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Christina Kostadinova
St. John Fisher College

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Special Education's Role In Health Education

Abstract

Adolescents with disabilities deserve to be taught about sex/health education issues in order to escape the unfortunate statistics awaiting them in the future if this education continues to be dismissed or simply ignored. Negative issues such as sexual abuse, substance abuse, and limited knowledge about STD's, HIV/AIDS and safe sex can be avoided with sufficient education on these topics. Fifteen teachers at two special education high schools in Rochester N.Y were asked about current knowledge levels of their students in regards to sex/health education topics and about the programs/curricula that are implemented at their schools. The results indicate that the students are not adequately educated in these topics.

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Special Education's Role In Health Education

By

Christina Kostadinova

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Dr. Susan M. Schultz

School of Education
St. John Fisher College

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Abstract

Adolescents with disabilities deserve to be taught about sex/health education issues in order to escape the unfortunate statistics awaiting them in the future if this education continues to be dismissed or simply ignored. Negative issues such as sexual abuse, substance abuse, and limited knowledge about STD's, HIV/AIDS and safe sex can be avoided with sufficient education on these topics. Fifteen teachers at two special education high schools in Rochester N.Y were asked about current knowledge levels of their students in regards to sex/health education topics and about the programs/curricula that are implemented at their schools. The results indicate that the students are not adequately educated in these topics.

Special Education's Role in Health Education

The research documented in this paper explores the need for students with developmental disabilities to be taught about sex and health education in school. Unfortunately, not much research exists about adolescents receiving the same knowledge as students without disabilities do in their health classes. Much of the research on this topic revolves around adults and the negative consequences that have occurred due to their lack of knowledge. These negative factors include pregnancy, sexual abuse, acquiring AIDS and other STDs, and substance abuse. Students with developmental disabilities who are now more often being included in general education programs are more susceptible to peer pressures than they were before. They are no longer sheltered from these and other issues within the realm of health education. One difficult factor to overcome is being able to teach these subjects in a way that is easy for students with cognitive challenges to comprehend. What are the best strategies for doing so and ensuring retention?

Since it would not be possible to conduct a study on adolescents and their knowledge about sexual education in such a short amount of time, special education teachers were surveyed on their thoughts about the issue at hand. Is there a need for teaching their students about health education? What do the teachers think their students should know? What do they know already? Do they address these topics in their own classroom? How?

Literature Review

Students with developmental disabilities such as Autism and Intellectual Disabilities need to be taught about sex education, drug abuse, and other components in

health education just as their typically developing counterparts are taught in school.

Ellery, Rabak-Wagener, and Stacy (1997) ask, "Who is responsible for the health education of students with disabilities?" (p.105). They explain this question by continuing with "the advent of P.L. 94-142, the Education for All Handicapped Children Act of 1975 and its introduction of the concept of 'least restrictive environment' has led to many changes in the placement of students with disabilities. This, in turn, has led to changes in teacher responsibilities involving health education" (p.106). Cocco and Harper (2002) also explain that,

Policy changes, especially those related to community integration and inclusion, have dramatically altered the lives of people with mental retardation over the past 30 years. The developmental disabilities legislation of the 1970s assisted in changing the perception of people with cognitive limitations by emphasizing the importance of functional issues as compared to "labeling" behavioral deficits and cognitive limitations. This legislation resulted in multiple benefits for people with mental retardation, including increased opportunities and better integration of their participation in the community. (p. 35)

To relate this to adolescents with developmental disabilities, one must realize that even though the best intentions were meant, this shift within the realm of special education toward including many students with developmental disabilities into the general education population has in turn created a plethora of social concerns for their well-being.

Utley, Reddy, Delquadri and Greenwood (2001) explain,

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).

Children with developmental disabilities that were previously unexposed to the peer pressures of substance abuse and sexual activity are no longer sheltered from the realities of life in a typical high school setting. These issues can be confusing for any adolescent to deal with. This coupled with any developmental deficits creates the need for educators to adapt current health education programs to meet the needs of all of the students that attend their schools. Utley, et al. (2001) also suggest that

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

Whether a child is educated in a separate or inclusive setting, the need for adequate sex and health education is apparent.

The website of the National Association of Parents with Children in Special Education (NAPCSE) (2007) describes intellectual disability (or mental retardation) as a term used when a person has certain limitations in mental functioning and in skills such as communicating, taking care of him or herself, and social skills. These limitations will cause a child to learn and develop more slowly than a typical child. Children with mental retardation may take longer to learn to speak, walk, and take care of their personal needs such as dressing or eating. They are

likely to have trouble learning in school. They will learn, but it will take them longer. (n.p)

The website goes on to state that “Most children with mental retardation can learn to do many things. It just takes them more time and effort than other children” (n.p). This being said, it is an unfortunate reality that topics in health education, especially sex education are often omitted from a curriculum that is tailored for children with special needs. Parents or caregivers may be against discussion of these topics for fear that it will lead to ideas of inappropriate behavior. Others may see no point in teaching these topics because the subjects may be too abstract for or too difficult to teach to students with cognitive impairments. It is clear that the need for education about these topics is necessary. How and why should we go about it?

The Council for Exceptional Children's (2011) website states that “Many students with mental retardation live more protected lives than do adolescents without disabilities. This overprotection often heightens the risk of abuse, lack of knowledge, habitual over compliance, limited assertiveness, and undifferentiated trusting are frequent by-products of this "protected" lifestyle” (n.p). Leutar, Z., & Mihoković, M. (2007) explain that

starting with adolescence, due to the lack of appropriate educational influences, people with mental disabilities very often feel unease, shame and fear, even guilt in relation to their sexual organs, sexual reactions and feelings which are part of the normal process of maturation. (p. 93)

In relation, Dukes and McGuire (2009) also write that people with intellectual disabilities lack in knowledge and experience with their sexuality, dating, and intimacy, and have less chances to learn about these topics (p.728). If sex and health education as a whole are

given more attention while people with disabilities are still in school, then many issues that arise as they get older would be avoided. Katoda (1993) deduces that unfortunately the teaching of these topics to people with intellectual disabilities is difficult not only due to their poor cognitive skills, but also because of the preconceived notions that their parents, teachers and other personnel hold about what teaching topics such as health and sex (p. 115).

Povilaitienė and Radzevičienė, (2010) write that “The stereotypic vision of the sexuality of people with disabilities is embedded in society which often hinders the expression of sexuality and the relevance of education” (p. 108). The authors continue with several facts and myths about sex education in relation to persons with intellectual disabilities. The facts include the idea that sexuality still exists even though a disability is present. Also, the sexual feelings of people with intellectual disabilities are not regarded as being as important as a typically developing person's feelings are. The myths that the authors outline are even more interesting. They write that society believes that persons with intellectual disabilities are considered to be eternal children, non-sexual and life-long virgins. Another myth is that sexuality is only the responsibility of ‘normal’ people, people who are able to control their sexual desires and emotions. People with disabilities should not be allowed to express these feelings and measures such as sedation and castration should be used to help control these feelings (p. 108). The values and beliefs of parents and caretakers, and even society can be difficult to change. If an educator is equipped with the proper tools to begin teaching a health/sex education program to his or her students, then we can begin to change the way students with disabilities are perceived in the outside world. Povilaitienė and Radzevičienė, (2010) also explain that a unit or

course on sex education can improve other social skills and situations in a person's life.

They write,

Sexuality education encompasses improvement of personal and social skills, such as management of emotional sphere; self-confidence and trust worthiness; improving communication and cooperation skills; understanding boundaries of peer limitations, the perception of gender role stereotypes; protection from sexual abuse and other conflict situations related to sexuality. (p.107)

It is important to remember that an educator should not begin a health/sex education curriculum with their students until they obtain the permission of the parents/caretakers beforehand. This paper will examine which issues are important in this realm of health education and what are the best strategies for teaching students with developmental disabilities about them.

HIV/AIDS

Johnson, Johnson and Jefferson-Aker (2001) simply state that "We need to help *all* our students avoid risky behavior that may lead to infection in adolescents--including students with mild mental retardation" (p. 28). This statement should include all students with all types of developmental disabilities as well. Blanchett (2000) says that,

Research on the HIV/AIDS knowledge of adolescents and young adults with disabilities is limited to a couple of small studies. Research on the risk behaviors of adolescents and young adults with disabilities is even more sparse than research on their HIV/AIDS knowledge. (p. 336)

Nora Groce (2003) seems to agree with this statement. She writes that

There is a real need to understand the issue of HIV/AIDS in disabled people in

global terms and to design and implement [programs] and policy in a more coherent and comprehensive manner. The roughly 600 million individuals who live with a disability are among the poorest, least educated, and most marginalized of all the world's peoples. They are at serious risk of HIV/AIDS and attention needs to be focused on them. (p.1402)

She also explains some background on the subject by saying that society believes that people with disabilities are not sexually active and therefore are not at risk. She goes on to say that despite this assumption, people with disabilities are likely to have more sexual partners than their people without disabilities. This is due to the stigma attached to marrying a person with a disability-- which results in a series of unstable relationships instead of committed ones (p. 1401). She continues her thought by saying that

Furthermore, literacy rates for disabled individuals are exceptionally low (one estimate cites an adult literacy rate of only 3% globally), thus making communication of messages about HIV/AIDS all the more difficult. Sex-education programs for those with disability are rare, and almost no general campaigns about HIV/AIDS target (or include) disabled populations. (p. 1402)

Leutar and Mihoković (2007) also concur that, "Insecurity and lack of knowledge about various sexually transmitted diseases is present" in regards to persons with intellectual disabilities (p. 93).

Substance Abuse

Cocco and Harper (2002) deduce that "The majority of investigations focusing on adolescents with mental retardation [and substance abuse] used school-based self-report measures" (p.36). This relies on honesty and therefore may not be valid. The authors also

state that, “Initiation of substance use and misuse appears to begin during the elementary school years in patterns similar to those demonstrated by non-disabled youth in the general population who are at high risk for developing substance-abuse problems” (p.38). This means that students with disabilities may turn to substance abuse just as their typically developing counterparts do if they are predisposed to addiction. Slayter (2010) explains this by stating that “People with mild to moderate levels of [intellectual disabilities] are posited to be most likely to develop [substance abuse] disorders, possibly given a higher likelihood of stigmatizing experiences while participating in community-based activities, school, or work programs” (p.49). This is an important fact to remember when educating children with intellectual disabilities, particularly in an inclusive setting—due to an increase in social activities with non-disabled peers. Other reasons are also outlined by Christian and Poling (1997). They describe a possible biological reason for persons with intellectual disabilities to abuse substances by saying that,

People with mental retardation may be especially vulnerable to some risk factors. For instance, inadequate self-regulatory behavior, which has been identified frequently as a predictor of drug abuse in the general population, is also a problem associated with mental retardation. If inadequate self-regulation causes, or is at least predictive of drug abuse, one would expect this variable to have a greater overall effect on people with mental retardation than on the population at large.

(p. 127)

Slayter (2010) explains a potential social reason. They write that “People with intellectual disabilities have experienced increasing levels of community participation since deinstitutionalization. This freedom has facilitated community inclusion, access to

alcohol and drugs, and the potential for developing substance abuse (SA) disorders” (p. 49). While immersion into general society is a positive step for people with disabilities, pressure to be “normal” can greatly affect their already poor decision making abilities. In relation, McGillivray and Moore (2001) write that “[De-institutionalization] has been a positive experience for the majority of people with intellectual disability. A potentially negative consequence that can arise from increased levels of freedom and mobility, however, is the greater exposure to alcohol and illicit substances inherent in community living” (p. 297). They also describe several components to why people with mild intellectual disabilities may develop these substance abuse problems. These include

A compromised tolerance to drugs, a tendency for both self-medication and over-medication, and the potentiation of effect caused by combinations of prescribed medication and alcohol or other non-prescribed substances. Second, intrapersonal and interpersonal variables such as low self-esteem, impaired self-regularity [behavior], susceptibility to peer pressure, and desire for social acceptance. Third, drug-seeking [behavior] may be influenced by environmental factors such as the presence of negative role models, inappropriate living conditions and excessive amounts of free time. (p. 297)

McGillivray and Moore (2001) also denote that “offenders with intellectuality disability differ from their non-offending counterparts in their knowledge about, and consumption of, both licit and illicit substances” (p. 305). In relation, Jobling & Cuskelly (2006) deduce that “a lower level of substance abuse is required to cause psychosocial crises and health problems in those with intellectual disability than in those developing typically, and alcohol use and offending [behavior] have been associated in this

population” (p.216). This means that licit and illicit drugs can have a greater effect on people with disabilities and may cause them to commit crimes or partake in other behavior that is not an ideal outcome. This information makes it apparent that education about these subjects is imperative in order to prevent addiction and potential abuse from happening.

Healthy Habits

One common issue that needs to be addressed with students with disabilities is hygiene, healthy eating and simply making healthy choices. Despite the prevalence of teaching these topics at school, Jobling and Cuskelly (2006) explain the deficits in many of the current such programs. They write that even though cooking and health programs may be offered in school to people with disabilities, the way the information is presented is not effective enough to increase their knowledge about the topics (p. 217). The authors also explain that

[Independence in] self-care is also a goal for [people with developmental disabilities] who continue to live with family, however independence will not occur for either group in the absence of: (i) the requisite knowledge on which to base health decisions; and (ii) the capacity to self-regulate. (p. 210)

They continue these thoughts by explaining that

If individuals with an intellectual disability are to have a quality lifestyle they need to understand what is required to keep themselves well. Little information has been published about the level of understanding individuals with an intellectual disability have about health-promoting [behaviors] and illness prevention. (p. 211)

All children, not just those with disabilities, that are not educated about healthy eating and wellness habits while they are young will develop difficult to change poor practices in regards to lifestyle as adults—if something is not done to try and change these adaptive behaviors.

Jobling and Cuskelly (2006) explain what children with intellectual disabilities have to look forward to if something is not done to encourage a healthy way of life. They write that,

The health status of adults with intellectual disability is extremely poor, with unacceptable levels of morbidity and mortality. These adults have a range of significant health problems, including chronic medical conditions such as cardiovascular diseases, osteoporosis and obesity, diabetes, muscular-skeletal problems and respiratory disorders. Although these problems are significantly higher than in the general population, many are believed to be preventable through appropriate education and by addressing the sedentary lifestyle of many adults with intellectual disability. (p. 210)

Throughout the article, Jobling and Cuskelly (2006) suggest several topics that should be addressed with students with intellectual disabilities during learning sessions. These could possibly include: the process of completing independent hygiene routines; proper dental care; knowledge of the food pyramid and healthy food choices; the importance of and benefits of exercising; being able to identify sanitary eating and living conditions—i.e. not eating food that fell on the floor; understanding the concept of germs and spreading diseases—i.e. covering one's mouth when coughing or sneezing; the importance of getting regular checkups at the doctor; among many other topics.

Sexual Relationships

Students with disabilities may struggle with making friendships, let alone beginning reciprocal sexual relationships. In order to be a part of a meaningful sexual relationship, a person must have the ability to be or to have a true friend. Jobling, Moni, and Nolan (2000) write that, "In part, understanding friendship stems from the ability of the individual to develop an understanding of, and experience 'having or being a friend'" (p. 236). The authors also explain that the social settings that people with disabilities are exposed to in day programs and in school are usually staged by the people who facilitate their programming. In these settings, *everyone* is their friend, which of course in reality is not the case (p. 237). It is important to ensure that all students are able to interact with one another whether or not the educational setting is in an inclusive or separate setting. Determining whether or not a person with developmental disabilities has an understanding of friendship will indicate his or her readiness to partake in a more serious relationship in the future.

When the attempt at actually teaching sexual education to people with intellectual disabilities occurs, Povilaitienė and Radzevičienė, (2010) discuss the importance of not just teaching "the basics" during a health/sex education unit. They write that

The scope of sexuality expression should be much wider than the understanding about sexual relationship, stages of embryo development, pregnancy planning and disease prevention...the most important thing is to focus on the expression of social relationship, emotions, decision making, responsibility for oneself and others, because sexuality consists of physical, mental, social and spiritual components. (p. 109)

Students with developmental disabilities may desire to begin experimenting with sex just as their typically developing counterparts do when they are in their teenage years.

Though these students may be cognitively lower functioning, they have the same feelings that all teenagers do. Rashikj (2009) continues this thought process by saying that “Persons with disabilities follow the same developmental cycle as [the rest of] population with possible small concessions in relation with the type and degree of disability.” She maintains this position with the notion that “All persons with disabilities are sexual creatures [and] they acquire information for sexual development from media or friends” (p. 137). As educators, it is important to ensure that students with disabilities have access to the same (and true) knowledge as everyone else. Healy, et al. (2009) further prove this statement by denoting that “Those under the age of 18 years had only rudimentary knowledge of sexuality issues, for example pregnancy and sexual anatomy, but aspired to relationships and marriage similar to those over the age of 18 years” (p. 905). They continue their explanation of this idea by saying that

Providing individually tailored sex education to people with an ID leads to direct and measurable improvements in their capacity to make decisions about sexual relationships. However, studies suggest that only half of those with an ID actually receive sex education. As a consequence, there may be compromised knowledge in *all* areas of sexuality resulting in increased risk of contracting sexually transmitted diseases (STDs) and increased risk of unplanned pregnancy compared with peers who do not have an ID. (p. 906)

One deterrent may be that outside people such as parents, staff, educators, etc. may carry the belief that any information that is taught to persons with intellectual disability about

sex education will not be able to be retained. This thought is refuted by W. R. Lindsay et al, (1992). They conducted a study that determined whether or not people with intellectual disability can be taught about sex education, and whether or not this information will be retained. They write, "This study gives a fairly strong suggestion that people with intellectual disabilities can acquire knowledge about sexuality following a sex education course and that this knowledge will maintain after the cessation of the [program]" (p. 532). This is due to the study's use of specific assessments in areas of knowledge such as parts of the body, masturbation, male puberty, female puberty, intercourse, pregnancy and childbirth, birth control, and venereal disease. The study used a control group and conducted a follow-up study after the preliminary data was taken and the course on sexual education topics was disbursed (p.538).

Sexual Abuse

Furey, Granfield, and Karan (1994) explain several reasons why people with mental retardation may be more susceptible to sexual abuse. It is due to the dependence of others for their care and the tendency to trust and obey all instructions from their caregivers. Also, sexual predators chose victims that they believe are not as powerful and will not be believed if allegations of abuse are made (p. 75). They continue with the notion that, "In addition to issues of trust, dependence and compliance, people with mental retardation traditionally have not received adequate sex education and/or assault prevention training, nor do they often have opportunities to learn appropriate sexual and social behavior through participation in clubs, parties and other events" (p.83). Lumley and Scotti (2001) seem to agree as well. They write that people with intellectual disabilities are more likely to be compliant, and have poor social skills/ judgment (p.110).

Furey, Granfield, and Karan (1994) warn that

Living with one's family or in one's own home reduces, but does not eliminate, the risk of sexual abuse. As the field of mental retardation moves toward supporting people with mental retardation to live on their own, it is essential that training concentrate not only on the technical aspects of independent living...but also the less defined areas of building friendships and sustaining mutually respectful intimate relationships. People with mental retardation, regardless of their residence, must also be taught how to protect themselves and how to seek help when challenged by a sexually abusive situation (p. 83).

Reliance to staff and persons they should be able to trust can make them victims in their own home setting. However, if students are given the proper training while in school, they may be better able to be aware of dangerous situations in the future.

Persons with all types of disabilities may be at a higher risk for being abused sexually due to their cognitive impairments. An inability to recognize social cues or a dysfunction with receptive/and or expressive language may inhibit the individual to give consent for a sexual act. Healy, et. al (2009) explain that "Individuals with an [intellectual disability] may have a compromised understanding of sexual consent, may be unable to distinguish abusive from non-abusive relationships, and are therefore highly vulnerable to sexual abuse" (p. 906). Dukes and McGuire (2009) go on to say that

Valid consent to sexual contact requires knowledge, understanding and voluntariness. Some individuals will never meet all the criteria in full, yet may be capable of consenting to some aspects of sexual expression, requiring different degrees of capacity to consent. The challenge for professionals and [caregivers] is

to determine the extent to which individuals can make informed sexuality-related decisions, reflecting these different aspects of sexual expression – such decisions can be difficult, even when an increase in knowledge has been demonstrated. (p. 728)

Dukes and McGuire (2009) also describe the Sexual Consent and Education Assessment (SCEA) and its use with persons with developmental disabilities. They say that

The notion underpinning this research is that capacity to consent is not static... while a person may be deemed incapable of giving consent at one point in time, it may be possible through facilitation or education for that same person to be deemed capable of giving consent at a future date. (p. 728)

This statement supports the notion that it is necessary and pertinent to provide to all students with sex education. It ensures that they are given the best chance at being armed with the right information, in order to make their own choices about the subject.

Strategies For Teaching Sex Education

Whichever sex education curriculum an educator decides to use, The Council for Exceptional Children's (2011) website suggests applying the following adaptations to enhance learning:

Simplified but age-appropriate reading materials or media that do not require reading, hearing, vision, or mobility, depending on the student's level of ability, the use of a variety of concrete teaching strategies to reinforce the information presented (e.g., written materials, audiovisual materials, role playing, interactive games, etc.), learning strategies that closely approximate real life, opportunities for interaction with non-disabled peers and role models and repeated opportunities

for ongoing learning. (n.p)

Leutar and Mihoković (2007) suggest “[increasing knowledge levels] through various associations and projects. Similarly, there is a need for higher number of counseling where the youth with mental disabilities can express their problems and dilemmas concerning sexuality” (p.108). Having open communication with your students in not only a group but also solo setting will ensure that all questions are asked and answered.

One option for special educators to use in their classroom is *Stanfield's Life Facts Series*. It includes seven programs with the following topics: intimate relationships, abuse prevention, AIDS, managing emotions, smart trust, substance abuse and managing illness and injury. The James Stanfield Company (2011) boasts that they are “the specialists in special education” (n. p) and this all inclusive program seems to fit the needs of many students with disabilities. The program can be bought online as a whole for \$1,299 or each subject could be bought for \$225 individually. The curriculum is available as a DVD or individual laminated pictorial representations of the subjects which let the educator choose which to use depending on student ability. It also includes pre and post assessments that will help the educator gauge prior knowledge and retention of information learned. This program seems to include all that is needed to begin instruction on sex education but if funds are low, a similar curriculum can probably be designed by a creative educator.

Healy, et. al (2009) describe a framework for opening discussion about sex with a group of people with intellectual disabilities:

Each group began with an introduction from the group facilitator and a request to audio record the discussion. A flip-chart using pictorial cues was used to explain

sections of the discussion. The confidentiality of the discussion was highlighted and each participant was encouraged to speak openly. (p. 907)

They go on to describe that the group discussed general views, experiences and aspirations about relationships and sexuality. The participant's comments were then grouped into key themes. These themes were as follows: general views of sexuality and relationships, personal relationships and the views of relatives, relationships within the service, sex and related issues and the future (p. 907). It is clear that allowing open dialogue and personal experience into the lesson is a good way to start the discussion of sex education. This way the teacher/group leader may gauge which issues need more focus due to inadequate background knowledge.

Johnson, Johnson and Jefferson-Aker (2001) outline a program to teach students with mild mental retardation about HIV/AIDS prevention in school. They suggest that "The content of an HIV/AIDS prevention program should include, a) teaching factual information, b) encouraging the learning behaviors that prevent infection, and c) facilitating parental involvement" (p. 30) An educator may choose any way they would like to present the information, and may even use an existing program that is tailored for the typically developing adolescent. To ensure that a students with developmental disabilities is able to fully comprehend the information, Johnson, Johnson and Jefferson-Aker (2001) also suggest the following modifications: "Building on students' existing experience, breaking tasks into small steps, [providing] opportunities for students to apply or transfer previously learned information, helping students generalize by using multiple examples, and presenting learning sessions in short periods of time" (p. 30). Other strategies may include,

Assigning tasks and using materials that are suited for student's abilities, using cooperative-learning procedures, responding supportively to students, maximizing instructional time for students, employing direct instruction, providing structure, encouraging active participation, providing feedback on student performance, and using a variety of instructional activities that alter pace and learning experiences. (p. 31)

Utley, et al (2001) describes a teaching method that may be adapted to create a health curriculum for students with developmental disabilities. They write that, "Implementing an effective health education program may be accomplished through incorporating and adapting Class Wide Peer Tutoring (CWPT). Class Wide Peer Tutoring is a highly structured instructional procedure that incorporates high levels of practice within the content to be taught" (p.3). The authors further describe this teaching method by describing its four major components. They are as follows:

The first involves teacher determined academic material for tutoring which includes verbal and written practice of skills (e.g., reading aloud, writing, spelling words, reciting math facts, etc.). The second component consists of all students in a classroom working in pairs. The third component incorporates immediate and corrective feedback provided by the tutoring student, when the student tutee makes an error. The fourth component involves individual and team reinforcement. (p. 3)

In order for CWPT to be successful, the students and teachers must be trained in advance to ensure that it is being carried out the proper way. The authors explain that "as a teaching strategy, CWPT has proven to be effective for increasing academic achievement

and improving the classroom behaviors of students with disabilities across a variety of subjects (e.g., spelling, math, social studies, and reading) and grade levels” (p. 4). Class Wide Peer Tutoring has been proven to work in many subjects, and can certainly be adapted to fit a health curriculum.

Method

Data will be collected through anonymous surveys completed by high school special education teachers at a private special education high school in the Rochester N.Y area. The surveys will be dispersed at a faculty meeting and will be handed in at the end of the meeting. One survey was completed by a health teacher at a private special school in the Rochester N.Y area. The data will include what knowledge levels their students are currently at surrounding the topics of health/sex education, what knowledge the teachers believe that their students have, what issues are prevalent in their classrooms/school, and how/if the teacher's address health education in their classrooms. The data collected will then be used to determine which strategies will work best to address these issues in the special education classroom.

Results

Fifteen of the twenty surveys that were distributed were returned. Of the fifteen, six were determined not relevant to this study because the students were described by their teachers as being non-verbal, non-ambulatory and as being at a cognitive level of below two years of age. For the purpose of the examination of the survey's results the teacher responses will be labeled Teacher 1-9. Teachers 1-8 are special education teachers at a special education high school. Teacher 9 is a health teacher at a separate special education high school.

The first question of the survey asked, "What are the ages and developmental disabilities of your students?" It was then separated into a section for females, and males. Teacher 1 labeled the students A-G. Student A is a 17 year old female with Down's syndrome and mental retardation. Student B is 17 year old female with multiple disabilities. Student C is also a 17 year old female with multiple disabilities. Student D is a 21 year old female with multiple disabilities. Student E is a 17 year old male with Down's syndrome and multiple disabilities. Student F is an 18 year old male with multiple disabilities.

Teacher 2 did not label the students, but just listed the ages and developmental disability. Under the section designated for females, Teacher 2 listed one 12 year old with multiple disabilities and one 15 year old with multiple disabilities. Under the section designated for males, Teacher 2 listed two 14 year olds with Autism and three 14 year olds with multiple disabilities.

Teacher 3 used general descriptions of the female and male students and did not provide an exact number of students. Under the section designated for females, Teacher 3 wrote, "Sixteen years, multiple disabilities." Under the section designated for males, Teacher 3 wrote, "Sixteen years to twenty-one years," and listed multiple disabilities, intellectual disabilities and Autism underneath.

Teacher 4 also used general descriptions of the female and male students and did not provide an exact number of students. Under the section designated for females, Teacher 4 wrote, "Eighteen to twenty: autism, intellectual disability and multiple disabilities." Under the section designated for males, Teacher 4 wrote, "Eighteen to twenty-one: Autism, intellectual disability and multiple disabilities."

Teacher 5 labeled the students 1-3 under the section designated for females. Female 1 is a 13 year old with Coffin-Sins Syndrome and multiple disabilities. Female 2 is a 13 year old with multiple disabilities. Female 3 is a 14 year old with Down's syndrome and multiple disabilities. Teacher 5 labeled the students 1-4 under the section designated for males. Males 1, 2 and 4 are 13 years old and have Autism. Male 3 is 14 years old with multiple disabilities.

Teacher 6 did not label the students, but just listed the ages and developmental disability. Under the section designated for females, Teacher 6 listed one 17 year old with mental retardation, and two 19 year old students with multiple disabilities. Under the section designated for males, Teacher 6 listed one 18 year old with multiple disabilities, one 19 year old with Autism, one 19 year old with multiple disabilities, and one 20 year old with multiple disabilities and Charge Syndrome.

Teacher 7 also listed the student ages and their developmental disability. Under the section designated for females, Teacher 7 listed one 15 year old and one 16 year old, both with Autism. Under the section designated for males, Teacher 7 listed one 14 year old, one 15 year old, and one 16 year old. All three males have Autism as well.

Teacher 8 used general descriptions of the female and male students and did not provide an exact number of students. Under the section designated for females, Teacher 3 wrote, "16 years to 21 years", and listed intellectually disabled, Autism and multiple disabilities underneath. Under the section designated for males, Teacher 3 wrote, "16 years to 21 years", and listed intellectual disabilities and multiple disabilities underneath.

Teacher 9 used general descriptions of the female and male students and did not provide an exact number of students. Under the section designated for females, Teacher 7

wrote "My students range from 10-17 years old. All of my female students are Deaf and/or have Cerebral Palsy, Mental Retardation, or Autism." Under the section designated for males, Teacher 7 wrote, "My students range from 10-17 years old. All of my male students are Deaf and/or have Cerebral Palsy, Spina Bifida, Mental Retardation, or Autism."

The second question of the survey asked, "What knowledge levels are your students at in regards to sex education? (Please rate each category from 1-5, 1 being no knowledge, and 5 being high knowledge.)" The categories were then listed as Anatomy, Basic Knowledge of Sex, Pregnancy, STD's, Sexual Abuse, and Safe Sex, and the response section was then separated into a section for females, and males. Teacher 1 did not distinguish between the categories, and wrote one number for the knowledge level for each student. Teacher 1 wrote that female students A and B were at level 1 (no knowledge) for all categories. Student C is at a level 3 for all categories and student D is at a level 2 for all categories. The males, students E, F and G are all at level 1 for all categories. Teacher 2 rated both of the female students at a level 2 for anatomy and basic knowledge of sex, but states that they have no knowledge of anything else. Of the male students, Teacher 2 rated four of the males at a level 2, stating that they "Have some knowledge of anatomy." Teacher 2 rated the remaining male student at a level 4 and states that, "He is very aware of sex but has no knowledge of abuse, STD's, safe sex or pregnancy." Teacher 3 did not distinguish between categories or students, and rated all students as a 1, but with "knows basic anatomy" written on the side. Teacher 4 also did not distinguish between categories or students, and rated all students as a 1-2 in knowledge levels. Teacher 5 did distinguish between students, but did not rate individual

categories. Females 1 and 3 were rated at a level 1 for all categories, and Female 2 was rated at a level 2 for all categories. Teacher 5 rated Males 1, 2, 3, and 4 all at a level 1 for all categories. Teacher 6 did not distinguish between categories or students, and rated all students at a level 1 for all categories. Teacher 7 also did not distinguish between categories or students, but did provide comments for the male section. Under the section designated for females, Teacher 7 rated all females at a level 1. Under the section designated for males, Teacher 7 rated the males at a level 1, but wrote that, "Male students are aware of sexual arousal/masturbation." Teacher 7 also rated one of the males at a level 2 and stated that, "One student is inappropriate sexually and has some knowledge of both male/female anatomies." Teacher 8 did not distinguish between categories or students, and rated all students at a level 2 for all categories. Teacher 9 did not rate any students numerically, but provided a general statement in regards to all students by saying that, "Many of my students are lacking knowledge when it comes to sexual education. Many do not know what is safe sex, what kind of STD's are out there and how they are spread. However, many are knowledgeable of what HIV/AIDS is, but not all the facts regarding the virus/disease."

The third question of the survey asked, "Do you think/know if your students are sexually active? Please describe why you believe so." It was then separated into a section for females and males. Under the section designated for females, Teacher 1 did not label the students A-D as before. Teacher 1 wrote only about two of the three 17 year olds previously listed, and about the 21 year old. About one of the 17 year olds, Teacher 1 wrote that. "One instance is known about sexual activity being attempted." For the other 17 year old, Teacher 1 wrote, "Talks about the possibility, but I'm not concerned." In

regards to the 21 year old, Teacher 1 wrote, “perhaps, talks are related to it but understanding is not accurate to facts.” Under the section designated for males, Teacher 1 wrote, “No, these students are under very close supervision at home.” Under the section designated for females, Teacher 2 answered, “No, both are very unaware of sex.” In regards to the male students, Teacher 2 responded with, “Four of my male students: no. One of my male students: maybe. He has expressed an interest in sex.” Teacher 2 did not indicate which of the five male students previously listed was being referred to. Teachers 3, 4, 5 and 7 all answered “No” for all students for this question. Teacher 6 wrote the following in regards to all students: “I do not think any of my students are sexually active due to the level of adult/staff assistance needed, they are not alone in a romantic/sexual situation.” Under the section designated for females, Teacher 8 answered with, “Yes. Two females talk about thinking they are pregnant (when stomach hurts).” Teacher 8 wrote “Not Sure” in regards to male students. Teacher 9 responded with the following for all students: “Yes. I do know my students are sexually active as the Deaf community is relatively small in Rochester, NY. People talk, and information gets around. Even though my students have not come forth and explicitly told me, I have heard from reputable sources that some of my students have engaged in sexual intercourse.”

The fourth question of the survey asked the teachers, “What knowledge levels are your students at in regards to substance abuse? (Please rate each category from 1 to 5, 1 being no knowledge, and 5 being high knowledge.) The categories were then listed as Alcohol, Tobacco, Prescription Drugs and Illicit Drugs. Teacher 1 labeled the students A-G; Students A-D are females and Students E-G are males. Students A, E, F, and G were

rated at a level 1 for all categories, while Students B, C and D were rated at a level 2. Teacher 2 rated both female students at a level 1. Under the section designated for males, Teacher 2 stated that, "Four of the male students have no knowledge, one of my students is semi aware of alcohol and drugs." Teacher 2 rated this one semi-aware male student at a level 3. Teacher 3 rated all students at a level 1 for all categories. Teacher 4 rated all students at a level 1 or 2, saying that "Maybe one girl is at a 2 or 3 because she knows that smoking is bad for you." Teachers 5 and 6 rated all students at a level 1. Teacher 7 rated all of the female students at having no knowledge, but under the section designated for males wrote, "One of my students is (or claimed) to have been exposed to alcohol, tobacco and illicit drugs at home, and he is aware of how to use them." For this reason, this one male was rated at a level 3, but it is unknown which of the three males it is. Teacher 8 rated all students at a level 2 and did not distinguish between categories. Teacher 9 wrote the following statement in regards to all students, "Many students are aware of basic dangers and risks involved with alcohol and tobacco. However, many of the students are unfamiliar with many of the illicit drugs like: cocaine, LSD, Meth, etc."

The fifth question of the survey asked, "Do you think/know if your students abuse substances? Please describe why you believe so." Teachers 1, 2, 3, 4, 5, 7 answered this question with "No", and did not offer any reasoning why they answered this way. Teacher 6 said "No, my students are never alone out in a community situation to interact with alcohol, tobacco, or drugs of either kind." Teacher 8 answered this question with "Not sure" and did not provide an explanation. Teacher 9 wrote the following statement in regards to all students: "I do not believe my students abuse substances. Many of them live in the dorms where drugs and alcohol are strictly forbidden. I have not heard of any

incidents involving substances on campus or off campus with our students. I have not heard from anyone that our students are involved either.

The sixth question asked the teachers, "Do you address these issues in your classroom? How? Please describe any programs/methods that you use." Teacher 1 wrote, "I try to answer questions discretely, however, we do not have home permission as of yet to really discuss issues completely." Teacher 2 wrote the following: "yes, I use the CIRCLES program to address levels of touch, talk, and trust with different levels of people (e.g. family, extended family, teachers, friends, strangers, community helpers.)" Teacher 3 answered the question by saying that, "I have used DARE in the past, not currently though." Teacher 4 also wrote that the CIRCLES program is used, while Teacher 5 uses redirection to the activity or verbal reminders of rules, such as: "Hands out" or "Keep your hands and feet to yourself" if an inappropriate situation occurs. Teacher 6 responded to the question by saying that, "We discuss the positive aspects of a healthy lifestyle but do not specifically mention alcohol, tobacco and other drugs. Teacher 7 answered the question by saying "no", but added that "we began to use the CIRCLES program in the beginning of the year but have not kept up with it due to behavior issues." Teacher 8 wrote, "I try to incorporate positive messages into daily lessons. Specific education is not allowed until it is approved (curriculum) by a supervisor." Teacher 9 wrote the following: "Every semester, I bring a Substance and Alcohol Intervention for the Deaf (SAISD) Counselor in from NTID to speak about ATOD (Alcohol, Tobacco, and Other Drugs) to my students. I also bring in a HIV positive Deaf individual to speak about his/her experiences with living with the disease. We discuss in depth about the facts, risks, and prevention techniques and skills they can

use to avoid these situations. We will use a variety of techniques to teach these skills: Film; Role Playing; Direct Instruction; and classroom discussion.”

The seventh question asked “Is this program sufficient enough to address these social issues with your students? What is positive about it? What is lacking?” Teacher 1 only wrote “No”. Teacher 2 stated that “I think it is okay, but it is extremely outdated and needs to be updated. I think it may be somewhat confusing for our population of students.” Teacher 3 responded with “In the past some of the information was at a higher level, but [I] was able to adapt [it] to lower levels using picture symbols.” Teacher 4 answered the question by saying that, “For my students with their cognitive abilities (around the age of a preschooler) these are a sufficient enough way to teach this type of information. It covers the basics without getting into too much detail.” Teacher 5 wrote “Yes. It is not restrictive and easy. It focuses the attention back to the activity in a positive way.” Teacher 6 said, “At this time and with my specific classroom I do not have a need to address those social issues. We try and focus on the positive aspects of health and safety. In the past years it has been necessary to address student questions so having a more formal program to address this would be beneficial.” Teacher 7 wrote, “Not applicable.” Teacher 8 responded by saying, “No specific program. CIRCLES is very general. Not specific enough to address sex/drug needs.” Lastly, Teacher 9 wrote the following: “as a certified health teacher, I want to say that I do my best to teach the necessary skills and knowledge to my students. Unfortunately, many of my students have hearing parents which causes a huge communication barrier at home which prevents them many times from sitting down with their parents to discuss these sensitive topics. I always feel that a lot of this information should be reinforced and/or discussed at home

with their parents.”

The eighth and final question of the survey asked “Any other thoughts/concerns?” Teachers 2, 3, 4, 5, 6, 7 and 9 left this section blank. Teacher 1 wrote, “We need to do so much more. The students are filled with incorrect information.” Finally, Teacher 8 answered with, “we need an explicit sex education and drug curriculum!”

Discussion

Of all of this information, it has been gathered that the students described by Teachers 1-8 for the purpose of this survey are between the ages of 13- 21 years old and have multiple disabilities. Many have developmental disabilities such as Autism or Intellectual Disability (Mental Retardation). Two students have Down's syndrome, one student has Coffin-Sins Syndrome and one student has Charge Syndrome. The students described by Teacher 9 are between the ages of 10-17, and are Deaf, and have other disabilities such as Cerebral Palsy, Mental Retardation, Autism or Spina Bifida.

According to the results of the survey, most students are described as being at a level 1 (no knowledge) or a level 2 (some knowledge) for all of the categories: anatomy, basic knowledge of sex, pregnancy, STD's, sexual abuse, and safe sex.) Repeatedly teachers said that most students were familiar with anatomy. No teachers indicated knowledge levels higher than a 2 for pregnancy, STD's, sexual abuse and safe sex. Teacher 1 did rate one 17 year old female at a level 3, but no explanation was provided as to why this is the case. Teacher 2 did rate one male at a level 4 for basic knowledge, but did stress that there was no knowledge about pregnancy, STD's, sexual abuse and safe sex. Teacher 9 indicated that some students are aware of HIV/AIDS, but that they still do not have all of the facts about the illness.

Most of the teachers surveyed do not believe that their students are sexually active. Reasons most commonly given were due to close supervision in their home setting. Teacher 1 mentioned hearing about incidents involving the female students in her classroom. Teachers 2 and 8 were not sure about some of the males in their classes. Only two teachers responded with “yes” and that is Teacher 8 (about the females) and Teacher 9. All students would benefit from a sexual health education curriculum, but the students that are known to be sexually active are being cheated by not having accurate information. It is just too dangerous for their well-being!

Knowledge levels about substances (alcohol, tobacco, prescription drugs and illicit drugs) and substance abuse was generally at a level 1 or 2. Only two males were rated at a level 3 (one by Teacher 3, the other by Teacher 7.) Most teachers surveyed do not believe that their students' abuse substances, only Teacher 8 responded with “not sure.” More information may be needed (by surveying parents and perhaps even students) to gain a better perspective of whether or not substances are an issue to this population of students.

Many teachers indicated that they use the CIRCLES program to teach boundaries and levels of trust with different degrees of people. It seems that some of teachers felt that it was not sufficient enough to deal with all of the issues that their students are facing. Others expressed frustration with not having permission to explore these topics due to restraints from parents and/or supervisors at their school.

Conclusion

All of the negative factors that the research has shown to occur to adults with developmental disabilities can be avoided if direct instruction of sex/health education is implemented while in high school. Adolescent students should be taught about the risk factors surrounding sexual activity (such as pregnancy and STD's), and how to protect themselves against and report sexual abuse if it occurs. The only way to reduce the current trends of pregnancy rates, sexual abuse, substance abuse and HIV/AIDS cases within the developmentally disabled population is if this knowledge can be taught to these students.

According to the results of this survey, this education is not occurring at the particular school that Teachers 1-8 are teaching at. Teacher 9 is a health teacher at a separate school and the strategies that are implemented there are better but still more could be done! It should be noted that some of the students that attend the school where Teachers 1-8 are teaching are significantly lower cognitively than elsewhere. The teachers who have these students that function at a lower cognitive level should continue to use the CIRCLES program to teach them about the dangers of sexual abuse. However, it is alarming that more is not being taught to the higher functioning students that could potentially be sexually active. If teachers feel that their students are engaging in, or thinking about engaging in sexual activity, then they should push to incorporate a more informative sexual curriculum that will teach students about all aspects of sexual education. Since the CIRCLES program is already in use, perhaps utilizing the more modern and updated *Life Facts Series* (also created by the James Stanfield Company), would be beneficial for the students that are engaging in or are curious about sex. The

topics covered in the *Life Facts Series* include intimate relationships, abuse prevention, AIDS, managing emotions, smart trust, substance abuse and managing illness and injury. Another important strategy may be to simplify general health education programs by using picture symbols that will make more sense to this population of students.

Of course, the parents must be on board with providing sexual education in the school setting before a teacher can begin any sort of curriculum in the classroom. Some parents may still have the mind-set that their teenager with special needs will forever be an eternal child, and therefore is not required to learn about such things. If more time was allotted, it would be interesting to conduct interviews with parents about their feelings about such a curriculum.

It all may go back to the original question, who is responsible for health education in the special education realm? Is it the special education teacher or the health teacher? Should special schools incorporate a health teacher to lead classes on such topics? Whichever way the school chooses to provide the instruction is up to them at the time being. To simply ignore the need for and the benefits that a sex/health education curriculum can provide to developmentally disabled adolescents demonstrates poor teaching and advocacy, and does nothing but maintain the horrific cycle that the research shows will continue within this population.

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Appendix

Teacher Survey Questions

1.) What are the ages and developmental disabilities of your students?

FEMALES:

MALES:

2.) What knowledge levels are your students at in regards to sex education? (Please rate each category from 1-5, 1 being no knowledge, and 5 being high knowledge.)

Anatomy, Basic Knowledge, Pregnancy, STD's, Sexual Abuse, Safe Sex

FEMALES:

MALES:

3.) Do you think that/know if your students are sexually active? Please describe why you believe so.

FEMALES:

MALES:

4.) What knowledge levels are your students at in regards to substance abuse? (Please rate each category from 1-5, 1 being no knowledge, and 5 being high knowledge.)

Alcohol, Tobacco, Prescription Drugs, Illicit Drugs

FEMALES:

MALES:

5.) Do you think that/know if your students abuse substances? Please describe why you believe so.

FEMALES:

MALES:

6.) Do you address these issues in your classroom? How? (Please describe any programs/methods that you use.)

7.) Is this program sufficient enough to address these social issues with your students? What is positive about it? What is lacking?

8.) Any other thoughts/comments?