Evaluation of the Opt-In Sexual Health and Abuse Prevention Education Policy in Texas

TEXAS SCHOOL REPRESENTATIVES' ATTITUDES AND EXPERIENCES

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EXECUTIVE SUMMARY

Recent legislation enacted in Texas requires that public schools implement an "opt-in" parental permission policy related to students receiving instruction on sexual health education and related to the prevention of child abuse, family violence, dating violence, or sex trafficking. The purpose of this report is to evaluate the impact of this new policy on the implementation of sexual health and abuse prevention education among youth in Texas schools, including those in the child welfare system. To conduct this evaluation, The University of Texas Health Science Center at Houston (UTHealth Houston) collaborated with Healthy Futures of Texas (formerly the Texas Campaign to Prevent Teen Pregnancy) to survey a diverse, bipartisan sample of 152 Texas school representatives (administrators, teachers, school health staff, and school health advisory council [SHAC] members) to assess their attitudes and experiences related to the policy. Both quantitative and qualitative data were collected and analyzed.

Overall, the majority of our sample of Texas school representatives perceived the opt-in policy related to sexual health and abuse prevention as a barrier to the delivery of education related to these topics. Our sample expressed concerns related to the additional burden and time that obtaining parental permission would take, especially in the context of their already busy schedules. Respondents reported that multiple parental permission distribution methods were needed to increase response rates and that lack of parental consent return does not necessarily indicate that parents do not want their child to participate in sexual health or abuse prevention education. Further, many respondents perceived that fewer students in 2021-2022 received sexual health education compared to previous academic years. Respondents expressed concerns that the opt-in policy could create or worsen health disparities by decreasing access to sexual health education, and create differential barriers for student access. Most respondents reported favoring an opt-out policy with respect to sexual health and abuse prevention education, and respondents highlighted particular possible safety concerns with the policy. Finally, given the limited participant-reported parental permission data, it was not possible to assess the impact of the opt-in policy on students' receipt of sexual health education, which points to the need for additional tracking of these student data and highlights the concern that there is no systematic tracking of the impact of this policy across Texas schools. One consistent trend from the participant permission form data, however, reflected the finding that among parents whose child did return a parental permission form, the vast majority provided permission for their child to participate in sexual health education; this result suggests strong parental support for their child's receipt of sexual health education in school.

Recommendations related to future implementation of the opt-in policy and sexual health and abuse prevention education in Texas schools for policymakers, school districts, and schools are provided.

BACKGROUND

In the 88th Legislative Session (2021), Texas enacted House Bill 1525, which requires schools to obtain written parental consent for children to receive and participate in sexual health education programming.[1] In a subsequent special session, the Texas Legislature passed Senate Bill 9, extending this parental consent requirement to any instruction on prevention of child abuse, family violence, dating violence, or sex trafficking. Per newly adopted state law, permission forms may not be included with any other notification or request for written consent, other than required parent notification related to the sexual health education or abuse prevention instruction.

These policies are referred to as "opt-in", referring to the process by which parents must actively opt their children in through written permission and consent in order to receive education related to sexual health and abuse prevention. The opt-in policy is in contrast to the opt-out policy in which schools automatically enroll all students in sex education and abuse prevention education, and parents can remove their children (or opt them out) from participating by providing written consent for removal. The opt-out policy was in effect in Texas prior to enactment of the 2021 legislation. According to the Guttmacher Institute, only five states in the U.S., including Texas, require active parental consent for students to participate in sex or HIV education.[2] Most states (35 and Washington DC) use an opt-out policy; eight states do not have a policy in place, and three states use other methods[i]; 25 states and Washington DC require parental notification be provided to a parent about sex and HIV education.[2] Texas is the only state to require parent opt-in for abuse prevention instruction. Regardless of parental consent policies, schools are often required to provide parents with written information on instructional content of sex education curricula.[3] Since the 1990s, Texas has required parent notification around the content of sexual health instruction, and HB 1525 also requires additional information to be provided in the parent notification letter.

The new Texas opt-in policy exists within the context of several Texas policies and statutes. First, in November 2020, the Texas Education Agency implement newly adopted Texas Essential Knowledge and Skills (TEKS) that add new sexual health education standards at the middle school level.[4] These standards had not been updated since 1998. The new TEKS include coverage related to puberty, menstruation, and reproduction, a strong focus on abstinence, contraception and STI prevention, screening, and treatment, and information on healthy relationships, including respecting the boundaries of other people. Second, public schools are required to adopt and implement a dating violence policy that includes training for teachers and administrators and awareness education for students and parents.[5] Additionally, Senate Bill 11 directs school districts to include instruction on establishing and maintaining positive relationships.[6]

Recognition of these policies is important given the significant public health concerns that teen births, sexually transmitted infections, dating violence, and maltreatment present for youth in Texas. Nationally, Texas has the 9th highest teen birth rate (22.4 per 1,000 females), the 7th highest teen pregnancy rate (38.7 per 1,000 females), and is tied for the highest percentage of repeat teen births (17%).[7,8] Rates of teen births show disparities by ethnicity, with Hispanic youth in Texas having a teen birth rate 2.5 times that of white youth.[9] Additionally, rates of sexually transmitted infections in Texas (e.g., chlamydia, gonorrhea, and syphilis) have risen sharply since 2010.[10] Further, 1 in 12 Texas high school students report experiencing physical dating violence,[11] and there were over 65,000 children who experienced some form of childhood maltreatment in 2020 (an increase of 13.5% from 2016).[12] These public health problems are associated with a host of adverse physical, psychological, behavioral, and societal outcomes.[13–15] For the 30,000 youth in the Texas child welfare system, these public health concerns, most notably teen pregnancy, are even more pronounced.[16]

[i]The three states include Kansas, North Carolina, and Indiana. Both Kansas and North Carolina have hybrid policies that allow the school districts to decide on using opt-in vs. opt-out. Indiana includes elements of both policies. It requires schools to make two attempts to receive written parental consent to participate in sexual education instruction. However, if permission is not confirmed or is not denied in these attempts, the student will automatically be enrolled.

While there is a dearth of research that examines how parental permission state policies impact student participation in sexual health and abuse prevention education, studies of adolescents and emerging adults have examined active (opt-in) versus passive (opt-out) parental consent as it relates to participation in adolescent health research. Four major findings emerge from these studies.

First, students are less likely to participate in school-based research when active parental permission is required. For example, Tigges[17] reported that parental permission was obtained from 30–60% of students when active permission was required for their child to participate in school-based research on adolescent risk behavior research, compared to 93-100% for passive consent requirements.

Further, a meta-analysis of 15 studies, examining adolescent participation in risk-behavior research in majority school-based environments, found that response rates were significantly lower for studies using active parental consent study samples, compared to passive consent samples.[18]

Second, extensive outreach is needed to increase participation when active parental permission is required. Ellickson and Hawes[19] examined whether the use of thorough retrieval methods, including reminders and re-sending consent materials, could bring active consent rates closer to passive consent rates among seventh graders in a school-based drug prevention study. This study found that only through extensive outreach from the school did active consent permission increase from 40% to 86%, which included phone call reminders, second consent packages sent home with the student, and daily reminders from teachers to students. This study suggests that high burden placed on school administration, teachers, and students to receive active consent may decrease student participation rates in sexual health and abuse prevention education.

Third, students who do not receive parental consent may be more likely to participate in adolescent risk behaviors and more at risk for other health problems (including teen pregnancy) than students who do receive parental consent. This finding suggests that requiring opt-in, active consent parental procedures can exacerbate health inequities and disparities among students.

Specifically, studies examining active consent procedures regarding parental permission for youth to participate in research resulted in an underrepresentation of youth who participate in adolescent risk behaviors, and greater representation for passive consent procedures.[17,18,20,21] Furthermore, one study by Chartier and colleagues[22] found not only did participation in a school-based emotional health depression screening program decrease by 19% when requiring active compared to passive parental permission, but participants who were at higher risk for screening positive were less likely to participate under active consent conditions. Finally, in a recent meta-analysis, youth were more likely to be female and younger, and less likely to be Black and to report substance use in studies that used active consent compared to passive consent procedures.[18]

Fourth, lack of parental consent may be more commonly related to logistical barriers rather than actual parent refusal. Follow-ups with parents in one adolescent health research study indicated that the majority who did not provide active consent intended to do so, indicating that nonresponse was not a sign of refusal, and more of latent consent.[19] In another study, follow-up with parents improved obtaining active consent permission, with 55-100% of parents granting permission; yet, this process was also reported as time consuming and very costly for the school, its administration, and its teachers.[17]

Given the above-described findings, The University of Texas Health Science Center at Houston (UTHealth Houston) collaborated with Healthy Futures of Texas (formerly the Texas Campaign to Prevent Teen Pregnancy) to conduct an evaluation of the new opt-in policy to assess its impact on implementation of sexual health and abuse prevention education among youth in Texas schools, including those in the child welfare system. The purpose of this report is to describe the results from this evaluation, which comprised a mixed-methods survey of the attitudes and experiences of Texas school representatives (administrators, teachers, school health staff, and school health advisory council [SHAC] members) related to this policy.

METHODS

Participants

Our priority population comprised school or school district staff in any independent or consolidated independent school district, private school, or charter school system in Texas. Participants were recruited through state-wide contacts known to Healthy Futures of Texas, IT'S TIME TEXAS, and the UTHealth Houston School of Public Health evaluation team through their school partnerships and previous research projects. Additionally, regional Texas Education Agency Education Service Centers, service organizations that support schools throughout Texas, were contacted and four agreed to distribute recruitment materials (Corpus Christi, Houston, Waco, and San Angelo Regions). Recruitment emails were also sent through two relevant listservs (Michael and Susan Dell Center for Healthy Living and Texas Is Ready Community of Practice) targeting Texas stakeholders. Finally, two recruitment presentations were made to the Region 4 - Houston School Health Leadership Team and to the IT'S TIME TEXAS SHAC meeting that is open to SHAC personnel throughout the state.

We received 228 surveys; respondents who were not representatives from Texas schools or school districts were excluded based on our eligibility criteria, leaving a final sample size of n = 152. Respondents categorized as "not representatives" included individuals who self-excluded based on the eligibility criteria (n = 74), or were later excluded because they indicated that their official role as a Texas school representative was "parent" (n = 1) and "health department representative" (n = 1). Eligible respondents were employed or worked in approximately 90 districts and schools throughout the state of Texas. Of these, eight participants provided data regarding parental permission form return rates. All participants were informed of the purpose and voluntary nature of the survey and that they could discontinue participation at any time.

Survey Protocol

The survey consisted of a 15-20-minute internet-based survey, located on UTHealth Houston's secure surveying platform, Qualtrics. The survey assessed attitudes, perceived barriers, and experiences following the implementation of HB 1525 and SB 9. Participants were also asked to provide data concerning student opt-in rates at their school or district during the 2021-2022 school year, if available. Upon completion, participants received a $50 Amazon gift card. The Institutional Review Board at the UTHealth Houston deemed that this program evaluation was exempt from review or approval because it was not considered "research."[23]

Data Collection

Data collection occurred during June through September 2022. The survey consisted of questions regarding demographic information (e.g., school type, school size, and primary role in the school), sexual health education implementation during the 2021-2022 school year (e.g., which, if any, curricula were taught and at what grade levels), permission form distribution during the 2021-2022 school year (e.g., how were permission forms distributed), factors that influenced opt-in policy implementation, and attitudes and beliefs regarding the opt-in policy (e.g., perceptions regarding ease and clarity of the policy). Open-ended questions asked participants to share their policy preferences (opt-in or opt-out) and the rationale behind these preferences. They were also asked to elaborate on factors that influenced their implementation of sexual health and abuse prevention education. See the appendix for further description of measures.

Participants were also asked to provide data regarding parental permission form return rates for the 2021-2022 school year. Participants who reported using an opt-in permission form policy were asked to report, at each grade level, how many students were eligible to receive sexual health education, how many returned their parental permission forms providing consent, how many returned their parental permission forms refusing their child's participation, and how many did not return their parental permission form. Participants who reported using an opt-out permission form policy were asked to report, at each grade level, how many students were eligible to receive sexual health education and how many returned parental permission forms refusing consent. After the survey period was completed, we obtained data from one additional district.

Quantitative and Qualitative Analysis Procedures

Quantitative data were analyzed using frequencies and descriptive statistics. Analyses were performed with Stata 17 analytic software. Validated surveys with responses to open-ended text questions were downloaded from Qualtrics and imported into Atlas.ti 22 Web for management and qualitative analysis. We excluded open-ended responses from qualitative analysis from surveys in which the open-ended text boxes were left blank, as well as those with one- or two-word answers, such as "don't know" or "not applicable" from further coding and analysis. The final qualitative dataset consisted of responses from 96 respondents, primarily representing public schools or independent school districts (89.5%). A two-person team with training in qualitative methods, public health, anthropology, and adolescent and school health used the constant comparative method to conduct line-by-line review and coding of the data (Patton, 2002). The codebook (see appendix) was iteratively developed over five drafts throughout the coding process. The two coders met regularly to review the coding, note and code discrepant or disconfirming views, and resolve coding discrepancies through discussion and clarification of code meanings. Thematic analyses were conducted through review of code reports with reflection on partners' policy preferences and factors that facilitated and/or hindered implementation of sexual health and abuse prevention education in Texas schools over the 2021-2022 school year. We merged qualitative findings with quantitative findings to note areas of congruence or discrepancies between the two datasets.[24]

RESULTS

Quantitative Results

Table 1. Respondent Characteristics: School District Type, Geography, Enrollment, and Grade Levels[1]

Table 1 presents the characteristics of eligible survey respondents (n=152) with respect to school district representation, geography, enrollment, and grade levels. As seen below in Figure 1, a majority of respondents (91.6%, n=130) represented public schools or Independent School Districts (ISDs). Respondents reported representation from an approximately equal distribution of rural (33.6%, n=47), suburban (42.9%, n=60), and urban (23.6%, n=33) areas. About 41% of respondents represented school districts (or private schools) with less than 5,000 students, and most districts (91.4%) taught kindergarten through 12th grades.

	n (%)
School Type	
Public School or Independent School District (ISD)	130 (91.6)
Private School	6 (4.2)
Charter School	6 (4.2)
School Districts by Geographic Area[2]	
Rural	47 (33.6)
Suburban	60 (42.9)
Urban	33 (23.6)
School District Enrollment[2]	
Less than 5000 students	57 (40.7)
5000-25,000 students	43 (30.7)
Greater than 25,000 students	40 (28.6)
Grade Levels for School District/Schools[2,3]	
Grades K-5th	9 (6.4)
Grades K-8th	1 (0.7)
Grades 6th-8th	0 (0.0)
Grades 9th-12th	2 (1.4)
Grades K-12th	128 (91.4)

[1]There were 152 eligible survey respondents. Sample sizes for individual questions vary due to missing data; n = 142, n = 140, n = 140, n = 140, respectively.

[2]Includes data from both private and public schools.

[3]Grade levels were not mutually exclusive. Associated counts with the grade ranges indicate a respondent reporting at least one grade level in the range.

Table 2 & Figure 1. Respondent Characteristics: Primary Role and Political Affiliation[1]

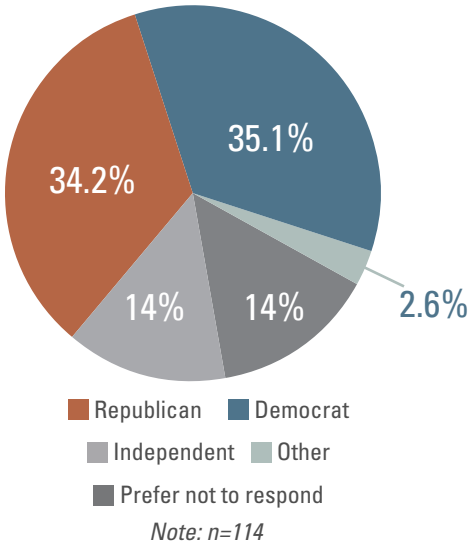
Table 2 & Figure 1 present the characteristics of eligible respondents with respect to their role and political affiliation. Respondents represented a variety of roles within their school and school district including administrators, school nurses, teachers, School Health Advisory (SHAC) board members, and counselors. Three-fourths of survey respondents (n=114) shared their personal political affiliation; about 34% said they were Republican and 35% were Democrat. Fourteen percent reported they were Independent voters.

	n (%)
Primary Role in School District or School	
Counselor or Social Worker	27 (19.1)
School Nurse	25 (17.7)
District/School Administrator	39 (27.7)
School Health Advisory Board (SHAC) member	33 (23.4)
Health Teacher and Other Teacher (Non-Health)	11 (7.8)
Curriculum Coordinator	6 (4.3)

[1]There were 152 eligible survey respondents. Sample sizes for individual questions vary due to missing data; n = 141, n = 114, respectively.

[2]Other political affiliations responses included: Centrist, a mix of Democrat or Republican depending on the topic of interest, non-specified Other.

Respondent Political Affiliation[2]

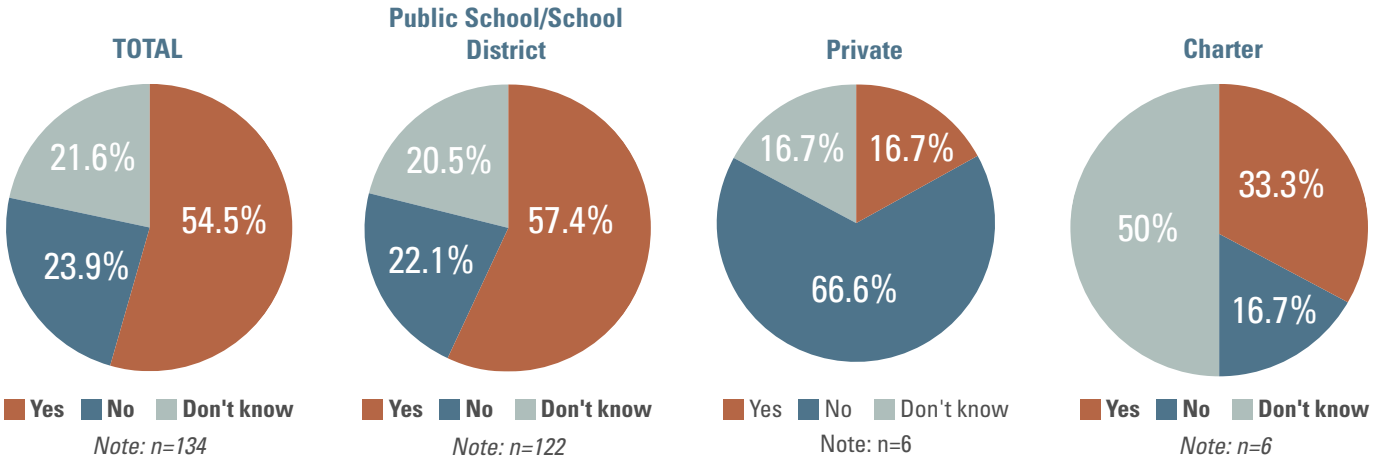


Note: n=114

Figure 2 & Table 3. Sexual Health Education Programs Implemented in 2021-22

Figure 2 & Table 3 present information about sexual health education program implementation at their school or school district during the 2021-2022 school year. About 55% of respondents (n = 73) reported that sexual health education was implemented and were then prompted to describe more about the implementation. Of respondents who reported implementing sexual health education, the most common program implemented by respondents was Choosing the Best Path (27.5%). Big Decisions, textbook/instructional materials, and Worth the Wait were the next most listed curricula implemented at 13.0%, 11.6%, and 8.7%, respectively.

School District/School Implemented Sexual Health Education in 2021-2022[1]



	n (%)
Program Curricula Among School Districts/Schools Implementing[2,3]	
Choosing the Best Path	19 (27.5)
Big Decisions	9 (13.0)
Textbook/Instructional Materials	8 (11.6)
Worth the Wait	6 (8.7)
Lifeguard	4 (5.8)
Draw the Line/Respect the Line	3 (4.3)
Wait Training	2 (2.9)
Heritage Keepers	2 (2.9)
SHAC or School-developed curriculum	2 (2.9)
Becoming a Responsible Teen	1 (1.4)
Making Proud Choices	1 (1.4)
It's Your Game… Keep it Real!	1 (1.4)
Making a Difference	1 (1.4)
Safer Choices	1 (1.4)
Always Changing	1 (1.4)
AIM for Success	1 (1.4)
Safe Dates	1 (1.4)
Camp Careful	1 (1.4)
Unhushed	1 (1.4)
Esteem Health (with contraception supplement)	1 (1.4)
Parenting and Paternity Awareness (P.A.P.A.)	1 (1.4)
Local pregnancy center-developed curriculum	1 (1.4)
Clinic-developed curriculum	1 (1.4)
Don't know	14 (20.3)
Grade Levels Taught Sexual Health Education[2,3]	
6th-8th	51 (50.0)
9th-12th	36 (35.3)
Don't know	15 (14.7)

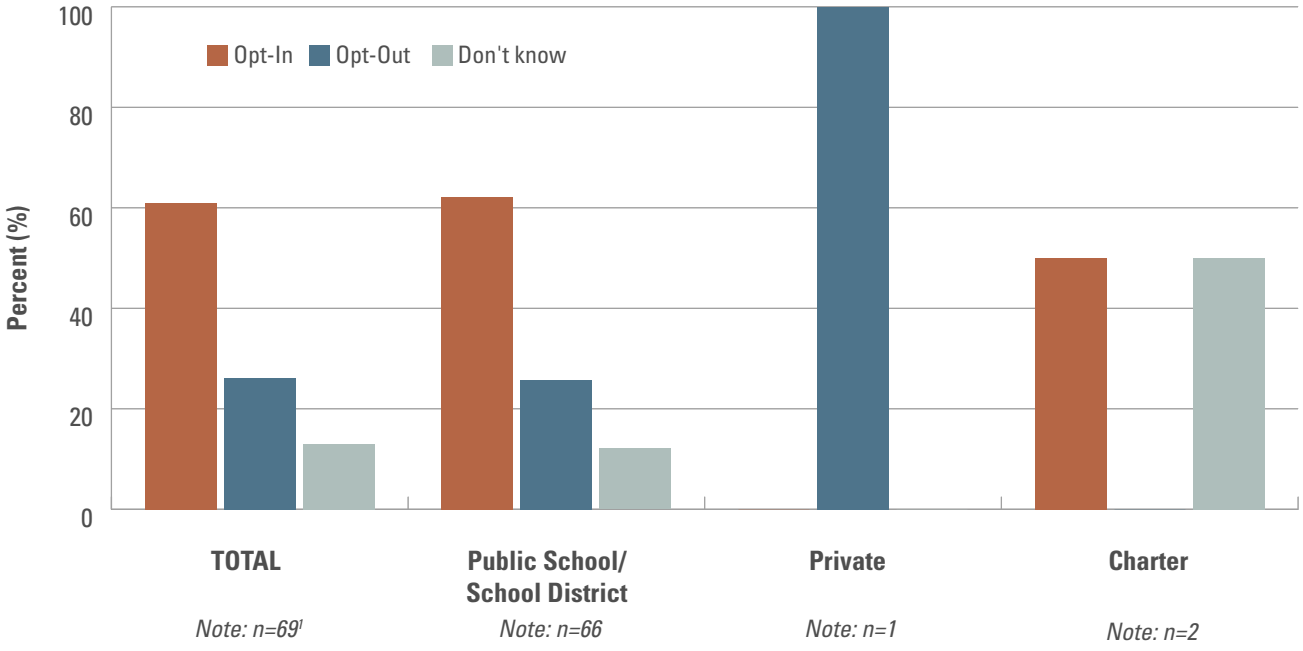
[1]n = 152 respondents were eligible to answer whether or not they implemented sexual health education. Due to missing or inconsistent data, n = 134 responses were analyzed for this question.

[2]Sexual health education program questions were asked of those respondents who said yes to implementing sexual health education, reducing the eligible sample size to n = 73. Due to missing data, n = 69 and n = 68, respectively, for questions related to programs and grade levels.

[3]Responses were not mutually exclusive. Some respondents named multiple curricula and grade levels.

Figure 3. Parental Consent Policy for Sexual Health Education, by Type of School/District among Sexual Health Education Implementers

Figure 3 presents information related to the type of parental consent policy reported by respondents who implemented sexual health education, by school/district type. Overall, more than half of respondents reported implementing an opt-in policy during the 2021-2022 school year; 26% reported implementing an opt-out policy.



[1]Denominator comprises those respondents who indicated replied yes to implementing sexual health education.

"I think parents should have the authority to allow their kids to participate rather than having to notify the school of [if] you don't want your kids involved! It's their choice and shouldn't be taken away by a formality."

(Non-health teacher in a private school)

Table 5. Permission Form Process among Opt-in and Opt-out Implementers[1]

Table 5 presents information related to permission form processes, by policy type (opt-in vs opt-out). Various methods were utilized to distribute permission forms for respondents from school districts or schools. Schools and districts using the opt-in policy utilized more distribution methods than those implementing the opt-out policy, including multiple use of reminders. Although a large percentage of respondents indicated not knowing how much time they spent obtaining parental consent, obtaining parental consent under the opt-in policy was more time-intensive than under the opt-out policy. When queried about their perception of the ease or difficulty of obtaining parental consent, 41.7% of opt-in policy implementers stated that it was difficult or very difficult compared to only 6.7% of opt-out policy implementers.

	Opt-In n (%)	Opt-Out n (%)
How Permission Forms Were Distributed[2]	**(n = 37)**	**(n = 14)**
At parent information session	0 (0.0)	2 (14.3)
At meet the teacher events	1 (2.7)	0 (0.0)
Email	16 (43.2)	2 (14.3)
Included with registration	4 (10.8)	0 (0.0)
Sent home with students	13 (35.1)	7 (50.0)
School's electronic communication platform for parents	3 (8.1)	1 (7.1)
Posted on school website	1 (2.7)	0 (0.0)
Don't know	3 (8.1)	3 (21.4)
Other[3]	1 (2.7)	0 (0.0)
Number of Hours Obtaining Parental Consent[4,5]	**(n = 35)**	**(n = 15)**
1-5 hours	3 (8.6)	2 (13.3)
6-10 hours	4 (11.4)	1 (6.7)
More than 10 hours	7 (20.0)	0 (0.0)
Don't know	21 (60.0)	12 (80.0)
Number of Reminders Sent to Parents/Guardians/ Students to Return Forms[4]	**(n = 36)**	**(n = 15)**
0-1 reminders	5 (13.9)	0 (0.0)
2-5 reminders	14 (38.9)	1 (6.3)
More than 5 reminders	2 (5.6)	0 (0.0)
Don't know	15 (41.7)	14 (93.8)
Perception of Ease or Difficulty Obtaining Parental Consent for 2021-2022[4]	**(n= 36)**	**(n= 15)**
Easy or very easy	3 (8.3)	6 (40.0)
Neutral	10 (27.8)	3 (20.0)
Difficult or very difficult	15 (41.7)	1 (6.7)
Don't know	8 (22.2)	5 (33.3)

[1]The total eligible sample size for this question was n = 42 and n =18 for opt-in and opt-out, respectively. Sample sizes vary due to missing data.

[2] The denominator comprised respondents who replied yes to implementing sexual health education and indicated how permission forms were distributed (n = 37 and n= 14 for opt-in and opt-out, respectively). Some people selected other and wrote in multiple methods of distributing permission forms. These methods were redistributed to their respective categories. Therefore, this question was considered not mutually exclusive.

[3]Permission forms distributed in "other" ways include: online QR codes (n = 1).

[4]Parental consent questions were asked of those respondents who indicated "yes" to implementing sexual health education, "yes" to using an opt-in or opt-out policy, and knowing how their school's permission forms were distributed. This also resulted in a lower sample size answering parental consent questions.

[5]One qualitative response that could not be quantified was removed since the question asked for numeric data.

Table 6. Attitudes and Experiences with Opt-In Policy in 2021-2022 Among Respondents who Indicated an Opt-in Policy was used at the School District/ School[1]

Table 6 presents respondents' attitudes and experiences with the opt-in policy during the 2021-2022 school year. About 66% of respondents perceived the opt-in policy as a barrier to the receipt of sexual health education for students; more than one-third perceived the opt-in policy as a barrier to the receipt of sexual health education for students in the child welfare system, in particular. Further, nearly half of respondents perceived a decrease in the number of students receiving such education as a result of the opt-in policy.

	n (%)
Perception of Opt-In Policy as Barrier to Students' Receipt of Sexual Health Education in School District/School in 2021-2022	
Not a barrier	6 (17.1)
Somewhat of a barrier	4 (11.4)
Moderate barrier	7 (20.0)
Extreme barrier	12 (34.3)
Don't know	6 (17.1)
Perception of Opt-In Policy as Barrier to Students' Receipt of Sexual Health Education in School District/School for *Students in the Child Welfare System* in 2021-2022	
Not a barrier	4 (11.4)
Somewhat of a barrier	0 (0.0)
Moderate barrier	4 (11.4)
Extreme barrier	9 (25.7)
Don't know	18 (51.4)
Perception of Number of Students Receiving Sexual Health Education as a Result of Opt-In Policy in 2021-2022	
Increased	2 (5.7)
Stayed the same	3 (8.6)
Decreased	16 (45.7)
Don't know	14 (40.0)

[1]n = 42 respondents were eligible to answer this question because they indicated having an opt-in policy. Participants responded "yes" to implementing sexual health education. Sample size was reduced to n = 35 due to missing data.

"I am concerned that the opt-in process will unnecessarily burden teachers and administrators and present an obstacle to ensuring students receive the education."

SHAC member in a public school district

Table 7. Attitudes towards Expected Experiences with Use of Opt-In Policy for Sexual Health Education in 2022-2023 among all Survey Respondents[1]

Table 7 presents respondents' expectations for the 2022-2023 school year as a result of the opt-in sexual health education policy among the entire sample. Most respondents (69.8%) perceived that there would be difficulty obtaining consent from parents. A majority of respondents also perceived the policy as a barrier to students' receipt of sexual health education in the 2022-2023 school year (80.6%). Similar results were obtained when considering students in the child welfare system, in particular.

	n (%)
Perception of Future Ease or Difficulty Obtaining Parental Consent in 2022-2023	
Very easy	2 (1.7)
Easy	12 (10.1)
No opinion	8 (6.7)
Difficult	62 (52.1)
Very difficult	21 (17.7)
Don't Know	14 (11.8)
Perception of Future Ease or Difficulty Obtaining Parental Consent in 2022-2023 for *Youth in the Child Welfare System*	
Very easy	1 (0.7)
Easy	7 (5.9)
No opinion	15 (12.7)
Difficult	42 (35.6)
Very difficult	33 (28.0)
Don't know	20 (17.0)
Perception of Opt-In Policy as Barrier to Students' Receipt of Sexual Health Education in School District/School in 2022-2023	
Not a barrier	11 (9.3)
Somewhat of a barrier	20 (17.0)
Moderate barrier	36 (30.5)
Extreme barrier	39 (33.1)
Don't know	12 (10.2)
Perception of Opt-In Policy as Barrier to Students' Receipt of Sexual Health Education in School District/School for *Students in the Child Welfare System* in 2022-2023	
Not a barrier	4 (3.4)
Somewhat of a barrier	21 (17.8)
Moderate barrier	29 (24.6)
Extreme barrier	43 (36.4)
Don't know	21 (17.8)

[1]There were 152 eligible survey respondents. Sample sizes vary due to missing data. Sample sizes for each question: n = 119, n = 118, n = 118, n =118, respectively.

Table 8. Consent Policy Preferences and Attitudes towards Texas Law regarding Sexual Health and Abuse Prevention Education among all Survey Respondents[1]

Table 8 presents consent policy preferences and attitudes towards Texas law regarding sexual health and abuse prevention education among survey respondents. Most respondents reported preference for an opt-out policy for sexual health education (70.4%) and abuse prevention education (65.2%). Approximately 60% of respondents indicated a strong preference for their policy choices. Figures 4a and 4b present the degree of support for the respondents' specific policy preference. Approximately one-third of respondents disagreed that the current law is clear.

	n (%)
Sexual Health Education Consent Policy Preference	
Opt-in	23 (20.0)
Opt-out	81 (70.4)
No preference	11 (9.6)
Abuse Prevention Education Consent Policy Preference	
Opt-in	28 (24.4)
Opt-out	75 (65.2)
No preference	12 (10.4)
Degree of Perceived Support for Preferred Sexual Health Education Consent Policy Preference	
Strongly prefer	70 (60.9)
Somewhat prefer	24 (20.9)
Slightly prefer	7 (6.1)
No preference	14 (12.1)
Degree of Perceived Support for Preferred Abuse Prevention Education Consent Policy Preference	
Strongly prefer	70 (61.4)
Somewhat prefer	24 (21.1)
Slightly prefer	7 (6.1)
No preference	13 (11.4)
Belief that Texas Laws are Clear Regarding Sexual Health Education and HIV/AIDS Education[2]	
Strongly disagree	5 (4.4)
Disagree	31 (27.2)
Neither agree nor disagree	34 (29.8)
Agree	19 (16.7)
Strongly agree	2 (1.8)
Don't know	23 (20.2)

[1]There were 152 eligible survey respondents. Sample sizes vary due to missing data. Sample sizes for each question: n = 115, n = 115, n = 115, n = 114, n= 114, respectively.

[2]Participants reported on their attitudes to the following statement: "The Texas laws governing sexual health education and HIV/AIDS education are clear."

Figure 4a. Degree of Support for Preferred *Sexual Health Education Consent* Preference among all Survey Respondents

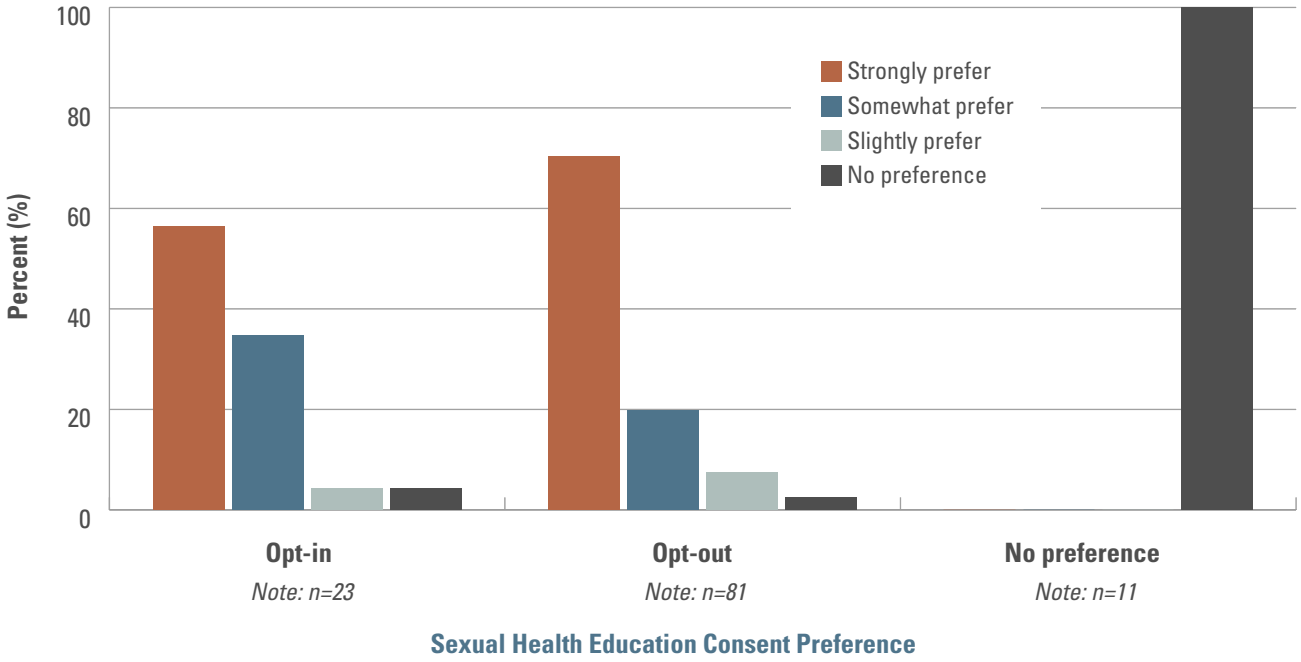
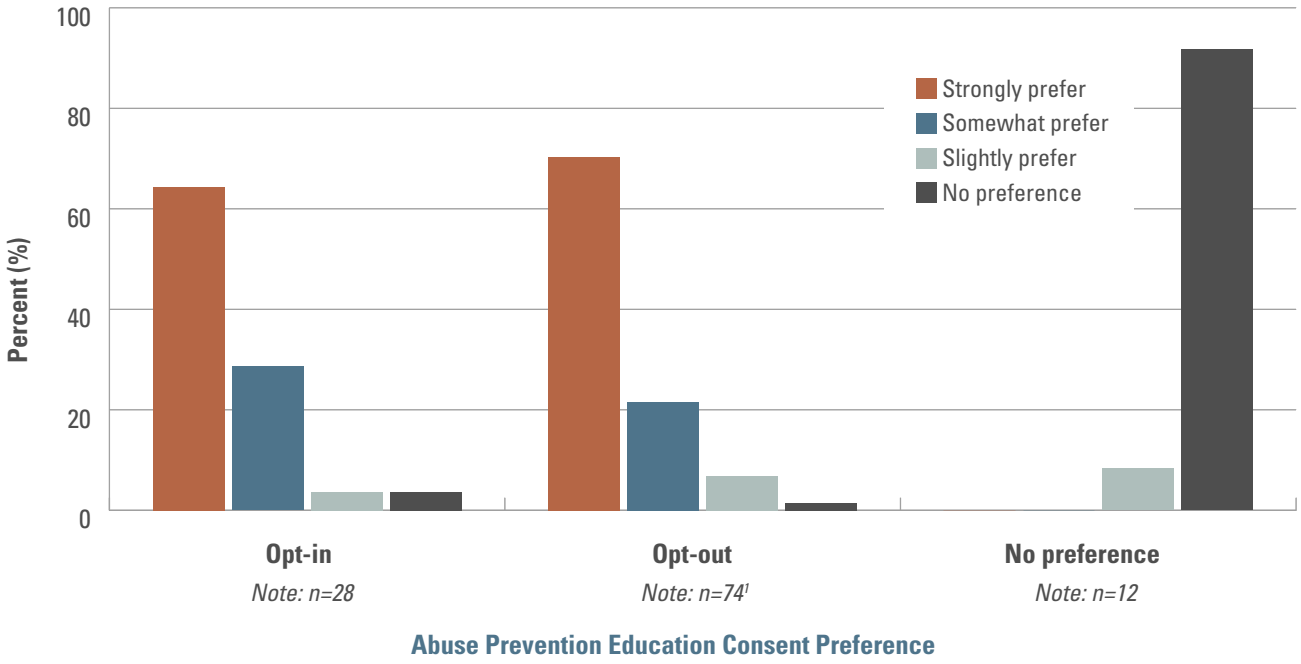


Figure 4b. Degree of Support for Preferred *Abuse Prevention Consent* Preference among all Survey Respondents



[1]There were 75 respondents who indicated a preference for an opt-out policy for abuse prevention education consent. Sample size was reduced to n=74 due to missing data.

Tables 9 and 10 present a summary of data received from participants who were able to provide parental permission form return rates for the 2021-2022 school year.

Table 9. Opt-In Permission Form Data Reported by Respondents[1]

Table 9 presents data for participants who reported having an opt-in policy for the 2021-2022 academic year. We received data from seven participants with middle school data and three participants with high school data. Data from two participants with middle school data were removed because the number of schools' participants indicated reporting data from was inconsistent with the number of eligible students reported.[ii] After the survey period was complete, we received data from one additional school district that provided data for middle and high school students.

With respect to the middle school data, total parental permission form return rates ranged from 32.8% to 100% of students returning their permission forms. Among students who returned parental permission forms, the proportion of parents who provided permission for their child to participate in sexual health education ranged from 84.5% to 100%. With respect to the high school data, total parental permission form return rates ranged from 2% to 76.6% of students. Among students who returned parental permission forms, the proportion of parents who provided permission for their child to participate in sexual health education ranged from 0% to 100%. In the case of the participant who indicated that no parents provided permission, only 4 forms were returned to the school (all were refusals). Across both middle and high schools, for the majority of respondents, the percent of parents indicating refusal was low.

Participant (# Of Schools Reported) (School/School District Description)	Total # of students eligible	Total Forms Returned n (%)[1]	Agree (Said Yes)[2] n (%)	Refuse (Said No)[2] n (%)
Middle School Participants				
Participant 1 (1)[3] (Urban ISD - 5000-25,000 students)	333	333 (100.0%)	332 (99.7%)	1 (0.3%)
Participant 2 (1)[3] (Rural ISD - less than 5000 students)	208	138 (66.4%)	125 (90.6%)	13 (9.4%)
Participant 3 (1)[3,4] (Rural ISD - less than 5000 students)	520	170 (32.8%)	170 (100.0%)	-
Participant 4 (1)[3] (Suburban public school - less than 5000 students)	214	133 (62.1%)	133 (100.0%)	0 (0.0%)
Participant 5 (3)[3] (Suburban ISD - 5000-25,000 students)	2324	1122 (48.3%)	1083 (96.5%)	39 (3.5%)
Participant 6 (2)[5] (Urban ISD- greater than 25,000 students)	77	71 (92.2%)	60 (84.5%)	11 (15.5%)

[1]Yes and no forms were summed for the total returned permission forms. Denominator for percentage comprises total number of students eligible.

[2]Denominator for percentage comprises total forms returned.

[3]Opt-in permission form data were self-reported. All participants were contacted for confirmation on the opt-in data they reported, but did not respond to repeated contact attempts.

[4]Participant did not provide an answer to the number of student permission forms refusing sexual health education. As opposed to entering a 0 here, the answer was left blank to indicate that no response was given.

[5]Data received from additional school district after survey period was complete.

[ii]In one case, a participant indicated providing data from 205 schools but reported only 196 eligible students. In the other case, the participant indicated reporting data from 150 schools with only 810 eligible students.

Participant (# Of Schools Reported) (School/School District Description)	Total # of students eligible	Total Forms Returned n (%)[1]	Agree (Said Yes)[2] n (%)	Refuse (Said No)[2] n (%)
High School Participants				
Participant 1 (1)[3] (Suburban public school - less than 5000 students)	254	46 (18.1%)	46 (100.0%)	0 (0.0%)
Participant 2[3] (Rural ISD - less than 5000 students)	200	4 (2.0%)	0 (0.0%)	4 (100.0%)
Participant 3 (1)[3] (Suburban ISD- 5000-25,000 students)	868	323 (37.2%)	306 (94.7%)	17 (5.3%)
Participant 4 (8)[5] (Urban ISD- 5000-25,000 students)	1305	1000 (76.6%)	894 (89.4%)	106 (10.6%)

[1]Yes and no forms were summed for the total returned permission forms. Denominator for percentage comprises total number of students eligible.

[2]Denominator for percentage comprises total forms returned.

[3]Opt-in permission form data were self-reported. All participants were contacted for confirmation on the opt-in data they reported, but did not respond to repeated contact attempts.

[4]Participant did not provide an answer to the number of student permission forms refusing sexual health education. As opposed to entering a 0 here, the answer was left blank to indicate that no response was given.

[5]Data received from additional school district after survey period was complete.

Table 10. Opt-Out Permission Form Data Reported by Respondents[1]

Table 10 presents data for participants who reported having an opt-out policy for the 2021-2022 academic year. We received data from three participants with middle school data and three participants with high school data. Due to the reasons described above for Figure 9, middle school data for one participant were removed; the same participant also provided high school data which was also removed. Thus, our middle and high school data are limited to n = 2 respondents (each). With respect to these data, the parent refusal rates ranged from 0% to 48.3%.

	Total # of students eligible	Refuse (said no) n (%)
Middle School Participants[1] (# Of Schools Reported) (School/School District Description)		
Participant 7 (1) (Suburban public school - less than 5000 students)	214	0 (0.0%)
Participant 15 (1) (Suburban ISD - 5000-25,000 students)	2324	1122 (48.3%)
High School Participants[1]		
Participant 1 (1) (Rural - less than 5000 students)	254	0 (0.0%)
Participant 15 (1) (Suburban ISD - 5000-25,000 students)	868	323 (37.2%)

[1]Opt-out permission form data were self-reported. Participants were contacted for clarification on the opt-out data they reported, but did not respond to repeated contact attempts.

Qualitative Results

In general, the qualitative responses aligned with the results from the quantitative data analysis. Key themes that emerged from the qualitative responses were: factors associated with implementation of sexual health education during the previous school year including barriers and facilitators to sexual education implementation; participants' attitudes and preferences for opt-in versus opt-out policies related to sexual health education; and attitudes and preferences for opt-in versus opt-out policies for abuse prevention education. Within each of these themes, there were sub-themes focused on more specific elements. **Table 11** provides an overview of themes and their associated sub-themes.

Table 11. Qualitative Analysis Themes and Sub-themes

Theme	Sub-theme
Barriers and Facilitators to Sexual Health Education in the 2021-2022 School Year	Barriers to opt-in sexual health education implementation
	Facilitators and lessons learned from implementing opt-in sexual health education
Attitudes and Preferences for Opt-in vs. Opt-out Policies for Sexual Health Education	Opt-in policies for sexual health education present another challenge to parent-school communication
	The opt-in sexual health education policy may widen socioeconomic and health disparities
	Participants with mixed or supportive attitudes towards opt-in policies for sexual health education highlighted parental rights to access and veto curricula
Attitudes and Preferences for Opt-in vs. Opt-out Policies for Abuse Prevention Education	Opt-in policies for abuse prevention education may have implications for student safety

Barriers and Facilitators to Sexual Education in the 2021-2022 School Year

Barriers to Opt-in Policies for Sexual Health Education Implementation

Participants described a number of factors that influenced implementation of sexual health education over the 2021-2022 school year. Respondents described the additional administrative burden caused by the opt-in policy. Obtaining permission from parents under the opt-in policy was time-consuming and detracted from teachers' and other school officials' time to work with students.

> *Chasing the paperwork for opt-in is very time consuming and staff could be spending their time directly supporting students instead of paperwork (District administrator in a public school #1)*

> *I am concerned that the opt-in process will unnecessarily burden teachers and administrators and present an obstacle to ensuring students receive the education. (SHAC member in a public school district #1)*

> *Opt-in places more unnecessary burden on campus personnel who are already stretched beyond capacity (District administrator in a public school #2)*

Further, under the previous opt-out policy, schools generally had fewer students for whom they would need to make alternative arrangements (e.g., study hall, alternative life skills education, or similar). With so many students unable to provide permission for opt-in sexual health education, schools struggled to know what to do with these students.

> *It is easier to prepare for a whole class with a few holdouts than the other way around. (District administrator in a public school #3)*

> *If I had a class of 40 and only 5 opted in... how do I justify teaching only 5...what do I do with the other 35? When it's reversed you can work with someone to take on the small group. (District administrator in a public school district #4)*

Without additional guidance and resources to address these challenges, respondents felt that implementing opt-in sexual health education would be difficult in future school years.

Facilitators and Lessons Learned from Implementing Opt-in Policies for Sexual Health Education

Despite the challenges associated with implementing an opt-in approach, some participants shared what they had learned from their experience and identified approaches that may be useful in future school years, or for other districts seeking to improve their participation rates in sexual health education. Common strategies usually involved several approaches to delivering permission forms directly to parents (for example, via email, with school registration forms, or in-person). One participant even explained that their school had always used opt-in, and offered a variety of suggestions as to how they obtained signed forms.

> *We have always done the opt-in policy. It's not hard. I as the counselor help call parents or talk to students if they do not return the sheet. We also offer the permission slip as a free 100 in the class that they are in. Detention is received if they do not return it. (Counselor or social worker in a public school district #1)*

> *Because it was a new option, I think students and/or parents did not feel comfortable committing to it. I believe for such a large population we should have had many more students participate. This year we will make the parent permission letters available at "Meet the Teacher" so that it can be completed and turned in before leaving campus. We will also have the curriculum available for reviewing. (Counselor or social worker in a public school #2)*

> *This is very hard and campuses do not have a place for students that are not able to participate to go? This prevents them from being taught all the TEKS. We started send[ing] a packet home for students to complete with their family if they do not opt-in. This has helped a lot. (District administrator in a public school district #3)*

As described above, many of these strategies revolved around how to make it easier for parents to receive, sign, and return permission forms. There were also suggestions on how to provide skill-building education and information to students who did not return a form opting them in to sexual health education.

Participants' Attitudes and Preferences for Opt-in versus Opt-out Sexual Health Education

Opt-in Policies for Sexual Health Education Present another Challenge in Parent-School Communication

Consistent with the quantitative findings, the majority of qualitative responses expressed a preference for an opt-out approach for sexual health education. There were a variety of reasons participants expressed a preference for opt-out, but these largely centered on challenges associated with obtaining permission from parents. Respondents repeatedly noted that busy or less engaged parents rarely receive or complete forms sent home concerning any topic, let alone permission for sexual health education. When parents do not complete the permission form, students do not receive sexual health education; however, it is not because parents are making an informed decision to withdraw their children from sex education, but rather that parents do not know that permission is being sought.

> *This is important information and many students are missing out due to the opt in procedures. Many parents don't sign because they just don't see it or get to it. (Curriculum coordinator in a public school district #1)*

> *If parents have a definite opinion of NOT wanting their child to participate, they WILL send back the opt out. I don't think that all parents really read the notice and don't understand the importance of returning the form. MOST of the ones that returned the form opted in. Our biggest problem was getting the forms brought back. (District administrator in a public school district #2)*

Relatedly, some respondents noted that there had been little parental education or notice of the change from an opt-out to opt-in policy, resulting in confusion. The lack of communication to parents about the policy and procedural changes created an additional barrier to the return of permission forms.

The Opt-in Sexual Health Education Policy May Widen Socioeconomic and Health Disparities

Among respondents who felt that opt-in was difficult to implement, several respondents stated that sex education was important for all students to receive, and felt an opt-in approach prevented even those students who might otherwise have permission from receiving information that they needed. Respondents reflected on how an opt-out approach allowed more students to receive sexual health education, whereas with opt-in, they had noticed a decline in schools providing sexual health education because there were not enough returned forms to warrant classes.

> *All students need to learn about sexual health - opt-in creates a barrier to learning. (SHAC member for a public school district)*

> *We sent the Opt In information to over 7,000 parents and received a response from about 500. The teachers then sent out paper copies. Several schools didn't have enough response to warrant teaching. (District administrator in a public school district #2)*

Another rationale for the opt-out preference was related to respondents' perceptions of credible sources of sexual health education. Respondents who preferred the opt-out policy indicated that schools are the most credible sources for sexual health education, and that parents/guardians may not be able to fully address students' needs. In particular, there was a concern that students who may have greater informational needs may also have parents who are unable to meet these needs.

> *Students on my campus are dating and are not receiving guidance at home. They are being exposed to material that does not teach them how to determine or defend their expectations so they need to hear research-based information in order to protect themselves. I believe very strongly in providing information to middle school students who are at risk. (Counselor or social worker in a public school #2)*

> **"Opt-in places more unnecessary burden on campus personnel who are already stretched beyond capacity."**
>
> District administrator in a public school

I believe TEA has done its job to select TEKS for sexual health that are developmentally appropriate, and the assumption is that the curricula provided by each school meets those TEKS. 'Opt-in' second-guesses the credibility of the school and school system to provide basic and adequate information about sexual health. (SHAC member for a charter school #1)

I trust the curriculum taught to my students and know that if there is anything in question that the district would give me the option to opt out. Knowing how some parents do not make it a point to read any communication from the schools, [means] that many children will not get needed education due to the lack of parent interest. (District administrator for a public school district #4)

Respondents also expressed concerns that the opt-in policy creates or worsens health disparities, by decreasing access to sexual health education, and creating differential barriers for student access. Respondents noted that some students may be unequally impacted by this policy, and it may have negative impacts on their health.

It will diminish knowledge of common sexual health topics that are explored in other states. It will lead to a rise in teen pregnancies and STIs. (Counselor or social worker in a public school #3)

I have concerns that parents don't have the time or energy to send in forms. The kids who are left on their own (without adequate parental support) are statistically the ones who need sexual education more. We should not depend on parents signing the forms to let their kids be educated sexually, but rather, use an opt-out policy. (SHAC member in a public school district)

Respondents highlighted particular communities, including LGBTQ+, English as a Second Language (ESL), low-income, and students with absentee parents as particularly vulnerable to poorer health as a result of the opt-in policy. These were groups identified by respondents as having specific health needs that are important to be addressed in sexual health education curricula, and highlighted the ways in which these communities may be adversely impacted by the opt-in policy.

...Schools such as mine have additional barriers created by an opt-in system, such as parents that may have limited or no literacy skills, English as a Second Language speakers, cultural barriers, and just the general return rate we get for parent compacts, permission slips, and other forms we send out. (Counselor or social worker in a public school #4)

Sexual Health education is vital to improving standards of living and health for low-income communities. (Counselor or social worker in a public school #3)

I think kids need to be educated about their sexual health, this includes the LGBTQ+ community. (District administrator in a public school district #5)

Participants with Mixed or Supportive Attitudes towards Opt-in Sexual Health Education Highlighted Parental Rights to Access and Veto Curricula

For respondents expressing either ambivalence towards opt-out, or those (16 out of 96 responses) who expressed a strong preference for the opt-in approach, they felt that opt-in ensured that parents were more informed about the content of their child's lessons and would have better insights into their school's sexual health education curriculum. We could not discern whether opt-in was more preferred among representatives from public or private schools in the qualitative data; however, only two respondents in the qualitative data set were from private schools and reported implementing sexual health education during the 2021-2022 school year.

> *I think parents should have the authority to allow their kids to participate rather than having to notify the school of [if] you don't want your kids involved! It's their choice and shouldn't be taken away by a formality. (Non-health teacher in a private school #1)*

> *Both sides have pros and cons. My worry is parents feeling that they aren't informed enough if we use opt out. (Health teacher in a private school #1)*

> *Parents have the right to choose for their child and opt-out is more difficult to oversee. (School nurse in a public school district #1)*

> *The Opt-In policy at minimum requires all parents to read the permission slip, and parents who take the time to do that will most likely take the additional step of requesting to review the sexual health curriculum, furthering parental engagement with the school district. It is the [deidentified] SHAC's belief that sexual health education is only successful with the active participation of parents. The Opt-In policy (and subsequent reminders) demonstrates proactive and transparent communication on behalf of the school, thereby strengthening the partnership between school and parents for the good of the student. (SHAC member in a public school district #1)*

These respondents also felt that parents had the right to have greater oversight over the materials being taught to their children, and that opt-in allowed this oversight.

Participants' Attitudes and Preferences for Opt-in versus Opt-out Abuse Prevention Education

Opt-in Abuse Prevention Education may have Implications for Student Safety

The qualitative responses were less mixed when it came to attitudes towards the new opt-in policy for abuse prevention education. Respondents are concerned that opt-in places abused youth at heightened risk, as abusive parents/guardians are unlikely to grant permission for education that might implicate themselves.

> *Abusers will not grant permission to abused children. (SHAC member in a public school district #2)*

> *The opt-in requires students to receive permission from possible abusers to learn about healthy relationships and appropriate sexual activity. (Counselor or social worker in a public school district #5)*

Survey participants also expressed a concern that opt-in requirements for abuse prevention education represented a legitimate safety concern for all students, as they are less likely to receive education that may help keep them safer and less likely to learn about how to get help or access resources in dangerous situations. In addition, similar to the barriers with opt-in sexual health education, there is the concern that parents who might be willing to opt in to education may simply not receive or return the form.

> *Students are better able to speak up for their safety when they receive education about family violence and abuse. (Counselor or social worker in a public school district #6)*

"It will diminish knowledge of common sexual health topics that are explored in other states. It will lead to a rise in teen pregnancies and STIs."

Counselor/social worker in a public school district

This is an important topic and all students need to be made aware of what might be happening and how to seek assistance for themselves or others. (Counselor or a social worker in a public school district #7)

I have concerns that parents don't have the time or energy to send in forms. I have concerns that students who need violence prevention, sexual abuse or trafficking [prevention education] may not get the education they need, if the parent(s) is/are violent/ trafficking/etc. at home. It doesn't make sense that the parents have to opt-in for this curriculum. (SHAC member in a public school district #3)

Parents that are sexually abusing their child will never opt in. Also, getting a signed paper back from a parent can really be classified as a miracle. (District administrator in a public school district #6)

DISCUSSION AND KEY FINDINGS

This report provides a snapshot of Texas school representatives' attitudes and experiences towards the new opt-in policies for sexual health and abuse prevention education. This policy requires parents to actively opt their children in through written permission and consent in order to receive education related to these topics. The sample was diverse in terms of respondent's geographic location, school size, political affiliation, and professional school role.

Key findings are as follows:

1) Many respondents perceived the opt-in policy as a barrier or potential barrier to the receipt of sexual health and abuse prevention education for students.

Sixty-one percent of respondents who implemented sexual health education reported that their school district employed an opt-in sexual health education permission form policy during the 2021-2022 school year. Of these, over 65% perceived the opt-in policy as a barrier to the receipt of sexual health education for all students in that academic year. Among all survey respondents, over 80% reported that the opt-in policy would present a barrier to students' receipt of sexual health education during the 2022-2023 academic year. Qualitative data supported these findings for sexual health and abuse prevention education. For youth in the child welfare system, who are at increased risk for teen pregnancy,16 the opt-in policy was also perceived as a potential barrier to students' receipt of sexual health education in the 2022-2023 school year among the majority of respondents. These findings suggest that the opt-in policy for sexual health and abuse prevention education may limit school districts' ability to comply with the required provision of education on healthy relationships as per the newly adopted TEKS curriculum standards and other required Texas statutes. On a related note, the fact that not all respondents reported implementing the opt-in policy suggests that additional communication and training may be needed for school districts to increase their awareness of the new opt-in policy.

2) Obtaining parental permission for sexual health education is time-consuming and burdensome.

Although many respondents in the sample could not recall specific details about the amount of time and difficulty it took to obtain parental permission, the amount of time and perceived difficulty obtaining parental permission was higher among respondents implementing opt-in compared to opt-out. Our qualitative findings supported these data further, suggesting that obtaining parental consent is time-consuming and takes away from teachers' and other school officials' time to work with students. Prior studies that have examined active (opt-in) versus passive (opt-out) parent consent policies in relation to adolescent participation in school-based research suggest similar findings. For example, Tigges[17] reported that parental permission was obtained from 30 – 60% of students when active permission was required for their child to participate in school-based research on adolescent risk behavior, compared to 93-100% for passive consent requirements. Additional follow-up with parents in the Tigges study improved obtaining active consent permission, with parental permission rates increasing to 55-100% of parents granting permission. However, this process was reported as time consuming and very costly for the school, its administration, and its teachers.

3) Multiple parental permission distribution methods may be needed to increase response rates under an opt-in policy.

Regardless of whether their school districts implemented an opt-in or opt-out policy for sexual health education, respondents reported distributing parental permission most often through students to their parents and via email. However, additional distribution methods (e.g., included with registration, meet the teacher, online QR codes, posted on school website) were reported by respondents from schools/districts using an opt-in policy compared to those from schools/districts using opt-out (e.g., parent information session). Qualitative data supported these findings. However, per newly adopted state law, permission

forms may not be included with any other notification or request for written consent, other than required notification related to the sexual health education or abuse prevention instruction. This provision in the law could impair the ability of districts to effectively distribute permission slips.

4) Lack of parental consent return does not necessarily indicate that parents do not want their child to participate in sexual health and abuse prevention education.

Qualitative data suggested that when parents do not return permission forms, it is not because they are making an informed decision to withdraw their child from sexual health or abuse prevention education, but rather only because parents do not know that permission is being sought or failed to overcome barriers (time, engagement, language, others) to return the permission slip. Relatedly, some respondents who provided qualitative data noted little parental education concerning the change from an opt-out to opt-in policy which resulted in confusion and suggests that parents need additional education on this policy change.

5) Many respondents perceived fewer students in 2021-2022 receiving sexual health education compared to previous academic years.

Nearly half of respondents who implemented sexual health education in the 2021-2022 academic year perceived a decrease in the number of students receiving such education as a result of the opt-in policy. Qualitative data also supported this finding. While there is a dearth of research that examines how student participation rates in sexual health education are impacted by parental permission state policies, some research has examined active (opt-in) versus passive (opt-out) parental consent as it relates to sexuality health research participation among adolescents and emerging adults. Research has indicated that requiring active parental permission for a student to participate in school-based programming or involvement in research can significantly decrease their likelihood of participation and ability to engage in these opportunities.[18,22] Further, a meta-analysis of 15 studies, conducted for the purposes of adolescent risk-behavior research in majority school-based environments, found that response rates were significantly lower for studies using active parental consent study samples, compared to passive consent samples.[18]

6) The opt-in sexual health and abuse prevention policies may widen socioeconomic and health disparities.

Qualitative data suggested that the opt-in policy could create or worsen health disparities, by decreasing access to sexual health and abuse prevention education, and creating differential barriers for student access. Respondents noted that some students may be unequally impacted by these policies, and it may have negative impacts on their health. Specifically, respondents highlighted certain communities, including LGBTQ+, English as a Second Language (ESL), low-income, and students with absentee parents/guardians as particularly vulnerable to poorer health as a result of the opt-in policy. Although limited, our opt-in permission form data reported by respondents revealed that six of nine participants reported that less than 50% of students returned their parental permission forms. Although we do not know the characteristics of youth who did not return their forms, these numbers suggest that a large portion of youth did not receive sexual health education during the 2021-2022 school year.

Our data are supported by other related empirical studies. For example, studies examining active consent procedures with regard to parental permission for youth to participate in research resulted in an underrepresentation of youth who are more likely to experience disparities, and greater representation for passive consent procedures.[17,18,20,21] Furthermore, Chartier and colleagues[22] found that not only did participation in a school-based emotional health depression screening program decrease by 19% when requiring active compared to passive parental permission, but participants who were at higher risk for screening positive for poor emotional health were less likely to participate under active consent conditions.

7) Some limited conclusions can be made from the participant data of parental permission form return rates; additional efforts should be made to track this data.

While we asked survey respondents to report their rates directly, few respondents were able to recall specific numbers, and thus limited conclusions can be made. Additionally, a large district that had intended to fully track opt-in data reported that data collection did not systematically occur. Among respondents who reported

> "Students are missing out due to the opt in procedures. Many parents don't sign because they just don't see it."
>
> Curriculum Coordinator in a public school district

having an opt-in policy, the middle school parent permission form return rate range ranged from 32.8% to 100.0% of students returning their permission forms. The permission form return rate range for the high school data, however, was much smaller (2.0%-37.2%) than the rate obtained for middle school data. No clear trends could be discerned in terms of which types of schools/districts were more likely to report higher parental permission rates than others. In the vast majority of cases, however, respondents reported that over 90% of forms returned reflected parental permission for their child to participate in sexual health education; thus, reflecting strong support for sexual health education among those parents whose children did return a parental permission form.

Based on the limited data collected, it was not possible to assess the impact of the opt-in policy on students' receipt of sexual health education; this points to the difficulty in collecting specific tracking data related to the distribution and collection of parental permission forms, and highlights the concern that there is no tracking of the impact of this policy. Tracking systems must be implemented in order to reliably collect this information rather than relying on participants for their recall which is subject to error. Obtaining these data will be critical for evaluating the impact of the opt-in policy on students' future receipt of sexual health and abuse prevention education.

8) Most respondents favor an opt-out policy with respect to sexual health and abuse prevention education, but there is a small minority who favor opt-in or are ambivalent towards their policy preference.

Most respondents reported preference for an opt-out policy for sexual health education (70.4%) and abuse prevention education (65.2%). For both sexual health and abuse prevention education, about one-third of respondents (each) did not report a preference or preferred opt-in. The qualitative data supported these findings though it was less mixed when it came to attitudes towards the opt-in policy for abuse prevention education. There were a variety of reasons participants expressed a preference for opt-out for sexual health education. These reasons centered on challenges associated with obtaining permission from parents, the perception that sexual health education was important for all students to receive, and the concern that students who may have greater informational needs may have parents who are unable to meet these needs. Among the few respondents in the qualitative data who expressed ambivalence toward opt-out or favored opt-in, there was a perception that parents would be more informed about the content of their child's sexual health education lessons. With respect to the opt-in policy for abuse prevention education, our qualitative data revealed that respondents were particularly concerned that it places abused youth at heightened risk, as abusive parents/guardians are unlikely to grant permission for education that might implicate themselves.

The finding that a majority of respondents prefer opt-out aligns with a recent meta-analysis of 23 surveys that reported the vast majority of adults (or parents) in the general public (almost 90%) support sexual health and relationship education in U.S. schools.[25] Similar findings were reported in a recent survey of 601 Texas voters across the political spectrum. In that survey, 75% of participants reported that "abstinence-plus" sexual health education, which includes information about contraception and prevention of sexually transmitted infections, should be taught in Texas public schools. Further, almost 90% of Texas voters reported that schools should teach information about consent, including respecting boundaries.

STRENGTHS AND LIMITATIONS OF EVALUATION

This study has several strengths, such as being a first-of-its-kind evaluation of Texas school representatives' perceptions and experiences related to the 2021 opt-in parental permission policy. Another strength is the bipartisan nature of the sample, with nearly equal amounts of respondents self-identifying as Democrat and Republican. Further, the use of qualitative data to provide additional context and clarification presents a more nuanced understanding of this complex policy issue than quantitative results alone.

This evaluation also has some limitations. First, generalizability is limited, as only a small sample of Texas school district representatives was surveyed. Additionally, the majority of respondents (>90%) represented public school districts; thus, results may not be generalizable to private and charter schools. Further, the non-random sampling techniques employed may result in selection bias. For example, recruitment heavily relied on pre-existing contacts. Further, while all 20 regional Education Centers were contacted about participating in the survey, only four agreed to aid in the distribution of recruitment material, likely resulting in disproportionate representation of these districts and regions among respondents. Therefore, the study sample may not represent Texas as a whole. It is worth noting, however, that the respondents represented a diverse sample of schools/districts with respect to geographic area and school size. An additional limitation is the use of self-report data, which are subject to recall bias. Further, we obtained only a limited number of participants who could recall parental permission data which could also be subject to recall bias. Additionally, few private and charter schools were surveyed; thus, their attitudes and experiences related to the opt-in policy need further examination. However, the opt-in policy may not be as relevant for private schools because that statute only applies to public schools. Finally, because the qualitative data were collected in a survey rather than through a traditional interview, we were not able to ask follow-up questions to clarify. Additionally, we could only explore the perceptions of those who felt strongly enough to write explanations of their policy preferences.

OVERALL CONCLUSIONS AND RECOMMENDATIONS

Overall, the majority of our bipartisan sample of Texas school representatives perceived the opt-in policy related to sexual health and abuse prevention as a barrier to the delivery of education related to these topics. Our sample expressed concerns related to the additional burden and time that obtaining parental permission would take, especially in the context of their already busy schedules. Respondents reported that multiple parental permission distribution methods were needed to increase response rates and that lack of parental consent return does not necessarily indicate that parents do not want their child to participate in sexual health or abuse prevention education. Further, many respondents perceived that fewer students in 2021-2022 received sexual health education compared to previous academic years. Respondents expressed concerns that the opt-in policy could create or worsen health disparities by decreasing access to sexual health education, and creating differential barriers for student access. Most respondents reported favoring an opt-out policy with respect to sexual health and abuse prevention education, and respondents highlighted particular possible safety concerns with the opt-in policy. Finally, when examining the limited participant-reported parental permission data, it was not possible to assess the impact of the opt-in policy on students' receipt of sexual health education; this points to the need for additional tracking of these student data and highlights the concern that there is no systematic tracking of the impact of this policy across Texas schools. Future research should systematically assess the percentage of parents who provide consent, do not provide consent, and fail to return these forms. One consistent trend from the participant permission form data, however, reflected the finding that among parents whose child did return a parental permission form, the majority provided permission for their child to participate in sexual health education; this result suggests strong parental support for their child's receipt of sexual health education in school.

Based on these conclusions, we offer the following recommendations for school districts and policymakers:

For policymakers:

1. Encourage school districts to collect empirical data on parental permission response rates and sexual health and abuse prevention education implementation experiences among a representative sample of Texas public schools to better understand the impact of the opt-in policy on the receipt of sexual health and abuse prevention education.

2. Remove administrative barriers that prevent schools from easily distributing permission forms to parents, such as the prohibition on sending out the opt in form with other documents.

3. Provide additional training and/or increase notifications to schools/districts on the recent policy changes so that all districts are complying with the new policy.

4. Talk with schools and parents to ensure the policy is meeting their needs and preferences related to students' receipt of sexual health and abuse prevention education.

> "The kids who are left on their own are statistically the ones who need sexual education more."
>
> SHAC member in a public school district

For school districts:

1. Increase knowledge related to the opt-in policy to ensure compliance.

2. Collect empirical data on parental permission response rates and sexual health and abuse prevention education implementation experiences in schools. This will require districts to put data collection tools in place prior to teaching sexual health and abuse prevention education.

3. Provide training to schools on best practices for obtaining consent and achieving high response rates. Such practices may include use of multiple parental permission distribution methods (e.g., through students to their parents, via email, meet the teacher events, posted on school website, classroom incentives, or phone reminders) to increase parental permission response rates among all students.

4. Identify and leverage district resources to support schools in obtaining parental consent.

5. Clearly communicate the opt-in policy change to parents to ensure they are well-informed about the new policy.

6. Clearly communicate the content of sexual health education lessons to parents, providing opportunities for them to learn more about the curriculum

For schools:

1. Collect empirical data on parental permission response rates and sexual health and abuse prevention education implementation experiences.

2. Connect with other schools for idea-sharing and lessons learned for obtaining consent and achieving high response rates.

3. Implement multiple parental permission distribution methods (e.g., email, school website, in-person events, etc.) to increase parental permission response rates.

> **"…Schools such as mine have additional barriers created by an opt-in system, such as parents that may have limited or no literacy skills, ESL speakers, cultural barriers, and just the general return rate we get for parent [consents]."**
>
> Counselor/social worker in a public school district

APPENDIX

Opt-In Policy Evaluation Survey Measures

Variable	No. Items	Sample Item	Response Options
Demographics	**7**		
School type	1	Do you represent a public independent school district, public school, charter school, or private school?	*public independent school district, public school, charter school, private school*
Primary role	1	What is your primary role in your school district/school?	*school administrator, curriculum coordinator, health teacher, other teacher (non-health), school nurse, counselor or social worker, school health advisory board member, other (please specify)*
Foster Care Liaison status	1	Do you serve as a Foster Care Liaison for your district?	*yes, no*
Student enrollment	1	What is the student enrollment in your school district/private school?	*less than 5,000 students, 5,000-25,000 students, greater than 25,000 students*
Rural, urban, or suburban area	1	Is your school district/private school located in a primarily rural, urban, or suburban area?	*rural, urban, suburban*
Grade levels taught	1	What grade levels are taught in your school district/private school? Please choose all that apply.	*first - twelfth, unsure*
Political Party	1	Generally speaking, do you usually think of yourself as a Republican, Democrat, Independent, or something else?	*republican, democrat, independent, other (please specify), prefer not to respond*
Sexual Health Education Implementation 2021-2022	**3**		
Was sexual health education taught in 2021-2022	1	Did your school district/ school attempt to implement sexual health education during the 2021-2022 school year?	*yes, no, don't know*
Curriculum	1	What curriculum and/or materials does/did your school district/school utilize for sexual health education instruction for the 2021-2022 school year? (Check all that apply)	*18 options provided, don't know, other (please specify)*

Variable	No. Items	Sample Item	Response Options
Grade levels receiving sexual health education	1	During what grade levels was sexual health education taught in your school district/ school during the 2021-2022 school year? (Check all that apply)	*seventh-twelfth, don't know*
Permission Form Processes 2021-2022	**5**		
Opt-in or opt-out form usage	1	For the 2021-2022 school year, did your school district employ an opt-in or an opt-out sexual health education permission form policy?	*opt-in, opt-out, don't know, we did not attempt to implement any sexual health education during the 2021-2022 school year*
Permission form distribution methods	1	How were parent permission forms related to sexual health education distributed at your school district/ school? Check all that apply.	*at a parent information night, sent home with students, email, at "meet the teacher" night, included with registration forms, other (please specify), don't know*
Hours spent on permission form distribution	1	Approximately how many hours did your school district/school devote to distributing and obtaining parental consent prior to students participating in sexual health education at your school district/school:	*free response, don't know*
Permission form reminders	1	Approximately how many reminders were sent to parents/guardians and/or students to return completed permission forms:	*free response, don't know*
Ease of obtaining consent	1	How easy or difficult was it to obtain parental consent to participate in sexual health education in your school/ district during the 2021-2022 school year? Would you say it was...?	*very easy, easy, no opinion, difficult, very difficult, don't know*
Factors influencing policy implementation	1	If you implemented the opt-in policy for sexual health education during the 2021-2022 school year, please share any specific factors that made it easier or harder to implement the policy.	*free response, don't know*

Variable	No. Items	Sample Item	Response Options
Attitudes and Beliefs	**13**		
Perceived barrier to sexual health education	4	To what degree was the "opt-in" policy for sexual health education a barrier to students' receipt of sexual health education in your school district/school during the 2021-2022 school year?	*not a barrier, somewhat of a barrier, moderate barrier, extreme barrier, don't know*
Perceptions of ease	2	How easy or difficult do you think it will be to obtain written consent from parents, guardians, or other adults authorized to provide consent for youth in the child welfare system (i.e., in the foster care system), in particular, to participate in sex education in school district/school during the 2022-2023 school year at your school district/school? Would you say it will be…?	*very easy, easy, no opinion, difficult, very difficult, don't know*
Policy preference	6	Considering both the "opt-in" and "opt-out" policy for [sexual health education/ prevention of child abuse, family violence, dating violence, or sex trafficking], which policy best describes your preference?; How strongly do you feel about your chosen preference in the previous question?; In a few words, can you share the reasoning behind your policy choice/ preference?	*opt-in, opt-out, no preference;* *strongly prefer, somewhat prefer, slightly prefer, no preference;* *free response*
Law clarity	1	The Texas laws governing sexual health education and HIV/AIDS education are clear.	*strongly agree, agree, neither agree nor disagree, disagree, strongly disagree, don't know*
Additional comments	1	Please share any additional comments that you have related to the "opt-in" policy for sexual health education that is now required for Texas schools.	*free response, don't know*

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