislators (NCSL) reminds us that sexual activity has consequences. Though the teen birth rate has declined to its lowest levels since data collection began, the United States still has the highest teen birth rate in the industrialized world with roughly one in four girls becoming pregnant at least once by their 20th birthday (NCSL, 2016). The NCSL also remind us that

“teenage mothers are less likely to finish high school and are more likely than their peers to live in poverty, depend on public assistance, and be in poor health. Their children are more likely to suffer health and cognitive disadvantages, come in contact with the child welfare and correctional systems, live in poverty, drop out of high school and become teen parents themselves.”

These costs add up, according to The National Campaign to Prevent Teen and Unplanned Pregnancy, which estimates that teen childbearing costs U.S. taxpayers at least \$9.4 billion annually, and in Kansas, approximately 100 million each year (2014).

RATIONALE

While each school district is unique in terms of its student population, community, and resources, all Kansas schools are required to teach students human sexuality as related to their sexual development. As such, schools should consider adopting a set of policies to help guide staff in the provision of sexual health education that is:

- Age- and developmentally-appropriate and sequential for students in K-12,

- Part of a larger coordinated school health curriculum,
- Focused on improving knowledge and skill-building to help students maintain and improve their sexual health by delaying sexual initiation, reducing sexual health-related risk behaviors, and preventing disease and pregnancy,
- Aligned with state and national standards,
- Developed and implemented in conjunction with parents, staff, students, administrators and other community members,
- Medically-accurate and bias free as reviewed on a periodic basis, and
- Evidence-based or evidence-informed (Advocates for Youth).

Of equal importance is for the staff responsible for teaching the human sexuality instructions to receive instruction and training to develop knowledge and skills to effectively deliver the curriculum (CDC, 2015). Lastly, parents should be invited not only to preview, but to engage in the instructional program (e.g. parent/student home discussion sheets, providing booklets ahead of time to parents to provide initial teaching to students, etc.). When processes as described above are in place, opt-out procedures are sufficient for allowing parents to refuse student participation based on individual preferences and needs.

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Adopted: July 2017