

Review of Personal, Social, Health and Economics (PSHE) Education

This document is in response to the DfE internal review of personal, social, health and economic (PSHE) education. A number of questions have been identified by DfE as requiring evidence and NICE is responding to this request for evidence in relation to questions 2 and 6 of the DfE document. The questions are:

Question 2. Have you got any evidence that demonstrates why a) existing elements and, b) new elements should be part of PSHE, and

Question 6. How do you think the statutory guidance on sex and relationships education (SRE) could be simplified, especially in relation to: a) strengthening the priority given to teaching about relationships, b) the importance of positive parenting, and c) teaching young people about sexual consent?

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to develop evidence-based guidance on school, college and community-based personal, social and health education, including health literacy, with particular reference to sexual health behaviour and alcohol. This guidance has been completed and was due to be published in November 2010. During that month DH asked NICE to put the guidance on hold to ensure that it fits with the new public health service and general configuration of services. DH Ministers have not yet decided whether work on this guidance will continue.

For details see: <http://guidance.nice.org.uk/PHG/Wave12/77>

To inform the development of the guidance, NICE commissioned 3 evidence reviews from Liverpool John Moores University and a review and economic analyses from the National Collaborating Centre for Women's and Children's Health to evaluate the effectiveness and cost effectiveness of interventions

and programmes that focus on interventions and programmes that focus on health literacy and personal skills in relation to alcohol education and sex and relationships education.

The evidence reviews and economic modelling reports are listed below. They can be found on the NICE website on these pages

<http://guidance.nice.org.uk/PHG/Wave12/77/EvidenceConsultation>

<http://www.nice.org.uk/guidance/index.jsp?action=folder&o=49244>

Primary School Review- Review 1

Jones L, Bates G, Downing J et al. (2009). A review of the effectiveness and cost-effectiveness of personal, social and health education in primary schools focusing on sex and relationships and alcohol education for young people aged 5 to 11 years.

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=47606>

Secondary and FE Review- Review 2

Jones L, Bates G, Downing J et al. (2009). A review of the effectiveness and cost-effectiveness of personal, social and health education in secondary schools focusing on sex and relationships and alcohol education for young people aged 11 to 19 years

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=47609>

Community Review – Review 3

Jones L, Bates G, Downing J et al. (2010). A review of the effectiveness and cost effectiveness of alcohol and sex and relationship education for all children and young people aged 5-19 years in community settings

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=47613>

Children’s and Young People’s Views Review – Review 4

Bardisa-Ezcurra L, Kwan I, Pledge D et al (2009) Children and young people’s perspectives on school, family, and community-based personal, social and health education (PSHE), in particular concerning alcohol, sexual health and relationships

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=49247>

Please note: All the following responses to the questions in this consultation on PSHE education refer to the recommendations in the NICE guidance and the evidence statements (ES) that underpin those recommendations. The guidance document, including all the evidence-based recommendations and related ES, is included in the Appendix to the NICE response to this consultation. For example, ES1.1a can be found in Review 1 as ES1a; ES 2.1a can be found in review 2 as ES1a. Appendix C of the NICE guidance sets out which ES underpin which recommendation and provides full details of all the evidence statements used in the guidance.

NICE responses to the consultation on PSHE education

Question 2. Have you got any evidence that demonstrates why:

a) Existing elements should be part of the PSHE education curriculum?

Evidence from the NICE primary school review indicates:

- that social development programmes can help to increase attachment to school, improve academic performance, improve social skills, and reduce aggressive and disruptive behaviour. The success of these programmes is particularly effective when started in primary school and when school education contains a home component. These may include:
 - providing a summary of what has been discussed at school for children to take home, with suggestions for follow up at home
 - encouraging further discussion at home of issues discussed at school and vice versa
 - setting homework that encourages discussion between parents and children
 - lending books and teaching resources to parents.

(NICE draft PSHE education guidance Recommendations 1&7: based on Evidence Statements (ES); ES 1.6a (Hawkins et al., 1999, 2005; Catalano

et al., 2003; Battistich et al., 2004; Flay et al., 2003) ES 1.6b (Catalano et al., 2003; Reid et al., 1999; Jalongo et al., 1999; Flay et al., 2003; Battistich et al., 2004)). (See Appendix for full reference).

- that programmes focusing on social development interventions, for example, those that focus on friendships and family relationships in younger age groups and develop communication, decision-making and negotiation skills, and are designed to positively influence behaviour in later life when combined with school- and family-based intervention components were shown to have long term positive impacts on alcohol use and sexual behaviour in young adulthood (Seattle Social Development Programme; Good Behavior Game) (Recommendation 1, 2, 3, 7 & 8; ES1.6c (Hawkins et al., 1999, 2005; Lonczak et al., 2002) and ES 1.6d Kellam et al., 2008; Poduska et al., 2008; van Lier et al., 2009).

Alcohol and drug education programmes

Evidence from the NICE secondary school and FE review indicates that

- a secondary school-based programme, provided by teachers trained in life skills and cognitive-behavioural techniques, such as demonstration, behavioural rehearsal, feedback, reinforcement and homework assignments can produce long-term reductions (greater than 3 years) in alcohol use. Other promising intervention approaches include: Keeping it REAL, the Midwest Prevention Project, Project Northland, Healthy School and Drugs, Project Alert, and SHAHRP (Recommendation 2, 7 & 8 ; ES 2.1a (Foxcroft et al., 2002, 2003; Spoth et al., 2008)). (See Appendix for full reference).
- classroom based alcohol specific programmes, for example, understanding the short-term and long-term effects of early alcohol use and binge drinking on physical and mental health, developing refusal skills to delay the start of alcohol use and to reduce the amount drunk, when combined with family- and/or community-based components are effective at increasing alcohol-related knowledge in the short term

(Recommendation 1, 2 & 7; ES 2.2a (Bagnall, 1990, McBride et al., Morgenstern et al., 2009, Newton et al., 2009, Schnepf 2002, Vogl et al 2009 Newman et al., 1992, Shope et al., 1996a)).

- alcohol-specific education programmes have mixed short-term effects on health outcomes relating to alcohol use. The SHAHRP programme focused on harm reduction through skills-based activities; effects were seen on risky drinking behaviours such as drunkenness and binge drinking in particular (Recommendations 2 & 8; ES 2.2d (McBride et al., 2000, 2003, 2007)).
- alcohol specific education programmes that cover themes in a way that is factually accurate and unbiased have medium to long term effects on health outcomes related to alcohol use, such as frequency of alcohol consumption and drunkenness (Recommendation 1, 2 & 8; ES 2.2e (Donaldson et al., 2000, Palmer et al., 1998, Klitzner et al., 1994, McBride et al., 2004, Morgenstern et al., 2009 Newman et al., 1992, Newton et al., 2009 Shope et al., 1994, Shortt et al., 2007, Vogle et al., 2009)).
- classroom-based programmes which focus on alcohol alone or as one of a number of substances, taught by people who have received appropriate or accredited training can have beneficial effects on alcohol-related knowledge, attitudes and values, drinking frequency and binge drinking (Recommendations 1, 2 & 3; ES 3.3a, Botvin et al., 1990a, (Botvin et al., 2001a, Shoop et al., 1996b, Cuijpers et al., 2001) ES 3.3b (Bennett, 1995, Clayton et al., 1991, Dukes et al., 1996, Ennett et al., 1994, Rosenbaum et al., 1994, Harmon 1993, Ringwalt et al., 1991, Perry et al., 2003, Botvin et al., 1990a, Botvin et al., 1990b, Botvin et al., 1995b, Botvin et al., 1997, Botvin et al 2001a, Cuijpers et al., 2001, Eisen et al., 2002, Caplan et al., 1992, Lennox and Cecchini, 2008, Dedobbeleer and Desjardins, 2001, Hecht et al., 2003, Kulis et al., 2005) and ES 3.3f (Botvin et al., 1990a, Botvin et al., 1995b, Botvin et al., 2001a, Botvin et al 1990b, Fraguera et al., 2003, Smith et al., 2004, Spoth et al., 2005, 2008)).

Sex and relationships education

- programmes that teach only about delaying first sex (abstinence-only programmes), are ineffective for preventing or reducing sexual risk behaviours, have no effect on the initiation of sexual behaviours or the maintenance of sexual abstinence, and may have no impact on sexual activity. (Recommendations 1, 2 & 3; ES 2.8a, 2.10c (Underhill et al., 2007, 2008, Bennett and Assefi, 2005, Kirby et al., 1995, Oakley et al., 1995)).
- programmes are likely to be more effective if they bring together education about relationships, sexual health and alcohol and substance misuse components of PHSE education. Those that [only] offer information on safer sex and contraceptive use may have positive, but limited effects on the prevention of sexual risk behaviour - in particular limited effects on contraceptive use: (Recommendations 1, 2, 3 & 8; ES 2.8b (Pedlow and Carey, 2003 Franklin et al., 1997, Kirby et al., 1994, Oakley et al., 1995 Underhill et al., 2008); ES 2.8c (Kirby et al., 1994, Pedlow and Carey 2003, Robin et al., 2004, Sales et al., 2006), ES 2.9a (Mellanby et al., 2001, Stephenson et al., 2004, Tucker et al., 2007, Wright et al., 2002); and ES 2.9d (Mellanby et al 1995, Stephenson et al., 2004, 2008 Wight et al 2002, Graham et al., 2002 Magnusson et al., 2004)).
- HIV and sexual risk-reduction programmes can improve sexual health and HIV knowledge in the short, medium and long term, (Recommendations 1, 2 & 8; ES 2.12a (Borgia et al., 2005, Coyle et al., 2006, Fisher et al., 2002, Larsson et al., 2006, Lemieux et al., 2008, Roberto et al., 2007, Schaalma et al., 1996, Workman et al., 1996)).
- HIV and sexual risk-reduction programmes may improve personal and social skills including behavioural prevention skills and condom negotiation skills in the short term (Recommendations 1, 2 & 8; ES 2.12c (Borgia et al., 2005, Fisher et al., 2002, Lemieux et al., 2008, Roberto et al., 2007)).

- HIV and sexual risk-reduction programmes can increase condom use or protected intercourse in the short to medium term (Recommendations 1, 2 & 8; ES 2.12e (Borgia et al., 2005, Coyle et al., 2006, Fisher et al., 2002, Kyalem et al., 1996 Larsson et al., 2006, Lemieux et al., 2008, Roberto et al., 2007, Schaalma et al., 1996, Workman et al., 1996, Traeen, 2003)).
- There is evidence that a sex and relationships education programme, Safer Choices: a planned curriculum involving role-playing, role model stories, parent newsletters, homework and school-community linkages may be cost-effective and cost saving (Recommendations 1&2; ES 2.14 (Wang et al., 2000)).

There is evidence from the children and young people's review that

- young people want factual, practical information about alcohol that applies to the realities of their lives (Recommendations 1 & 2; ES 4.2 (Buston and Wight, 2006; Lynch and Blake, 2004). (See Appendix for full reference).
- young people (aged 13-17) felt that SRE was delivered too late to be of practical use. Many had experienced sexual activity prior to it; there was also concern however that if it was delivered too early it may influence young people's wish to have sex (Recommendation 6; ES 4.5 (Buston & Wight 2002; Buston & Wight 2006; Forrest, Strange, & Oakley 2002; Hilton 2007; Lester & Allan 2006; Measor, Tiffin, & Miller 2000)

b) (What) new elements should be part of the PSHE education curriculum?

Evidence from the primary school review indicates:

- the need for a Joint Strategic Needs Assessment when determining the provision of and need for education about sex and relationships education (SRE) and alcohol within PSHE education

(Recommendation 2; ES 1.6a, (Hawkins et al., 1999, 2005; Catalano et al., 2003; Battistich et al., 2004; Flay et al., 2003) ES 1.6b (Catalano et al., 2003; Reid et al., 1999; Jalongo et al., 1999; Flay et al., 2003; Battistich et al., 2004); ES 1.6c (Hawkins et al., 1999, 2005; Lonczak et al., 2002) and ES 1.6d Kellam et al., 2008; Poduska et al., 2008; van Lier et al., 2009)).

- that multi-component social development programmes that include school and family based interventions were shown to have long term (>12 months) positive impacts on attachment to school, academic performance, and social skills and can reduce problem behaviour. (Recommendation 3; ES 1.6a, (Hawkins et al., 1999, 2005; Catalano et al., 2003; Battistich et al., 2004; Flay et al., 2003) ES 1.6b (Catalano et al., 2003; Reid et al., 1999; Jalongo et al., 1999; Flay et al., 2003; Battistich et al., 2004); ES 1.6c (Hawkins et al., 1999, 2005; Lonczak et al., 2002)).
- that flexibility is important in designing PSHE education, for example offering young people the opportunity to participate in, plan and evaluate PSHE education, involving them in activities to identify what is most relevant to their lives, using their feedback to improve lessons and giving them opportunities to act as peer educators. (Recommendations 4&5; ES 1.1 (Gottfredson & Wilson, 2003; Spoth et al., 2008); ES 1.6a, (Hawkins et al., 1999, 2005; Catalano et al., 2003; Battistich et al., 2004; Flay et al., 2003) ES 1.6b (Catalano et al., 2003; Reid et al., 1999; Jalongo et al., 1999; Flay et al., 2003; Battistich et al., 2004); ES 1.6c (Hawkins et al., 1999, 2005; Lonczak et al., 2002)).

Evidence from the secondary school and FE review indicates

- the need for consultation with children and young people in the provision of alcohol education (Recommendation 4; ES 2.1b (Gottfredson and Wilson, 2003, Cuijpers, 2002)).

- the need for parent consultation in the provision of sex and relationships education (Recommendation 3; ES 2.8b (Pedlow and Carey, 2003 Franklin et al., 1997, Kirby et al., 1994, Oakley et al., 1995 Underhill et al., 2008), ES 2.9d (Mellanby et al 1995, Stephenson et al., 2004, 2008 Wight et al 2002, Graham et al., 2002 Magnusson et al., 2004) and ES 2.10c (Blake et al., 2001, Borawski et al., 2005, Denny et al., 1999, Jorgensen et al., 1993, Roosa and Christopher, 1990, Trenholm et al., 2008, Denny and Young 2006)).
- the need for setting learning outcomes and evidence-based teaching methods, for example, skills-based methods, active and interactive techniques such as role play, drama, debates and thinking maps. (Recommendation 7; ES 2.1a (Foxcroft et al., 2002, 2003; Spoth et al., 2008), ES 2.8c (Kirby et al., 1994, Pedlow and Carey 2003, Robin et al., 2004, Sales et al., 2006), ES 2.12a (Borgia et al., 2005, Coyle et al., 2006, Fisher et al., 2002, Larsson et al., 2006, Lemieux et al., 2008, Roberto et al., 2007, Schaalma et al., 1996, Workman et al., 1996), ES 2.12e (Borgia et al., 2005, Coyle et al., 2006, Fisher et al., 2002, Kyalem et al., 1996 Larsson et al., 2006, Lemieux et al., 2008, Roberto et al., 2007, Schaalma et al., 1996, Workman et al., 1996, Traeen, 2003) and ES 2.14 (Wang et al., 2000).
- the need to enable children and young people to identify and manage risks, and to recognise and avoid exploitation and abuse and that giving consent means understanding what is involved and its implications. (Recommendation 8; ES 2.1a (Foxcroft et al., 2002, 2003; Spoth et al., 2008), ES 2.2a, (Bagnall, 1990, McBride et al., Morgenstern et al., 2009, Newton et al., 2009, Schnepf 2002, Vogl et al 2009, Newman et al., 1992, Shope et al., 1996a), ES 2.2d (McBride et al., 2000, 2003, 2007), ES 2.2e (Donaldson et al., 2000, Palmer et al., 1998, Klitzner et al., 1994, McBride et al., 2004, Morgenstern et al., 2009 Newman et al., 1992, Newton et al., 2009 Shope et al., 1994, Shortt et al., 2007, Vogle et al., 2009); ES 2.3f (Botvin et al., 1990a, Botvin et al., 1995b, Botvin et al., 2001a, Botvin 1990b, Fraguela et al.,

2003, Smith et al., 2004, Spoth et al., 2005, 2008), ES 2.8b (Pedlow and Carey, 2003 Franklin et al., 1997, Kirby et al., 1994, Oakley et al., 1995 Underhill et al., 2008); ES 2.8c (Kirby et al., 1994, Pedlow and Carey 2003, Robin et al., 2004, Sales et al., 2006); ES 2.12a (Borgia et al., 2005, Coyle et al., 2006, Fisher et al., 2002, Larsson et al., 2006, Lemieux et al., 2008, Roberto et al., 2007, Schaalma et al., 1996, Workman et al., 1996), ES 2.12c (Borgia et al., 2005, Fisher et al., 2002, Lemieux et al., 2008, Roberto et al., 2007) and ES 2.14 (Wang et al., 2000)).

- the valuable contribution from external contributors to PSHE education, for example the provision of free, personal, confidential and non-judgmental information, advice and support without an appointment and evidence that these external contributions in the classroom need to have specialist knowledge and skills (Recommendations 9 and 10; ES 2.8c (Kirby et al., 1994, Pedlow and Carey 2003, Robin et al., 2004, Sales et al., 2006)).
- the need for specialist training for PSHE education as part of initial teacher training and opportunities for continuing professional development (Recommendation 12; ES 2.8c (Kirby et al., 1994, Pedlow and Carey 2003, Robin et al., 2004, Sales et al., 2006)).

There is evidence from the children and young people's views review that:

- children and young people use a range of sources of information and that the preferred sources of information were related to gender, experience of sexual intercourse and ethnicity (Recommendation 1; ES 4.3 (Buston & Wight 2002; Buston & Wight 2006; Lester & Allan 2006; Measor, Tiffin, & Miller 2000; Schubotz, Simpson, & Rolston 2002; Selwyn & Powell 2007; Simpson, Lafferty, & McConkey 2006; Lynch & Blake 2004)).
- family members are popular sources of information about sex for girls (Recommendation 3; ES 4.3 (Buston & Wight 2002; Buston & Wight

2006; Lester & Allan 2006; Measor, Tiffin, & Miller 2000; Schubotz, Simpson, & Rolston 2002; Selwyn & Powell 2007; Simpson, Lafferty, & McConkey 2006; Lynch & Blake 2004).

- young people feel that SRE is a sensitive and potentially threatening subject and there is a need to reduce the levels of anxiety felt by pupils (Recommendation 4; ES 4.2 (Buston and Wight, 2006; Lynch and Blake, 2004); ES 4.7 (Buston, Wight and Hart, 2002; Forrest, Strange and Oakley, 2002, Measor, Tiffin and Miller, 2000, Forrest, Oakley and Strange, 2003, Hirst, 2004)).
- young people would not seek information from teachers because they consider teachers to not care about the subject and are not trustworthy because, unlike health professionals, they do not have to abide by a duty of confidentiality. Recommendation 7; ES 4.2 (Buston and Wight, 2006; Lynch and Blake, 2004).
- young people want alcohol and sex to be dealt with in more depth in SRE lessons. They want to understand the influence of alcohol on sexual behaviours and also where to get confidential support to manage their emotions if they make a bad decision (Recommendation 8; ES 4.2 (Buston and Wight, 2006; Lynch and Blake, 2004)).
- There is evidence that young people value the contribution of peer educators. Teachers are considered more knowledgeable and peer educators more understanding, realistic and patient (Recommendation 9 & 12; ES 4.2 (Buston and Wight, 2006; Lynch and Blake, 2004).
- young people would seek information and advice from youth workers and school nurses because they are considered technically well trained and offer confidentiality on alcohol issues (Recommendation 9 & 10; ES 4.2 ES 4.2 (Buston and Wight, 2006; Lynch and Blake, 2004)).
- young people do not receive consistent, systematic information on alcohol (Recommendation 12; ES 4.2 ES 4.2 (Buston and Wight, 2006; Lynch and Blake, 2004)).

Question 6. How do you think the statutory guidance on sex and relationships education could be simplified, especially in relation to:

a) Strengthening the priority given to teaching about relationships.

Evidence from the primary school review indicates that:

- PSHE education should begin with the nature of friendships and family relationships, progressing to the mental and physical changes that occur when growing up. It should begin in primary school and develop and continue through all key stages of education, until early adulthood. It should respond to young people's needs and use a variety of teaching methods to suit the range of learning styles. (Recommendations 1, 6 and 8; ES 1.6a, (Hawkins et al., 1999, 2005; Catalano et al., 2003; Battistich et al., 2004; Flay et al., 2003) ES 1.6b (Catalano et al., 2003; Reid et al., 1999; Jalongo et al., 1999; Flay et al., 2003; Battistich et al., 2004); ES 1.6c (Hawkins et al., 1999, 2005; Lonczak et al., 2002) and ES 1.6d (Kellam et al., 2008; Poduska et al., 2008; van Lier et al., 2009)).

Evidence from the secondary school and FE review indicates that

- HIV and sexual risk reduction programmes may improve personal and social skills including behavioural prevention skills and condom negotiation skills in the short-term (Recommendation 8; ES 2.12c (Borgia et al., 2005, Fisher et al., 2002, Lemieux et al., 2008, Roberto et al., 2007)).

Evidence from the community review indicates that

- children and young people who may not be in regular contact with education or health and social services, or who may have particular needs should have access to good quality community-based sex and relationships and alcohol education that is consistent with PSHE education in schools and other places of education (Recommendation 1 and 2; ES 3.1 (Foxcroft et al., 2002; 2003, Petrie et al., 2007 Smit et al., 2008), ES 3.8a (Di Noia and Schinke, 2007; Jemmott et al., 1992;

Jemmott et al., 1998; Kipke et al., 1993; Pearlman et al., 2002; Philliber et al., 2002; Smith et al., 2000); ES 3.8b (Di Noia and Schinke, 2007; Elliott et al., 1996; Stanton et al., 1996); ES 3.8d (Jemmott et al., 1992; Jemmott et al., 1998; Postrado and Nicholson, 1992; Sikkema et al., 2005; Villarruel et al., 2006, Jemmott et al., 1992; Jemmott et al., 1998; Sikkema et al., 2005; Villarruel et al., 2006, Villarruel et al., 2006); ES 3.8f (Philliber et al., 2002); ES 3.9a (Boekeloo et al., 1999; Danielson et al., 1990; DiClemente et al., 2004; Downs et al., 2004; Jemmott et al., 2005; Morrison-Beedy et al., 2005)). (See Appendix C for full reference).

- a family-based programme which offers joint parent and child personal and social interaction skills-building and communication sessions (Iowa Strengthening Families (ISFP) can produce long-term reductions (greater than three years) in alcohol use and heavy alcohol use (Recommendation 1; ES 3.1 (Foxcroft et al., 2002; 2003, Petrie et al., 2007 Smit et al., 2008)).
- the need for parent consultation and involvement in the provision of alcohol education (Recommendation 3; ES 3.1 (Foxcroft et al., 2002; 2003, Petrie et al., 2007 Smit et al., 2008), ES 3.3b (Brody et al., 2004; Schinke et al., 2009), ES 3.3c (Schinke et al., 2004; Schinke et al., 2009), ES 3.4b, (Beatty et al., 2008; Toomey et al., 1996; Carlson et al., 2000); ES 3.6 (Spath et al., 2002) ES 3.15b (Prado et al., 2007; Stanton et al., 2004)).
- the need for parent consultation and involvement in the provision of sex and relationships education (Recommendation 3; ES 3.10a, (Dilorio et al., 2006; Scheinberg et al., 1997; Winett et al., 1992; Winett et al., 1993; Miller et al., 1993; Lederman et al., 2008), ES 3.11a (Dancy et al., 2006), ES 3.11e (Dancy et al., 2006) and ES 3.15b (Prado et al., 2007; Stanton et al., 2004)).

- programmes delivered to families may be cost effective and cost saving (Recommendation 3; ES 3.6 (Spoth et al., 2002)).
- youth development groups that target disadvantaged young people may have a positive impact on sexual behaviours among young women including sexual activity, condom use and pregnancy (Recommendation 8: ES 3.8f (Philliber et al., 2002)).
- interventions and programmes delivered to families and parents, and which target alcohol use and sexual health, may improve parent-child communication and family functioning (Recommendation 11; ES 3.15b (Prado et al., 2007; Stanton et al., 2004)).

Evidence from the children and young people's views review suggests that

- young people would prefer more information in SRE which relates to emotions and relationships (Recommendation 8; ES 4.4 (Buston and Wight, 2002, Buston and Wight 2006, Buston, Wight and Hart, 2002, Forrest, Oakley, and Strange 2003, Forrest, Strange and Oakley 2002, Hilton 2007, Lester and Allan, 2006, Measor, Tiffin and Miller 2000, Schubotz, Simpon and Rolson, 2002, Selwyn and Powell, 2007, Simpson, Lafferty and McConkey, 2006, Forest, Strange and Oakley 2004, Hirst 2004, Lyncy and Blake, 2004)).

b) The importance of positive parenting.

Evidence from the primary school review indicates that

- providing combined school- and family-based learning opportunities have been shown to improve academic performance among children of primary school age (Recommendations 3 and 7; ES 1.6a, (Hawkins et al., 1999, 2005; Catalano et al., 2003; Battistich et al., 2004; Flay et al., 2003) ES 1.6b (Catalano et al., 2003; Reid et al., 1999; Jalongo et al., 1999; Flay et al., 2003; Battistich et al., 2004); ES 1.6c (Hawkins et al., 1999, 2005; Lonczak et al., 2002)).

Evidence from the secondary school review indicates that

- there is a need for raised awareness amongst parents of the positive effects of planned and comprehensive PSHE, including education about sex and relationships and alcohol, and health and well-being (Recommendation 1; ES 2.8b (Pedlow and Carey, 2003 Franklin et al., 1997, Kirby et al., 1994, Oakley et al., 1995 Underhill et al., 2008); ES 2.9d (Mellanby et al 1995, Stephenson et al., 2004, 2008 Wight et al 2002, Graham et al., 2002 Magnusson et al., 2004) and ES 2.10c (Blake et al., 2001, Borawski et al., 2005, Denny et al., 1999, Jorgensen et al., 1993, Roosa and Christopher, 1990, Trenholm et al., 2008, Denny and Young 2006)).

Evidence from the community review indicates that

- programmes delivered to families which target family interaction may have positive effects on family communication, parental monitoring and parental rules about alcohol (Recommendations 3 and 11; ES 3.3c (Schinke et al., 2004; Schinke et al., 2009), ES 4a, (Koutakis et al., 2008; Toomey et al., 1996; Cohen and Rice, 1995); ES 4b (Beatty et al., 2008; Toomey et al., 1996; Carlson et al., 2000); ES 4.15b (Prado et al., 2007; Stanton et al., 2004).

c) Teaching young people about sexual consent.

There is evidence from the primary school review that

- social development programmes, which combine school- and family-based components, may have long term positive impacts on social skills, alcohol use and sexual health (Recommendation 8; ES 1.1 (Gottfredson & Wilson, 2003; Spoth et al, 2008); ES 1.6a, (Hawkins et al., 1999, 2005; Catalano et al., 2003; Battistich et al., 2004; Flay et al., 2003) ES 1.6b (Catalano et al., 2003; Reid et al., 1999; Jalongo et al., 1999; Flay et al., 2003; Battistich et al., 2004); ES 1.6c (Hawkins et al., 1999, 2005; Lonczak et al., 2002) and ES 1.6d Kellam et al., 2008; Poduska et al., 2008; van Lier et al., 2009).

Evidence from the secondary school review indicates that

- HIV and sexual-risk reduction programmes may improve personal and social skills including behavioural prevention skills (Recommendation 1; ES 2.12c (Borgia et al., 2005, Fisher et al., 2002, Lemieux et al., 2008, Roberto et al., 2007)).

There is evidence from the community review that:

- Group based education and/or skill-based interventions may help children and young people to understand their rights and responsibilities, to themselves and others. This includes the right not to be pressured or coerced into doing something that is unsafe or unwanted, and the responsibility to recognise that it is wrong to put pressure on others to do something they do not want to do. (Recommendations 8 & 12; ES 3.8a, 3.8d (di Noia and Schinke, 2007; Jemmott et al., 1992; Jemmott et al., 1998; Kipke et al., 1993; Postrado and Nicholson, 1992; Sikkema et al., 2005; Stanton et al., 1996; 1997; Villarruel et al., 2006) ES3.9f, (DiClemente et al., 2004; Downs et al., 2004; Jemmott et al., 2005 ; Morrison-Beedy et al., 2005))

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Primary School Review

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Appendix

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH GUIDANCE

School, college and community-based personal, social, health and economic education focusing on sex and relationships and alcohol education

Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce public health guidance on school, college and community-based personal, social, health and economic education, including health literacy¹, with particular reference to sexual health behaviour and alcohol.

The guidance is for school and college governors, school heads and teachers, college principals, lecturers and tutors, and commissioners and managers in children's services and their partners, local authorities, primary care and healthcare trusts.

It is also for those who have responsibility for or a direct or indirect role in school, college and community-based personal, social, health and economic (PSHE) education focusing on sex and relationships and alcohol. This includes health professionals and practitioners who work with young people in schools and colleges, those working in the NHS, local authorities, youth services, and the wider public, private, voluntary and community sectors.

It may also be of interest to children and young people, parents and those with parental responsibility, commissioners and providers of educational materials and members of the public.

¹ A level of knowledge, personal skills and confidence that allows improvements to personal and community health and wellbeing. World Health Organization (1998) Health promotion glossary [online]. Available from www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

The guidance complements, but does not replace, NICE guidance on: community-based interventions to reduce substance misuse; reducing sexually transmitted infections and teenage pregnancy; social and emotional wellbeing in primary and secondary education and alcohol use disorders – preventing the development of hazardous and harmful drinking. The guidance supersedes NICE guidance on school-based interventions on alcohol (for further details, see section 7).

The Programme Development Group (PDG) developed these recommendations on the basis of reviews of the evidence, economic modelling, expert advice, stakeholder comments and fieldwork.

Members of the PDG are listed in appendix A. The methods used to develop the guidance are summarised in appendix B.

Supporting documents used to prepare this document are listed in appendix E. Full details of the evidence collated, including fieldwork data and activities and stakeholder comments, are available on the NICE website, along with a list of the stakeholders involved and NICE's supporting process and methods manuals. The website address is: www.nice.org.uk

This guidance was developed using the NICE public health programme process.

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1 Recommendations

This is NICE's formal guidance on school, college and community-based personal, social, health and economic education focusing on sex and relationships and alcohol education. When writing the recommendations, the Programme Development Group (PDG) (see appendix A) considered the evidence of effectiveness (including cost effectiveness), fieldwork data and comments from stakeholders and experts. Full details are available at www.nice.org.uk/PHXX

The evidence statements underpinning the recommendations are listed in appendix C.

The PDG considers that the recommended measures are cost effective.

For the research recommendations and gaps in research, see section 5 and appendix D, respectively.

The evidence reviews, supporting evidence statements and economic modelling report are available at www.nice.org.uk/PHXX

PSHE education – what this guidance covers

Personal, social, health and economic (PSHE) education is 'a planned programme of learning opportunities and experiences that help children and young people develop as individuals and as members of families and of social and economic communities'².

This guidance focuses on two PSHE education themes – sex and relationships, and alcohol – and the links between them, in schools, colleges and the wider community. It also focuses on promoting inclusion and tolerance, reducing health inequalities, and on children and young people's needs.

² PSHE Association (2010) 'What is PSHE?' [online]. Available from www.pshe-association.org.uk/content.aspx?CategoryID=335

Where a recommendation refers to sex and relationships and/or alcohol education for schools and colleges, it is in the context of the wider PSHE education curriculum.

In primary schools, personal, social and health education is integrated with citizenship. There is no requirement for schools and further education colleges to provide personal, social and health education (with or without an economic component); however, schools are currently encouraged to do so.

This guidance is intended to complement other sources of guidance and advice for teachers. An expert advisory committee has used the most recent and up to date research to produce these recommendations.

The recommendations cover all children and young people in primary and secondary schools, colleges and other places of education such as pupil referral units and the community, including those:

- with particular needs
- aged 19 years and younger
- aged 21 and under who are looked after or are leaving care
- aged 25 and under who have learning disabilities.

The recommendations are based on sex and relationships education and alcohol education programmes that have been shown to be effective with all children and young people. They support a universal and inclusive approach to PSHE education. The recommendations are also based on the principle of 'progressive universalism' which emphasises additional tailored support in accordance with the particular needs of children and young people who are disadvantaged (Marmot 2010)³.

In the recommendations, 'parent' describes anyone with parental responsibility, which may be a parent, step-parent, a parent's spouse or civil partner or another named adult. In the case of looked after children, this

³ Marmot M (2010) Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England
post 2010
www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

responsibility may have been acquired by another adult or the local authority under the Children Act⁴.

In the 'Who should take action?' section of the recommendations, 'schools and other education settings' refers to all schools, special schools, sixth form and further education colleges, academies and free schools, pupil referral units, young offender institutes and secure accommodation for young people.

Children and young people with particular needs could include but is not limited to those:

- with learning or communication difficulties
- with physical or mental health problems or disabilities
- who do not attend school or college regularly
- who are over 16 and not in education, employment or training
- from families whose first language is not English
- from some black and minority ethnic groups
- who are coping with difficult circumstances (for example, those in families where there is alcohol misuse)
- who are lesbian, gay, bisexual or transgender
- who are looked after
- who are (or whose families are) homeless, gypsies or travellers, or asylum seekers.

Recommendations 1 and 2 cover the provision of PSHE education, recommendations 3 and 4 cover consultation with children and young people and their parents, recommendations 5–8 cover planning and teaching, recommendations 9 and 10 cover external contributions and support, recommendation 11 is specifically for community-based education and recommendation 12 covers training of educators.

Whose health will benefit?

These recommendations should benefit all children and young people, including those with particular needs, aged 19 years and younger in education, aged 21 and under for children and young people who are looked

⁴ Children Act 1989. www.legislation.gov.uk/ukpga/1989/41/contents

after or are leaving care, and aged 25 and under for those with learning disabilities.

Providing PSHE education

Recommendation 1

Who should take action?

- Directors, commissioners and managers in children's services and their partners, local authorities, youth services, primary care, healthcare trusts, and voluntary and community services with responsibility for children's and young people's health and wellbeing.
- Senior managers and governors and all those involved in designing, planning and managing PSHE education in schools and other education settings.
- Ofsted and National College for Leadership of Schools and Children's Services.

What action should they take?

- Raise awareness that PSHE education can help to increase attachment to school, improve academic performance, improve social skills, and reduce aggressive and disruptive behaviour. It is particularly effective when started in primary school and when school education contains a home component (see recommendation 7).
- Raise awareness among the whole school and college community, and parents, of the positive effects of planned and comprehensive PSHE education, including education about sex and relationships and alcohol, on health and wellbeing. Explain that it helps children and young people understand their physical and emotional development. This includes helping them:
 - develop the knowledge, understanding and skills needed to be healthy and safe
 - understand the risks, motivators and consequences of their actions
 - gain the confidence to know when and how to seek advice and help from parents and health services

- take increasing responsibility as they get older for their health and wellbeing and that of others.
- Raise awareness among educators, parents, local voluntary organisations and community groups that research evidence does not support sex and relationships education that teaches only about delaying first sex.

Recommendation 2

Who should take action?

- Directors, commissioners and managers in children’s services and their partners, local authorities, youth services, primary care, healthcare trusts, and voluntary and community services with responsibility for children’s and young people’s health and wellbeing.
- Senior managers and governors and all those involved in designing, planning and managing PSHE education in schools and other places of education.
- Ofsted and National College for Leadership of Schools and Children’s Services.

What action should they take?

- Assess the provision of and need for education about sex and relationships and alcohol within PSHE education. This should be part of the Joint Strategic Needs Assessment. Pay particular attention to children and young people who may not be in regular contact with education or health and social services, or who may have particular needs.
- Ensure all children and young people are taught effectively PSHE education that includes education about sex and relationships and alcohol in schools and colleges. Involve support workers and carers to support learning where children and young people have particular needs.
- Start PSHE education with the nature of friendships and family relationships, progressing to the mental and physical changes that occur when growing up. It should begin in primary school and develop and

continue through all key stages of education, until early adulthood. It should respond to young people's needs and use a variety of teaching methods to suit the range of learning styles.

- Directors, commissioners and managers of young people's services should ensure that children and young people with particular needs (see page 8) have access to good quality community-based sex and relationships and alcohol education. The information, advice and support provided by young people's services and community-based organisations should be consistent with PSHE education in schools and other places of education.
- Ensure young people's services and community-based organisations have accurate and up-to-date information and staff with the skills to advise and support children and young people in learning about sex and relationships and alcohol.

Consulting children and young people and their parents

Recommendation 3

Who should take action?

- Governors, head teachers, principals, teachers, lecturers and tutors in schools and other education settings.
- Those commissioning health and local authority services for children and young people and their parents.
- Faith (including the Standing Advisory Council for Religious Education), secular and cultural organisations.
- Voluntary organisations and community groups representing those with particular needs or with a remit for education about sex and relationships and alcohol.
- Nurses and other health professionals working in schools and other places of education, youth workers and other professionals who contribute to PSHE education.

What action should they take?

- Explain that PSHE education enables children and young people to make the most of opportunities to be healthy, happy and successful, now and in the future (see recommendation 1). Explain that education about sex and relationships and alcohol can help children and young people to resist pressure to get involved in harmful activities and to take increasing responsibility for their health and wellbeing and that of others.
- Ensure parents have the opportunity to help develop and review, and are consulted about, policies on education about sex and relationships, alcohol and other personal, social and health issues such as homophobic bullying. Respond to the interest and concerns parents may have, and encourage them to get involved.
- Communicate with parents about the content of sex and relationships education and address any preconceptions they may have. Explain the focus on friendships, family relationships and health, particularly for younger age groups. Make the materials to be used with pupils and students available to parents. Discuss with parents how they can support their children's learning at home.
- Communicate regularly with parents and help them to talk with their children about emotions, friendships, relationships, parts of the body, physical and emotional development, puberty, sexual health and alcohol and the links between them. Advise parents about how to help their children develop communication, decision-making and negotiation skills. In particular, offer information and support to any parents who wish to withdraw their child from the non-statutory elements of sex and relationships education.

Recommendation 4

Who should take action?

- Governors, head teachers, principals, teachers, lecturers and tutors in schools and other places of education.

- Those commissioning health and local authority services for children and young people and for parents.
- Faith (including the Standing Advisory Council for Religious Education), secular and cultural organisations, special educational needs organisations and other voluntary organisations and community groups.
- Nurses and other health professionals working in schools and colleges, youth workers and other professionals who contribute to PSHE education.

What action should they take?

- Provide opportunities for children and young people to help develop and review policies on education about sex and relationships, alcohol and other personal, social and health issues such as homophobic bullying. This could be through focus groups or representative bodies such as school and college councils.
- Provide young people with the opportunity to participate in, plan and evaluate PSHE education sessions. For example, involve them in activities to identify what is most relevant to their lives, use their feedback to improve lessons and give them opportunities to act as peer educators.

Planning and teaching

Recommendation 5

Who should take action?

- Governors, head teachers, college principals in schools and other places of education.

What action should they take?

- Head teachers should designate a PSHE education coordinator to plan, coordinate and evaluate education about sex and relationships and alcohol. This may be part of a wider responsibility for PSHE education or as part of the Healthy Schools programme.

- College principals should designate a lead for student health and wellbeing as part of the Healthy Further Education programme. Their role should include PSHE education coordination.
- Allocate discrete time for teaching PSHE education and assessing learning. Only use 'Drop down'⁵ or occasional themed days to enhance the curriculum because they are much less effective in isolation. Similarly in colleges, fresher's events and health fairs can help raise awareness but are not a substitute for a planned programme of education.
- Ensure all educators who teach about sex and relationships and alcohol have received accredited training either as part of their initial teacher training or their continuing professional development (see recommendation 12). They should be committed to developing PSHE education as part of the curriculum.
- Ensure continuity and progression between key stages of the PSHE education curriculum. This is particularly important during transition points in a child's education, for example, from primary to secondary school and from secondary school to college.

Recommendation 6

Who should take action?

All those involved in planning and managing PSHE education in schools and other places of education, including:

- governors, head teachers and principals in schools and other education settings
- local coordinators of the Healthy Schools programme.

What action should they take?

- Ensure education about sex and relationships and alcohol is introduced in a way that is suited to the maturity and experience of pupils. It should begin with the understanding of the nature of friendships and family relationships, managing emotions and behaviour and progress to learning about the

⁵ Sometimes called 'off-timetable' or 'suspended timetable' days. These are days that are not part of the regular school curriculum; they are infrequent special events that do not allow for a series of progressive lessons www.pshe-association.org.uk/news_detail.aspx?ID=703

mental and physical changes that occur when growing up. Education about sex and relationships is more effective if the early elements on the nature of friendships, managing emotions and mental and physical development are introduced in primary school before puberty.

- Plan a programme that meets the personal and social development needs of all children and young people and helps them to feel valued. Address issues as they arise in a manner that is suited to the maturity and experience of pupils. For example, calling someone 'gay' as a playground insult meaning someone is bad or inferior is a form of homophobic bullying, though the children involved may not realise this, and should be deterred in a way that is appropriate to the maturity of the children involved.
- Introduce themes in a timely manner. Expand and revisit themes in secondary school and college. Ensure there is consistency with other subjects in the wider curriculum.
- Use formal and informal methods of assessment to track pupil's progress and inform future learning.
- Bring together the relationships, sexual health, alcohol and substance misuse components of PSHE education, as appropriate. For example, explore the effects of alcohol (and other substances) on sexual behaviour.
- Base PSHE education on pupils' needs, being sensitive to diverse cultural, faith and family perspectives and circumstances. Promote an understanding of diversity and anti-discriminatory attitudes, values and behaviour, including addressing the stigma associated with HIV.
- Offer children and young people with particular needs personalised help to learn about sex and relationships and alcohol. This could include working with the special educational needs coordinator or support workers.
- Obtain current health information and advice from those specialising in relationships, sexual health and alcohol. These could be:

- health professionals

- public health specialists
 - national voluntary sector organisations specialising in relationships, sexual health and alcohol
 - heads of children and young people’s services
 - drug and alcohol action teams
 - teenage pregnancy coordinators and sexual health advisers in local authorities and health care trusts (see recommendation 9).
- Use the information to help develop a comprehensive, relevant and up-to-date curriculum for teaching about sex and relationships and alcohol within PSHE education that meets the needs of all pupils.
 - Link PSHE education about sex and relationships and alcohol with health services in schools and colleges and in the wider community.

Recommendation 7

Who should take action?

- Those involved in providing, planning and teaching PSHE education in schools and other places of education.
- Health service staff and voluntary and community organisation staff.

What action should they take?

- Set learning outcomes that will help achieve health and wellbeing goals. These could include:
 - knowing about the short-term and long-term effects of early alcohol use and binge drinking on physical and mental health
 - developing refusal skills to delay the start of alcohol use and to reduce the amount drunk
 - recognising and accepting diversity to prevent homophobic bullying
 - knowing about different types of sexually transmitted infections, how to use a condom to reduce the risk of contracting a sexually transmitted infection and how to

support a friend who may need to attend a contraceptive and sexual health service.

- Cover a broad range of themes in a way that is factually accurate, unbiased and non-judgmental. Teaching should help pupils and students to distinguish between facts and opinions and find and use consistent and reliable sources of information.
- Use a range of evidence-based teaching methods to suit different learning styles, including skills-based methods, active and interactive techniques (for example, role play, drama, debates and thinking maps).
- Use up-to-date, high-quality resources to support effective teaching and active and participatory learning styles. Teaching and the resources used should be flexible enough to meet the needs of different children and young people and be relevant to their lives. For example, resources on a school's intranet or the internet can be accessed anonymously outside school hours and in private.
- Allow young people, especially socially disadvantaged young people, access to communication technology to obtain sexual health and alcohol information and advice. This could include websites such as NHS Choices and national telephone helplines that provide reliable, up-to-date, evidence-based health information and advice. These are also a useful resource for those working with young people.
- Provide combined school- and family-based learning opportunities. These have been shown to improve academic performance among children of primary school age. These may include:
 - providing a summary of what has been discussed at school for children to take home, with suggestions for follow up at home
 - encouraging further discussion at home of issues discussed at school and vice versa
 - setting homework that encourages discussion between parents and children

- lending books and teaching resources to parents.

Recommendation 8

Who should take action?

- Those involved in providing, planning and teaching PSHE education in schools and other places of education.
- Those who commission and provide educational materials, including national and regional public sector organisations, and voluntary and private sector organisations.

What action should they take?

- Help all children and young people to develop and sustain friendships and relationships. Ensure they understand the importance of valuing and having respect for others.
- Help children and young people to understand their rights and responsibilities, to themselves and others. These include:
 - the right not to be harmed, and the responsibility not to harm themselves or others
 - the right not to be pressured or coerced into doing something that is unsafe or unwanted, and the responsibility to recognise that it is wrong to put pressure on others to do something they do not want to do
 - the responsibility to assist others who are in risky situations, for example, having strategies to help friends who have drunk too much.
- Explain school and college rules, and UK laws such as those about alcohol and sex.
- Help children and young people to explore their attitudes and appreciate the benefits of responsible, healthy and safe choices.

- Enable children and young people to identify and manage risks, and to recognise and avoid exploitation and abuse. Help them to understand that giving consent means understanding what is involved and its implications.
- Help children and young people to develop negotiation and refusal skills. This includes learning how to resist pressure to do things that are unsafe or that they are not comfortable with, and how to deal with difficult situations. For example, what to do if their friend who is driving them home has drunk alcohol.
- Give children and young people the information and ability to make confident, responsible, healthy, safe and informed choices and to act on them.
- Make children and young people aware of how alcohol can impair mental and physical functions, for example, when making judgements and decisions, and carrying out those decisions. Help them to relate this to their personal safety and behaviour, for example, being aware of the risk of injury or being a victim of violence when drunk.
- Inform children and young people where they can get confidential advice and support from health and other advisory services. Explain that health professionals have a duty of confidentiality⁶.

External contributions and support

Recommendation 9

Who should take action?

- Directors of public health and specialists in public health observatories, healthcare trusts and other healthcare organisations and local authorities.

⁶ Department of Health (2004) Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health Available from: www.dh.gov.uk

- PSHE education advisers, drug and alcohol advisers, teenage pregnancy and sexual health advisers, nurses and other health professionals in primary care and schools and colleges, and voluntary sector organisations.

What action should they take?

- Offer PSHE education coordinators and lead teachers relevant information to inform the curriculum. This could include the results of national and local surveys of:
 - alcohol use and alcohol-related incidents among young people
 - rates of under-18 conceptions
 - sexually transmitted infections.
- Help coordinators and teachers to interpret the data so that they can develop a PSHE education curriculum that reflects local circumstances and helps meet local needs.
- Provide accurate information about the degree of risk and protection associated with behaviours. For example, the degree of protection from sexually transmitted infections by using a condom and the relative efficacy of different methods of contraception.
- Provide accurate, up-to-date and unbiased information about sexual health and alcohol services available to young people, including services supplied by voluntary organisations. This includes explaining that these services provide free, personal, confidential and non-judgmental information, advice and support without an appointment⁷.
- Healthcare trusts and other health organisations and local authorities should ensure that education in schools and other education settings is supported by confidential and welcoming young people’s health and

⁷ For more details about contraceptive services see ‘Contraceptive services for socially disadvantaged young people’, NICE public health guidance XX (2010) www.nice.org.uk/guidance/PHXX

Please refer to ‘Alcohol-use disorders: preventing harmful drinking’ for information about the approach that services should take when working with young people. NICE public health guidance 24 (2010) www.nice.org.uk/guidance/PH24

advisory services. The information given by teachers and these services should be complementary.

- Public health specialists should work with PSHE education advisers and coordinators and voluntary organisations to contribute to training days and developing teaching resources.
- PSHE education advisers should offer opportunities for teachers and practitioners to share knowledge, research findings and good practice.

Recommendation 10

Who should take action?

- Head teachers, PSHE education coordinators, teachers, and college principals and lecturers.
- Public health specialists, local coordinators of the Healthy Schools programme, PSHE education advisers, drug and alcohol advisers, teenage pregnancy and sexual health advisers in local authorities and health trusts, and health teams in schools and colleges.
- Voluntary organisations and community groups (including faith, secular and cultural organisations).

What action should they take?

- Teachers and lecturers should work with external contributors to plan and manage their contribution. They should ensure it conforms to the school or college policy on PSHE education and is consistent with the objectives of PSHE education as a whole.
- Teachers and lecturers should encourage and support health professionals, members of other agencies (for example, specialist alcohol advisers), voluntary organisations, individuals and members of local community groups (such as faith or cultural organisations) who contribute to PSHE education.
- Head teachers, PSHE education coordinators, lead teachers, college principals and lecturers should ensure that everyone who contributes to

PSHE education in schools and colleges has the specialist knowledge and skills to teach it successfully. If possible, they should have received accredited training⁸ and be confident and competent to use a wide range of strategies and approaches, including interactive and participatory techniques (see recommendation 12).

- Teachers and lecturers should always be present to monitor and evaluate the contribution made by health professionals and members of external organisations, and follow up on the session. Individuals and representatives of external organisations should always conform to the school or college policies, for example, they should not address or refer to personal issues relating to pupils or themselves.
- Nurses and health professionals in schools and colleges and counsellors who work with children and young people on an individual basis (for example, by providing school- or college-based sexual health advisory services) should conform to Department of Health guidance on consent and observe the duty of confidentiality⁹. All young people should be made aware that one-to-one consultations with health professionals in school or college will be confidential unless there are serious professional concerns about their safety, health or welfare.

Community-based education

Recommendation 11

Who should take action?

- Commissioners of children's services and community services concerned with children's and young people's health and wellbeing.
- Social workers and family support workers and all those providing support for parents in children's services, GP consortia and other health services

⁸ Recognised national, accredited training is that which meets clearly specified criteria as assessed by an independent authoritative body, such as a professional organisation or university, using a rigorous and transparent process.

⁹ Department of Health (2004) Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health Available from: www.dh.gov.uk

and local authorities. This includes youth workers, drugs and alcohol advisers and sexual health advisers, Connexions personal advisers, social care and educational welfare officers, those working with youth offenders and those developing training for parents.

What action should they take?

- Commission community-based education about relationships, sexual health and alcohol for all children and young people. Provide special education for groups of young people who may have missed some of their school- or college-based education, or who did not feel it met their needs.
- Ensure community-based education is taught by confident, competent people who have received appropriate or accredited training (see recommendation 12) and who have access to high-quality resources.
- Provide community-based programmes of sex and relationships and alcohol education that educate parents and children together (programmes for parents only are effective, but are less effective than when parents and children are educated together). These should start early, before the child reaches 13, because it is important to establish strong communication in the early years of a child's life. Programmes should be complementary to the PSHE education provided in schools and other education settings.

Training educators

Recommendation 12

Who should take action?

- Providers of specialist training in PSHE education, sex and relationship and alcohol education
- Training agencies that provide initial teacher training and local and national support for continuing professional development for teachers and other professionals.

What action should they take?

- Provide specialist training for PSHE education as part of initial teacher training. This includes sex and relationships and alcohol education.

- Provide specialist training in sex and relationships and alcohol education as part of initial training for community, health and youth workers.
- Provide accredited continuing professional development in PSHE education, sex and relationships and alcohol education for educators in schools and other education settings, children and young people's services, health settings and the community. Ensure teachers, lecturers and tutors, health professionals, young people's practitioners (such as youth workers) and those who work with parents have access to this.
- Ensure training enables teachers, lecturers and tutors in schools, colleges and the wider community to:
 - conduct a needs assessment to inform the curriculum and identify where universal or targeted education might be required
 - plan, design, teach, evaluate and update comprehensive PSHE education
 - help develop school or college policies that are consistent with, and complement, the PSHE education curriculum
 - use a wide range of effective teaching strategies
 - communicate and work with children and young people, parents, community groups (including faith, secular and cultural communities), local authorities, health professionals and young people's health and advisory services
 - comply with ethical codes, such as those relating to confidentiality and child protection
 - give young people the opportunity to be peer educators, based on training and support.

2 Public health need and practice

Personal, social, health and economic (PSHE) education covers issues that are central to children's and young people's health and development.

Effective PSHE education is a planned programme of learning. It equips children and young people with the knowledge and practical skills to live

healthy, safe, capable and responsible lives and to develop as individuals, family members and members of communities (Department for Children, Schools and Families 2010a). PSHE education is a non-statutory part of the national curriculum. Schools use it to provide sex and relationships and drugs and alcohol education.

In a national survey, 40% of young people rated their sex and relationships education (SRE) as 'poor' or 'very poor' (UK Youth Parliament 2007). Ofsted reports improvements in the teaching of PSHE education, but SRE and alcohol education are noted as being weak areas of the curriculum, often because of a lack of discrete curriculum time or priority (Ofsted 2010; Department for Children Schools and Families 2008a; 2008b).

Schools are required to have an up-to-date policy on providing SRE outside the national curriculum. This should be available to parents. Schools are also expected to have a drugs policy that includes alcohol and states how the school will manage all drug-related matters.

In primary schools PSHE education is taught within the citizenship framework. Some biological aspects of SRE and alcohol education form part of the statutory national curriculum for science and are taught in all primary and secondary schools (Qualifications and Curriculum Authority 1999).

There is no planned programme for PSHE education in sixth forms or colleges, despite 80% of young people aged 16–18 being in education or training (Department for Children, Schools and Families 2009a).

Particular difficulties accessing sex and relationships and alcohol education are likely to be experienced by the 10% of young people aged 16–18 not in education, employment or training (Department for Children, Schools and Families 2009a).

PSHE education in schools and colleges may be supported by health professionals and representatives of other services, including nurses, youth workers and Connexions personal advisers. External contributors can help

familiarise young people with local services for relationships, sexual health and alcohol.

Inequality of access to services is apparent. Although most (72%) further education and sixth form colleges provide some level of on-site student sexual health services, provision varies between and within regions. In some cases young people aged 14–16 attending college are excluded from services (Emmerson 2008).

Sex and relationships education

Almost two thirds of young women and more than half of young men aged 15–18 (64 and 56% respectively) ranked school as the preferred setting for SRE, irrespective of ethnic group (Testa and Coleman 2006). Most parents want schools to teach SRE (Stone and Ingham 1998). Parents have the legal right to withdraw their children from aspects of SRE taught outside the national curriculum, although few do so (Ofsted 2002). Inspection evidence suggests that many schools consult parents as part of reviewing or developing their SRE programme, which reduces the likelihood of parental withdrawal (Macdonald 2009). However, too few schools make a concerted effort to consult or include parents in the planning of the curriculum (Ofsted 2010).

An estimated quarter to one third of young people has sex before the age of 16. Of those who leave school at 16 without qualifications, 60% of boys and 47% of girls had sex before they were 16. Sex before the age of 16 is associated with greater levels of regret, poorer contraceptive use and higher rates of teenage pregnancy compared with first sex after the age of 16 (Wellings et al. 2001).

Sexually transmitted infections (other than HIV) are disproportionately prevalent in young people aged 16–25. Young people represent 12% of the population, but accounted for nearly half of all sexually transmitted infections diagnosed in UK genitourinary medicine clinics in 2007 (Health Protection Agency Centre for Infections 2008).

England's teenage pregnancy rate has dropped but remains one of the highest in western Europe, with more than 40,000 conceptions for under 18s in England and Wales in 2008 (Office for National Statistics 2010).

Furthermore, 20% of these conceptions are repeat pregnancies (Teenage Pregnancy Independent Advisory Group 2009). About half of under-18 conceptions end in abortion (Department for Children, Schools and Families 2010b).

Teenage conceptions are linked to alcohol consumption, even when deprivation is controlled for. In electoral wards with the highest levels of alcohol-related hospital admissions in 15–17 year olds the conception rate in girls of the same age was 41 per 1000; in wards with the lowest levels of alcohol-related hospital admissions it was 34 per 1000 (Bellis et al. 2009a).

Alcohol education

Children and young people identified parents (74%), television (73%) and teachers (63%) as sources of helpful information about drinking alcohol (Fuller 2009). In a recent survey parents were identified as the first source of alcohol information and advice by many children (65% would go to their mother, 51% to their father). However, one in four said that their parent had never talked to them about alcohol. Those from ethnic minorities and from social gradient C1, C2, D and E households were significantly less likely than average to have talked to a parent about alcohol (Department for Children, Schools and Families 2010c).

Current alcohol guidance states that an alcohol-free childhood is the healthiest and best option. However, if children drink alcohol, it should not be until at least the age of 15 (drinking, even at age 15 or older, can be hazardous to health). If young people aged 15–17 consume alcohol, it should always be with the guidance of a parent or carer or in a supervised environment and only infrequently; certainly on no more than 1 day a week. They should never exceed recommended adult daily limits and, on days when they drink, consumption should be below these limits (Donaldson 2009).

The proportion of young people between 11 and 15 reporting they have never drunk alcohol has risen from 39% in 2003 to 49% in 2009. However, of those that drink, almost one in five reported having a drink in the past week. Mean alcohol consumption among young people aged 11–15 who drank in the previous week was 11.6 units (Fuller and Sanchez 2010). The proportion that drink in less-regulated environments, such as at parties, with friends and outdoors, increased between 1999 and 2008 (Fuller 2009).

For children and young people who had drunk alcohol in the previous 4 weeks, 28% of those aged 11–12 and 63% of those aged 15 reported having been drunk. In addition, 12% of drinkers aged 11–12 and 42% of drinkers aged 15 reported having deliberately tried to get drunk (Donaldson 2009).

A survey of nearly 10,000 young drinkers aged 15–16 in northwest England reported that 28% had experienced violence when drunk, 13% had regretted alcohol-related sex and 45% had forgotten things. These outcomes were significantly associated with increases in drinking frequency, binge frequency and units consumed per week (Bellis et al. 2009b).

Homophobic bullying

Ninety per cent of secondary school teachers and 44% of primary school teachers say that children and young people experience homophobic bullying, name calling or harassment at school, yet most incidents go unreported (Guasp 2007). Pupils who experience homophobic bullying are more likely to miss school and less likely to stay in full-time education (Department for Children, Schools and Families 2009b). Further, most teachers and non-teaching staff in primary and secondary schools have not received training in how to tackle this form of bullying, and most would not feel confident in providing pupils with information, advice and guidance on lesbian and gay issues (Department for Children, Schools and Families 2007).

3 Considerations

The Programme Development Group (PDG) took account of a number of factors and issues when developing the recommendations.

- 3.1 Parents are children and young people's primary educators about sex, relationships and alcohol, through the example of their own behaviour and through their communication with their children. For some children and young people parental supervision and boundaries may not exist.
- 3.2 Most parents wish to communicate with their children about sex and relationships and alcohol and drug use and children want them to. However, parents can often feel ill-equipped to do so, and value support and information that increases their confidence and knowledge.
- 3.3 The degree of parental involvement in PSHE education will vary with the age of the child or young person and the environment in which it is provided. As children mature they move beyond the family environment and want to learn from other sources of information.
- 3.4 Parents will have differing views about what constitutes education that is suitable for their children's age and maturity. Parents may want schools to introduce sensitive issues earlier than some teachers might assume. Children are likely to want information earlier than their parents might consider appropriate.
- 3.5 Assumptions about the influence of children and young people's cultural, faith or family background may be misleading because their behaviour may not always represent those perspectives (for example, young people may drink alcohol, contrary to their religion, when socialising with peers).

PSHE, sex and relationships and alcohol education

- 3.6 Personal, social, health and economic (PSHE) education aims to equip children and young people with the knowledge, understanding, values and practical skills to deal with the real-life issues they face as they move through childhood, puberty and adolescence and into adulthood.

- 3.7 PSHE education also aims to increase healthy behaviour and to reduce health inequalities and social exclusion for all young people. This reflects the characteristics of an inclusive school, where every young person's achievement and wellbeing matters. This does not mean that every pupil and student is treated in the same way. Good teachers of PSHE education monitor the progress of every pupil and student, take into account their varied circumstances, experiences and needs, and tailor sessions accordingly.
- 3.8 There was little evidence about the provision of PSHE education for children and young people with particular needs. However, the PDG's view was that the formal PSHE education curriculum should be augmented by specialist provision for children and young people with particular needs.
- 3.9 The evidence showed positive effects of education in primary schools on school attachment and attainment. The PDG considered that it was appropriate to extrapolate from this to older age groups.
- 3.10 There is no good evidence to suggest that sex and relationships education that teaches only about delaying first sex is effective.
- 3.11 Comprehensive education programmes that focus on delaying sex as well as promoting sexual health, including protection from sexually transmitted infections, methods of contraception and availability of sexual health services, have been shown to have positive effects on sexual health behaviour. Effects include delayed first sex and reducing the number of partners a young person may have in the future. It does not cause them to have sex at an earlier age, or to have more sex, or sex with more partners; nor does it increase the number of unwanted teenage conceptions and abortions.
- 3.12 The PDG noted that an overemphasis on the potential negative consequences of sex for young people, including teenage pregnancy and sexually transmitted infections, has sometimes led to an unbalanced approach to SRE that ignores the importance of consent

and mutually rewarding sexual relationships for individual wellbeing.

- 3.13 Exposure to graphic sexual images and sexually explicit language and content on the internet and television and in films and magazines can start at a very early age. The PDG were concerned that some young people access pornography and derive their views and expectations about sexual behaviour and relationships from it. This exposure can result in children and young people forming inaccurate views. A trained and confident teacher will give children and young people appropriate and accurate information to help them make sense of the imagery that surrounds them.
- 3.14 Some young people may use mobile phones to send revealing photographs or intimidating messages that can put themselves or others at risk of harm or abuse. SRE can give children and young people the confidence to resist pressures and knowledge about where and how to get help if they feel upset or threatened.
- 3.15 Most adults drink alcohol, and in the UK it can be legally purchased by anyone 18 years and older. Images of, and references to, alcohol and its consumption are pervasive. Children and young people acquire information and develop their values and attitudes towards alcohol use from what they see around them in their families and communities, and from role models and the media. Regular heavy alcohol use within a family can affect both parents and children's perceptions about alcohol. They may not understand that there is no safe level for those under 18.
- 3.16 Social attitudes about the age at which young people begin to drink small quantities of alcohol vary. Parents giving alcohol to their children sends a message that drinking is acceptable. However, the Chief Medical Officer's advice, based on medical evidence of the impact of alcohol on brain and physical development, is that there is no safe level of drinking for those younger than 18 years. Therefore, the guidance advises that alcohol education should emphasise and

encourage delaying the start of drinking.

Schools and colleges

- 3.17 The PDG recognises the importance of factually accurate information about sex and relationships and alcohol to inform children's and young people's values and attitudes and the development of interpersonal and decision-making skills.
- 3.18 Most schools recognise that good communication with parents about PSHE education is important, to ensure information is provided at home and at school is consistent. They may not be aware that PSHE education that also involves the family can have a positive impact on primary school children's attitudes to school and on their attainment.
- 3.19 Schools and other educational settings will have their own values and ethos within which SRE and alcohol education is provided. They will vary in the way they recognise and respond to the realities of children and young people's lives and the values of the different ethnic and faith groups within their community. As public bodies they have a responsibility to meet the needs of all children and young people, including those who are lesbian, gay, bisexual or transgender. PSHE education can help children and young people to know and understand their legal and civil rights. It can also help them to understand more about health and religious, secular and cultural perspectives on different behaviours.
- 3.20 The mix of full- and part-time students at further education colleges poses challenges for the teaching of PSHE education in terms of both staff numbers and staff skills. Access to pastoral care may also be limited. The rise in the school leaving age to 18 years is likely to increase these challenges.
- 3.21 For some children and young people, their school, college or other educational setting provides an environment in which they have contact with trusted adults and where they can feel safe. Both teaching and non-teaching staff need to be aware of their potential

effect as role models and mentors for these children and young people.

3.22 All professionals, including health professionals, working in the classroom are required to work within the school or college's PSHE education policy. Health professionals can provide confidential advice in a one-to-one setting, such as a school- or college-based health service, according to their professional code of ethics. Many schools and colleges now have these services or provide information and signposting to community-based services.

3.23 Child protection is a broad concept and can incorporate protection from harm from other children and young people, from parents, carers and professionals, and self-damaging behaviour. All professionals working with children and young people have safeguarding responsibilities and a requirement to comply with the statutory guidance on safeguarding children in education.

Education programmes

3.24 Many of the education programmes reviewed were short and the follow-up period to assess outcomes was often limited. The PDG recognised that short-, as well as the medium- and long-term effects of an educational programme can be of value. For example, a short-term reduction in alcohol consumption may lead to a reduction in alcohol-related incidents.

3.25 The PSHE education curriculum should progress and develop throughout school and college to keep pace with children and young people's development and educational needs.

3.26 Few studies provided enough evidence to show whether positive outcomes were a result of the programme itself, the characteristics of the person teaching it or the teaching methods used. However, training for those delivering these programmes was seen to be important.

- 3.27 Adhering to all aspects of an educational programme that has been shown to be effective is important to achieve the expected outcomes. However, in practice many professionals adapt an educational programme to local needs. This approach is more likely to be effective if the original principles and methodology are followed, with elements customised to local circumstances. Changes should be documented and outcomes assessed. Using components from several programmes or initiatives brought together in an untested format is less likely to have positive outcomes.
- 3.28 Much of the evidence on alcohol education comes from the USA, where the social context is different from the UK. In the USA children and young people are more likely to be encouraged to abstain from alcohol, whereas in the UK a 'harm reduction' approach to education about alcohol is generally favoured.
- 3.29 The ten key points of effective SRE outlined in expert paper 1 were considered by the PDG to fit with the evidence review conclusions. They are reflected in the recommendations but are not listed explicitly (see appendix C).
- 3.30 The PDG heard expert testimony on the social norms approach¹⁰ to education. However, this evidence related to an older age group and had not been applied to SRE. The PDG did not consider it was sufficient to warrant a recommendation.

Limitations of the evidence

- 3.31 Most of the evidence is from named educational programmes in the USA. These studies provided little information about teaching methods. The evidence generally lacked detail about comparators, which were referred to as 'usual practice'. Costs were rarely reported. The PDG was aware that this could affect how applicable it was to

¹⁰ The social norms approach aims to prevent problem behaviour and promote and reinforce positive behaviour by dispelling the idea that the problem is the norm among peers. The intervention allows peers to identify the actual norms regarding the attitudes and behaviour of concern. The intervention uses media campaigns and interactive programmes in educational venues.

the UK, but considered that the evidence could inform the recommendations.

- 3.32 Effective programmes tended to be based on theory, but there was insufficient evidence to say that programmes based on one particular theory are more effective than those based on other theories.
- 3.33 Few of the studies reported behavioural outcomes such as alcohol consumption or sexual activity. There was little evidence about personal, social, cultural, ethnic or other factors that might directly influence health-related behaviours. In general, methods of measuring outcomes were not clearly specified.
- 3.34 Most studies focused on changes in knowledge and attitudes, or the development of personal and social skills. The PDG recognised that behaviour change was rarely a priority in education research. However, intermediate outcomes such as increased knowledge and understanding, coping skills and resilience were thought likely to lead to positive decisions about health and ultimately to healthier behaviours.
- 3.35 There was insufficient high-quality data for the modelling to estimate cost effectiveness. Either the effectiveness of an intervention was known but not the value of the resources needed to gain those benefits, or the resources were known but not the level of benefits. It was particularly difficult to estimate differences in costs or effects against 'usual practice'. For that reason, a method called 'threshold analysis' was used. This method gives the level of resources and estimates the size of the effect needed for the intervention to be cost effective. The PDG considered whether an effect size of a specific amount or more would be attained in each scenario modelled.
- 3.36 If the net cost of an intervention was small or negative, as in, for example, many of the process innovations, the PDG concluded that the intervention would be cost effective.

4 Implementation

NICE guidance can help:

- NHS organisations, social care and children's services meet the requirements of the DH's revised 'Operating framework for 2010/11'.
- National and local organisations improve quality and health outcomes and reduce health inequalities.
- Local authorities fulfil their remit to promote the wellbeing of communities.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.
- Provide a focus for multisector partnerships for health and wellbeing, such as local strategic partnerships.

NICE has developed tools to help organisations put this guidance into practice. For details, see our website at www.nice.org.uk/guidance/PHXX

5 Recommendations for research

The Programme Development Group (PDG) recommends that the following research questions should be addressed in planned programmes of research. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful or negative side effects.

Studies of effectiveness and cost effectiveness should investigate and report the differential effectiveness for children and young people from specific populations such as those with physical and/or learning disabilities, those from black and minority ethnic groups, those who are lesbian, gay, bisexual or transgender, those from refugee or traveller groups, those from faith groups, those not in employment, education or training, those who are looked after, or

those who are in the criminal justice system. Data should be examined for differences between gender groups.

Data should be collected on children's and young people's knowledge, values, attitudes and skills in relation to alcohol and SRE education. With increasing age behavioural outcomes should be included, such as those relating to alcohol consumption. Additional health, educational and social outcomes to be considered include those relating to educational achievement, alcohol-related injuries, incidents or convictions, number of sexually transmitted infections, number of conceptions, terminations and births, and history of employment.

Data should also be collected on:

- the short-term and long-term effects of these educational, health and social outcomes on children and young people, and
- children and young people's views and experiences of PSHE education in relation to alcohol and SRE – particularly regarding content, method, timing, place of delivery, and professional, parental and community involvement.

Design of all evaluations should be informed by Medical Research Council guidance¹¹ on the development, evaluation and implementation of complex interventions to improve health. Evaluations should include a coherent theoretical explanation of how the intervention may lead to change and a clear description of the intervention. The degree to which the intervention is delivered to participants as intended ('intervention fidelity') should also be evaluated.

Primary school-based PSHE education

- 1 How effective and cost effective are primary school-based PSHE curricula relating to alcohol and SRE (taught separately or in combination) in relation to positive changes in children's and young people's knowledge,

¹¹ Medical Research Council (2008) Developing and evaluating complex interventions: new guidance. Medical Research Council: London

values, attitudes and skills? In particular, programmes of research should determine:

- the most effective and cost-effective elements of PSHE curricula relating to alcohol and SRE that contribute to positive changes in children's and young people's knowledge, values, attitudes and skills
- the most effective and cost effective methods for teaching PSHE education in the primary school setting relating to alcohol and SRE
- the effectiveness of different teaching formats (such as active learning), different contributors (including the competence and confidence of teachers, school nurses and external agencies) and the impact of PSHE education training for teachers
- the impact of education and support delivered via extracurricular activities and after-school clubs.

Secondary school, college and community-based PSHE education

2 How effective and cost effective are secondary school, college and community-based PSHE curricula relating to alcohol and SRE (taught separately or in combination) in relation to positive changes in children's and young people's knowledge, values, attitudes, skills, and behaviour. Programmes of research should seek to identify:

- the effectiveness and cost effectiveness of different methods of providing SRE and alcohol education in school, college and community settings, for example, the social norms approach
- whether alcohol and SRE should be taught as two separate subjects or combined as an integrated topic area
- the most effective and cost-effective elements that contribute to positive changes in children's and young people's knowledge, values, attitudes, skills and behaviours in these subjects
- the most effective and cost effective methods for teaching alcohol and SRE, including:

- different teaching methods (such as active learning)
- different contributors (including the competence and confidence of teachers, school nurses and external agencies)
- PSHE education training for teachers and community workers
- school, college and community policies
- joint working initiatives between secondary schools, colleges and community and voluntary organisations
- extracurricular activities and after-school clubs involving secondary schools, colleges and community and voluntary organisations.

Parents as educators

- 3 What are the characteristics of parents that allow them to effectively teach their children about alcohol and SRE?
- 4 What are the most effective and cost-effective ways of enabling parents to educate their children on the themes of alcohol and SRE? This could include, for example, the provision of parenting courses and teaching resources, as well as the evaluation of teaching materials and resources.
- 5 To what extent does parental involvement contribute to the effective delivery of PSHE education in relation to alcohol and SRE in the school and community setting? The research should seek to:
 - identify effective ways of involving parents in the education of children and young people in alcohol and SRE within school and community-based settings
 - evaluate parental involvement in the education of children and young people in alcohol and SRE within school and community-based settings.

Longitudinal effects of PSHE

- 6 What is the effectiveness of alcohol and SRE on the knowledge, values, attitudes, skills and behaviours of children and young people over time? A cohort of children and young people should be studied (and reassessed at

regular intervals, for example, every 3–5 years) up to the age of 25 years to determine their knowledge, values, attitudes, skills and behaviours in relation to alcohol and SRE on entering and leaving the educational system. It should examine:

- the strength of the association between behaviour and knowledge, values, attitudes and skills and behaviour
- the differential impact of the number and frequency of alcohol and SRE sessions that the children and young people received over the lifetime of the study on knowledge, values, attitudes, skills and behaviour
- the effectiveness of alcohol and SRE on health, educational and social outcomes such as alcohol-related injuries, sexually transmitted diseases, conceptions, terminations and births and educational attainment and employment history
- whether the effectiveness of alcohol and SRE in primary school influences the effectiveness of alcohol and SRE in secondary school, college and community settings.

Cost effectiveness

- 7 What are the opportunity costs of delivering PSHE?
- 8 What is the value of the health, educational and social outcomes relating to alcohol and SRE, such as avoiding an alcohol-related injury, incidents or conviction and preventing a sexually transmitted infection or conception, termination or birth?
- 9 What is the relative cost effectiveness of alcohol and SRE delivered as part of the PSHE curriculum, compared with SRE delivered as part of the broader curriculum, such as science or social emotional aspects of learning (SEAL) modules, in contributing to positive changes in children and young people's knowledge, values, attitudes, skills and behaviours?

More detail on the gaps in the evidence identified during development of this guidance is provided in appendix D.

6 Updating the recommendations

This guidance will be reviewed 3 years after publication to determine whether all or part of it should be updated. Information on the progress of any update will be posted at www.nice.org.uk/guidance/PHXX

7 Related NICE guidance

Published

Alcohol use disorders – preventing harmful drinking. NICE public health guidance 24 (2010). Available from www.nice.org.uk/guidance/PH24

Social and emotional wellbeing in secondary education. NICE public health guidance 20 (2009). Available from www.nice.org.uk/guidance/PH20

Social and emotional wellbeing in primary education. NICE public health guidance 12 (2008). Available from www.nice.org.uk/guidance/PH12

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Prevention of sexually transmitted infections and under 18 conceptions. NICE public health guidance 3 (2007). Available from www.nice.org.uk/guidance/PH3

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Appendix A Membership of the Programme Development Group (PDG), the NICE project team and external contractors

The Programme Development Group

PDG membership is multidisciplinary, comprising teachers and advisory teachers, education professionals, public health practitioners, school nurses, local authority officers, youth services professionals, young people and parent community representatives, academics and technical experts as follows.

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Susan Burlace/Alison Lake Editors

External contractors

Evidence reviews

Review 1: 'A review of the effectiveness and cost-effectiveness of personal, social and health education in primary schools focusing on sex and relationships and alcohol education for young people aged 5–11 years' was carried out by the Centre for Public Health, Liverpool John Moores University. The principal authors were: Lisa Jones, Geoff Bates, Jennifer Downing, Harry Sumnall and Mark A Bellis.

Review 2: 'A review of the effectiveness and cost-effectiveness of personal, social and health education in secondary schools and further education colleges focusing on sex and relationships and alcohol education for young people aged 11–19 years' was carried out by the Centre for Public Health, Liverpool John Moores University. The principal authors were: Lisa Jones, Geoff Bates, Jennifer Downing, Harry Sumnall and Mark A Bellis.

Review 3: 'A review of the effectiveness and cost effectiveness of alcohol and sex and relationship education for all children and young people aged 5–19 in community settings' was carried out by the Centre for Public Health, Liverpool John Moores University. The principal authors were: Lisa Jones, Geoff Bates, Jennifer Downing, Harry Sumnall and Mark A Bellis.

Review 4: 'Children and young people's perspectives on school, family, and community-based personal, social and health education (PSHE), in particular concerning alcohol, sexual health and relationships' was carried out by The National Collaborating Centre for Women's and Children's Health. The principal authors were: Lauren Bardisa-Ezcurra, Irene Kwan, Debbie Pledge, Anna Bancsi and Jay Banerjee.

Cost effectiveness

The economic modelling undertaken was:

'A model to assess the cost-effectiveness of Sex and Relationship Education (SRE) developed for NICE public health guidance on personal, social and

health education (PSHE)', carried out by the National Collaborating Centre for Women and Children's Health. The principal authors were: Leo Nherera and Paul Jacklin.

'A model to assess the cost-effectiveness of alcohol education developed for NICE public health guidance on personal, social and health education (PSHE)', carried out by the National Collaborating Centre for Women and Children's Health. The principal authors were: Leo Nherera and Paul Jacklin.

Fieldwork

The fieldwork Report on School, College and Community based Personal, Social and Health Economic (PSHE) education, focusing on sex and relationships and alcohol education was carried out by GHK.

Expert testimony

Expert paper 1: 'Sex and STI/HIV education programmes for youth: their impact and important characteristics' by Douglas Kirby PhD Senior Research Scientist, ETR Associates.

Expert paper 2: 'Alcohol and sexual health' by Mark A Bellis, Centre for Public Health, Liverpool John Moores University.

Expert paper 3: 'Education for all – tackling homophobic bullying in Britain's schools' by Chris Gibbons, Senior Education Officer, Stonewall Education and Prevention Consultant.

Expert paper 4: 'Faith, ethnicity and cultural issues' by Hansa Kanwel-Patel.

Expert paper 5: 'Perspectives of the religious education council' by Brian Gates, Chair, Religious Education Council of England and Wales.

Expert paper 6: 'Social norms theory and evidence' by Wesley Perkins, Professor of Sociology, Hobart and William Smith Colleges, Geneva, New York.

Appendix B Summary of the methods used to develop this guidance

Introduction

The reviews, primary research, commissioned reports and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Programme Development Group (PDG) meetings provide further detail about the Group's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available at www.nice.org.uk/guidance/PHXX

Guidance development

The stages involved in developing public health programme guidance are outlined in the box below.

1. Draft scope released for consultation
2. Stakeholder meeting about the draft scope
3. Stakeholder comments used to revise the scope
4. Final scope and responses to comments published on website
5. Evidence reviews and economic modelling undertaken and submitted to PDG
6. PDG produces draft recommendations
7. Draft guidance (and evidence) released for consultation and for field testing
8. PDG amends recommendations
9. Final guidance published on website
10. Responses to comments published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by the PDG to help develop the recommendations. The overarching question was:

What are the most effective and cost-effective ways of delivering PSHE education – in particular, sex and relationships and alcohol education – in schools, colleges and communities to meet the needs of the most disadvantaged and vulnerable groups of children and young people?

The subsidiary questions were:

1. What are the elements of effective and cost-effective services, interventions, programmes, policies or strategies for children and young people that contribute to the achievement of 'Every child matters' outcomes for PSHE education, particularly related to sexual health and/or alcohol?
2. How can schools, colleges, governors, parents, families and communities contribute to the effective delivery of PSHE education – in particular, sex and relationships and alcohol education – to achieve health-related 'Every child matters' outcomes, for example, being healthy, staying safe and making a positive contribution?
3. In what ways can professionals, practitioners, peers, volunteers and services in education and health settings provide effective and cost-effective support for the delivery of PSHE education – in particular sex and relationships and alcohol education – in schools, colleges and communities?
4. What are children and young people's views and experiences of effective PSHE education – in particular sex and relationships and alcohol education – particularly related to content, method, timing, place of delivery, and professional, parental and community involvement?

These questions were made more specific for each review (see reviews for further details).

Reviewing the evidence

Effectiveness reviews

Four reviews of effectiveness and cost effectiveness were conducted.

Identifying the evidence

The following databases were searched in April 2009 for systematic reviews, randomised controlled trials, controlled non-randomised studies and, controlled and uncontrolled before-and-after studies, published since 1990:

- ASSIA (Applied Social Science Index and Abstracts)
- Australian Education Index
- British Education Index
- CINAHL (Cumulative Index of Nursing and Allied Health Literature)
- Database of Abstracts of Reviews of Effectiveness (DARE)
- EconLit
- EMBASE
- EPPI-Centre (Evidence for Policy and Practice Information and Co-ordinating Centre) databases
- ERIC (Education Resources Information Center)
- HMIC (Health Management Information Consortium; or Kings Fund catalogue and DH data)
- MEDLINE
- NHS EED (NHS Economic Evaluations Database)
- PsycINFO
- Sociological Abstracts
- Social Science Citation Index
- The Campbell Collaboration
- The Cochrane Library
- C2-SPECTR (Campbell Collaboration Social, Psychological, Educational, and Criminological Trials Register) and C2-PROT (Campbell Collaboration Prospective Trials Register)

The search strategy for the qualitative review included searching databases and scanning relevant websites and journals and contacting key professionals in the field. Following up on the references cited in the papers identified by the search was used to obtain relevant grey literature in the area.

Selection criteria

Studies were included in the effectiveness and cost effectiveness reviews if:

- They were primary studies set in the UK, Western Europe, Australia, New Zealand, Canada and the USA.
- They were published in English from 1990 onwards.
- They examined interventions that focused on sex and relationships education and/or alcohol education. Relevant intervention approaches included:
 - interventions and programmes agreed, planned or delivered by teachers or other professionals
 - interventions and programmes planned and/or delivered by external agencies and individuals
 - interventions involving the ‘informal’ and extended school curriculum
 - peer-led education.
- They compared the intervention of interest with a no-intervention control or with another intervention approach.
- The education was directed at children and young people in primary and secondary schools, sixth form and further education colleges and those receiving education outside of a mainstream school setting, including those receiving home education, or in pupil referral units.
- They included children and young people between the ages of 5 and 19 years, 21 years for those in or leaving care and 25 years for those with learning disabilities.

Studies were excluded if:

- They did not report health and social outcomes relating to alcohol use and sexual health.

Qualitative review

One review was conducted.

Identifying the evidence

The following databases were searched in November 2007 for studies and surveys of qualitative design, carried out in the UK, as well as for unpublished studies and surveys and 'grey literature' produced between 1997 and 2007:

- Assia (Applied Social Index and Abstracts)
- ERIC (Education Resources Information Center)
- OpenSIGLE (System for Information on Grey Literature in Europe)
- PsycINFO
- Sociological Abstracts

The following journals were searched:

- Children and Society
- Sociology of Health and illness
- Critical Public Health
- Culture, Health and Society
- European Journal of Public Health
- Health Education
- Health Education Journal
- Health Education Research
- Journal of Health and Social policy
- Journal of Public Health
- Sex Education
- Sexually Transmitted Infections

Website searches included (please see reviews for complete lists):

- Barnardo's (www.barnardos.org.uk)
- British Youth Council (www.byc.org.uk)
- Brook (www.brook.org.uk)
- Connexions (www.connexions-direct.com)
- Department for Education (formerly Department for Children, Schools and Families) (www.education.gov.uk)
- Department of Communities and Local Government (www.communities.gov.uk)
- Department of Health (www.dh.gov.uk)
- Drugscope (www.drugscope.org.uk)

- Economic and Social Research Council (ESRC) (www.esrc.ac.uk)
- Family and Parenting Institute (www.familyandparenting.org)
- Joseph Rowntree Foundation (www.jrf.org.uk)
- National Children's Bureau (www.ncb.org.uk)
- National Youth Advocacy Service (www.nyas.net)
- National Youth Agency (www.nya.org.uk)
- Office of the Children's Commissioner (www.childrenscommissioner.gov.uk)
- Parentline Plus (www.parentlineplus.org.uk)
- ParentTalk.co.uk (www.parenttalk.org.uk)
- Positive Parenting (www.parenting.org.uk)
- PSHE Association (www.pshe-association.org.uk)
- Schools Health Education Unit (www.sheu.org.uk)
- Scottish Executive (www.scotland.gov.uk)
- The Children's Society (www.childrenssociety.org.uk)
- UK Youth Parliament (www.ukyouthparliament.org.uk)

Selection criteria

Studies were included in the review if:

- they were from the UK, published in English from 1997 onwards
- they reported the views of children and young people aged 5–19 years on PSHE education, SRE and/or alcohol education
- they included children and young people between the ages of 5 and 19 years, 21 years for those in or leaving care and 25 years for those with learning disabilities.

Studies were excluded if:

- they did not relate specifically to children and young people's views on PSHE education, SRE and or alcohol education.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for the development of NICE public health guidance' (see appendix E). Each study was graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

Study quality

- ++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.
- + Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.
- Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

The main reasons for studies being assessed as (–) were:

- Lack of clarity of the aims, objectives and research question and lack of discussion about underpinning values and assumptions.
- No clear account of the criteria used for sampling, data collection, data analysis. Undefined characteristics of the participants and settings, lack of consideration of context bias.
- Insufficient methodological data making it difficult to assess internal validity, for example, the reliability of selected outcome measures, inadequate reporting of randomisation, blinding of participants and investigators, and validity and reliability of outcome measures. Very few studies reported details about the source population or whether the selection of participants resulted in a representative sample.
- Lack of clarity about data collection or unsystematic data analysis, so that it was hard to see how the themes and concepts were derived from the data, and uncertainty about the plausibility of the conclusions. Very few studies reported an intention-to-treat analysis, few studies were reported to be sufficiently powered or presented power calculations, and effect size estimates were rarely reported or there were insufficient data to calculate effect sizes.

- Poorly reported baseline comparison of intervention and control groups, lack of information on numbers assigned to each group and failure to report numbers located on follow-up.

The evidence was also assessed for its applicability to the areas (populations, settings, interventions) covered by the scope of the guidance. Each evidence statement concludes with a statement of applicability (directly applicable, partially applicable, not applicable).

Summarising the evidence and making evidence statements

The review data were summarised in evidence tables (see full reviews).

The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see appendix A). The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

Cost effectiveness

There was a review of economic evaluations and an economic modelling exercise.

Review of economic evaluations

Databases searched were as for the reviews described above.

Studies were eligible for inclusion in the assessments of cost effectiveness if they were:

- economic evaluations conducted alongside trials
- modelling studies and analyses of administrative databases
- full economic evaluations that compared two or more options and considered both costs and consequences (including cost effectiveness, cost-utility and cost-benefit analyses).

Economic modelling

Two separate economic models were constructed, one for SRE interventions and the other for alcohol interventions. The results are reported in: 'A model to

assess the cost-effectiveness of sex and relationship education (SRE) and ‘A model to assess the cost effectiveness of alcohol education’.

They are available from: www.nice.org.uk/guidance/PHXX

Fieldwork

Fieldwork was carried out to evaluate how relevant and useful NICE's recommendations are for practitioners and how feasible it would be to put them into practice. It was conducted with practitioners and commissioners who are involved in sex and relationship and alcohol education. They included those working in schools, colleges, the community, in the NHS, for local authorities and voluntary sector organisations.

The fieldwork comprised:

- Seventeen focus groups carried out in nine local authority areas and in education settings in nine areas, by GHK with heads, senior managers, governors, teachers, lecturers, teaching support staff, school nurses and counsellors and chaplains in education settings. In local authority settings participants were NHS and local authority service commissioners and managers, PSHE leads, youth workers and outreach workers, teenage pregnancy coordinators, drug and alcohol action teams, young offender and probation services, and staff from community and voluntary organisations who deliver aspects of PSHE education on behalf of local commissioners.
- Twelve telephone or face-to-face interviews were carried out by GHK. These took place when individuals indicated that they were willing to participate in the research but were unable to attend a focus group. An additional consultation was undertaken with 65 young people aged 10–25 by Qa Research. The aim was to gather their views about the relevance, usefulness and acceptability of the draft guidance. The consultation comprised focus groups at 11 sites (including faith and non-faith schools, colleges and a pupil referral unit).

- The main issues arising from these two studies are set out in appendix C under fieldwork findings. The full fieldwork report 'Fieldwork report on school, college and community based Personal, Social and Health Economic (PSHE) education, focusing on sex and relationships and alcohol education' and 'Testing the recommendations in the draft guidance on PSHE: consultation with young people' are available at www.nice.org.uk/guidance/PHXX

How the PDG formulated the recommendations

At its meetings in February 2008 to April 2010, the PDG considered the evidence, expert testimony and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- where relevant, whether (on balance) the evidence demonstrates that the intervention or programme/activity can be effective or is inconclusive
- where relevant, the typical size of effect (where there is one)
- whether the evidence is applicable to the target groups and context covered by the guidance.

The PDG developed draft recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS, education and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where possible, recommendations were linked to an evidence statement(s) (see appendix C for details). Where a recommendation was inferred from the

evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

The draft guidance, including the recommendations, was released for consultation in June 2010. At its meeting in September 2010, the PDG amended the guidance in light of comments from stakeholders and experts and the fieldwork. The guidance was signed off by the NICE Guidance Executive in December 2010.

Appendix C The evidence

This appendix lists the evidence statements from three reviews provided by Liverpool John Moores University and one review provided by The National Collaborating Centre for Women's and Children's Health (see appendix A) and links them to the relevant recommendations. (See appendix B for the key to quality assessments.) The evidence statements are presented here without references – these can be found in the full review (see appendix E for details). It also lists five expert papers and their links to the recommendations and sets out a brief summary of findings from the economic analysis.

The four reviews of effectiveness are:

- Review 1: 'A review of the effectiveness and cost-effectiveness of personal, social and health education in primary schools focusing on sex and relationships and alcohol education for young people aged 5–11 years'
- Review 2: 'A review of the effectiveness and cost-effectiveness of personal, social and health education in secondary schools and further education colleges focusing on sex and relationships and alcohol education for young people aged 11–19 years'
- Review 3: 'A review of the effectiveness and cost effectiveness of alcohol and sex and relationship education for all children and young people aged 5–19 in community settings'
- Review 4: 'Children and young people's perspectives on school, family, and community-based personal, social and health education, in particular concerning alcohol, sexual health and relationships'.

Evidence statement number 1.1 indicates that the linked statement is numbered 1 in review 1. **Evidence statement number 2.3** indicates that the linked statement is numbered 3 in review 2. **ER1** indicates that expert paper number 1 is linked to the recommendation.

The reviews, expert reports and economic analysis are available at www.nice.org.uk/guidance/PHX

Where a recommendation is not taken directly from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

Recommendation 1: evidence statements 1.6a, 1.6b, 1.6c, 1.6d, 2.1a, 2.2a, 2.2d, 2.2e, 2.3a, 2.3b, 2.3f, 2.8a, 2.8b, 2.8c, 2.9a, 2.9d, 2.10c, 2.12a, 2.12c, 2.12e, 2.14, 3.1, 4.3; ER1, ER3

Recommendation 2: evidence statements 1.6a, 1.6b, 1.6c, 1.6d, 2.1a, 2.2a, 2.2d, 2.2e, 2.3a, 2.3b, 2.8a, 2.8b, 2.8c, 2.10c, 2.14, 3.7a, 3.7b, 3.7c, 3.8a, 3.8d, 3.8f, 3.9a, 3.8b, 3.8f, 4.2, 4.3; ER1, ER3, ER4, ER5

Recommendation 3: evidence statements 1.1, 1.6a, 1.6b, 1.6c, 1.6d, 2.8b, 2.9d, 2.10c, 3.1, 3.3b, 3.3c, 3.4b, 3.6, 3.10a, 3.11a, 3.11e, 3.15b, 4.3, 4.9, ER4

Recommendation 4: evidence statements 2.1b, 4.2, 4.7

Recommendation 5: evidence statements 2.8c, 2.9a, 2.9d

Recommendation 6: evidence statements 1.6a, 1.6b, 1.6c, 1.6d, 2.8c, 4.2, 4.3, 4.4, 4.5, ER3, ER4, ER5

Recommendation 7: evidence statements 1.1, 1.6a, 1.6b, 1.6c, 1.6d, 2.1a, 2.8c, 2.12a, 2.12e, 2.14, 4.2, 4.7

Recommendation 8: evidence statements 1.1, 1.6a, 1.6b, 1.6c, 1.6d, 2.1a, 2.2a, 2.2d, 2.2e, 2.3f, 2.8b, 2.8c, 2.12a, 2.12c, 2.14, 3.7c, 3.8a, 3.8d, 3.9f, 4.2, ER1, ER2

Recommendation 9: evidence statements 2.8c, 4.2; IDE

Recommendation 10: evidence statements 2.8c, 3.7b, 4.2; IDE

Recommendation 11: evidence statements 3.1, 3.3b, 3.3c, 3.4b, 3.6, 3.7a, 3.7b, 3.7c, 3.8a, 3.8d, 3.8f, 3.9a, 3.9b, 3.9f, 3.10a, 3.11a, 3.11e, 3.15b, 4.2, 4.3, 4.4, 4.7

Recommendation 12: evidence statements 2.8c, 3.7b, 4.2; IDE

Evidence statements

Please note that the wording of some evidence statements has been altered slightly from those in the evidence reviews to make them more consistent with each other and NICE's standard house style.

Evidence statement 1.1

There is strong evidence from two systematic reviews (++) , which focused on the prevention of alcohol use, to suggest that interventions targeting primary school aged children may be less effective than those that target young adolescents. Interventions targeting alcohol use in primary school aged children may be more effective if they take place in more than one domain, for example by combining school and family components.

Evidence statement 1.6a

There is moderate evidence from one randomised controlled trial (RCT) (+), three non-randomised controlled trials (NRCTs) (+) and one case control study (CSS) (+) to suggest that programmes that target social development and combine school and family-based components may positively affect attachment to school and academic performance. This evidence may be only partially applicable to the UK because these programmes were developed and evaluated in the USA, and the findings may not be applicable beyond the populations studied.

Evidence statement 1.6b

There is moderate evidence from three RCTs (two [+], one [-]), one NRCT (+) and one CSS study (+) to suggest that programmes that target social development and combine school and family-based components may have a positive impact on problem behaviours and social skills. This evidence may be only partially applicable to the UK because these programmes were developed and evaluated in the USA, and the findings may not be applicable beyond the populations studied.

Evidence statement 1.6c

There is moderate evidence from three NRCTs (+) to suggest that a social development programme that combines school and family-based components may have long term impacts on alcohol use and sexual behaviour in young

adulthood. This evidence may be only partially applicable to the UK because these programmes were developed and evaluated in the USA, and the findings may not be applicable beyond the populations studied.

Evidence statement 1.6d

There is strong evidence from three RCTs (++) to suggest that the Good Behavior Game, which targeted behaviours in the classroom, may impact on alcohol abuse and dependence in adulthood and slow the rate of alcohol use in adolescence. This evidence may be directly applicable to the UK because although the programme was developed and evaluated in the USA, it has been replicated in populations outside the USA.

Evidence statement 2.1a

There is strong evidence from two systematic reviews (++) to suggest that a secondary-level school-based programme, Botvin's Life Skills Training (LST), can produce long-term reductions (greater than 3 years) in alcohol use. Other promising intervention approaches include: Keepin it REAL, the Midwest Prevention Project, Project Northland, Healthy School and Drugs, Project ALERT and SHAHRP.

Evidence statement 2.1b

There is moderate evidence from two systematic reviews (one [++], one [-]) to suggest that programmes delivered by peer leaders may be more beneficial than programmes delivered by teachers or other contributors. However, there is strong evidence from one systematic review (++) to suggest that the positive benefits of peer involvement may disappear if teachers were also involved in delivery.

Evidence statement 2.2a

There is strong evidence from four RCTs (one [++], two [+], one [-]), two NRCTs (one [+], one [-]) and two controlled before-and-after (CBA) studies (one [+], one [-]) to suggest that classroom-based alcohol specific programmes are effective at increasing alcohol-related knowledge in the short-term, but have inconsistent or mixed effects on alcohol-related knowledge in the medium- to long-term. Findings may be only partially applicable to the UK because studies were implemented within Australia,

Germany and the USA and may not be applicable beyond the populations studied.

Evidence statement 2.2d

There is moderate evidence from five RCTs (one [++], two [+], two [-]) three NRCTs (one [+], two [-]) and two CBA studies (one [+], one [-]) to suggest that alcohol-specific education programmes may have mixed short-term effects on health outcomes relating to alcohol use. One NRCT (+) of a programme focusing on harm reduction through skills-based activities (SHAHRP) showed short-term reductions in alcohol use. In particular effects were seen on risky drinking behaviours such as drunkenness and binge drinking. Findings may be only partially applicable to the UK because this study was conducted in Australia and may not be applicable beyond the populations studied.

Evidence statement 2.2e

There is moderate evidence from eight RCTs (one [++], three [+], four [-]), one NRCT (+) and one CBA study (+) to suggest that alcohol-specific education programmes have limited medium- to long-term effects on health outcomes related to alcohol use, such as frequency of alcohol consumption and drunkenness. Findings may be only partially applicable to the UK because studies were implemented outside the UK and may not be applicable beyond the populations studied.

Evidence statement 2.3a

There is moderate evidence from two RCTs (+), one NRCT (-) and one CBA (-) study to suggest that classroom-based substance use programmes are effective at improving knowledge relating to substance use and its effects in the short to medium term, but that these effects are not sustained in the long term. Findings may only be partially applicable to the UK as studies were implemented outside the UK and may not be applicable beyond the populations studied.

Evidence statement 2.3b

There is moderate evidence from 12 RCTs (five [+], seven [-]), seven NRCTs (four [+], three [-]) and two CBA studies (one [+], one [-]) to

suggest that classroom-based substance use programmes may have mixed effects on student's attitudes and values about substance use. There is moderate evidence from seven RCTs, four NRCTs and two CBA studies to suggest that these programmes may impact on attitudes to substance use in the short to medium term and further evidence from five RCTs and three NRCTs to suggest that they may have a positive impact on long-term behavioural intentions. There is weak evidence from six RCTs, one NRCT and one CBA study to suggest that classroom-based substance use programmes have no medium- to long-term effects on peer norms. Findings may only be partially applicable to the UK as studies were implemented in the USA and may not be generalisable applicable beyond the populations studied.

Evidence statement 2.3f

There is moderate evidence from three RCTs (+) to suggest that LST has positive short-, medium- and long-term effects on drinking frequency and binge drinking. However, there is moderate evidence from three RCTs (all [+]) and one NRCT (-) to suggest that there may be issues with the transferability of LST to other settings. Findings may be only partially applicable to the UK because studies were implemented in Spain and the USA and may not be applicable beyond the populations studied.

Evidence statement 2.8a

There is strong evidence from three systematic reviews (two [++], one [+]) to suggest that abstinence-only programmes have limited effects or are ineffective for preventing or reducing sexual risk behaviours.

Evidence statement 2.8b

There is moderate evidence from five systematic reviews (two [++], three [+]) to suggest that interventions incorporating information on safer sex and contraceptive use may have positive but limited effects on preventing sexual risk behaviours. There is no evidence that such programmes increase the occurrence of sexual activity among young people.

Evidence statement 2.8c

There is moderate evidence from four systematic reviews (one [++], three [+]) to suggest that effective characteristics of sexual risk reduction interventions include: a theoretical basis; use of trained adult health educators as providers; and provision of highly specific content focusing on sexual risk reduction.

Evidence statement 2.9a

There is moderate evidence from two RCTs (both [++]) and two CBA (one [+], one [-]) studies to suggest that comprehensive sex education programmes may be effective at increasing students' knowledge about sexually transmitted infections in the short- to long-term. In addition, there is weak evidence from one RCT(+) and two CBA studies (both [-]) to suggest that brief interventions focusing on HIV prevention, such as theatre in education or a comic-based intervention, may have short-term positive effects on knowledge about HIV and AIDs. This evidence is directly applicable because these studies were conducted in the UK.

Evidence statement 2.9d

There is moderate evidence from one RCT (++) and one NRCT (+) to suggest that comprehensive SRE programmes that include peer-led sessions, such as RIPPLE and APAUSE, may delay sexual initiation. There is strong evidence from three RCTs (all [++]) and one NRCT (-) to suggest that SRE programmes and single session interventions focusing on contraceptives and contraceptive services may have no impact on condom or contraceptive use. This evidence is directly applicable because the studies were conducted in the UK.

Evidence statement 2.10c

There is moderate evidence from two RCTs (one [+], one [-]) and four NRCTs (two [+], two [-] to suggest that abstinence-only programmes may have no impact on the initiation of sexual behaviours or the maintenance of sexual abstinence. In addition, there is moderate evidence from one RCT (+) and three NRCTs (one [+], two [-]) to suggest that abstinence-only programmes may have no impact on or increase sexual activity. This evidence may be only partially applicable because the programme's emphasis on abstinence is of

limited relevance to delivery of PSHE education focusing on SRE and alcohol education in secondary schools.

Evidence statement 2.12a

There is moderate evidence from five RCTs (one [++], three [+], one [-two NRCTs (one [++], one [+]) and one CBA study (-) to suggest that HIV and sexual risk reduction programmes can improve sexual health and HIV knowledge in the short, medium and long term. This evidence may be only partially applicable to the UK because five of the studies were conducted in the USA, one in Italy and one in the Netherlands, and they may not be applicable beyond the populations studied.

Evidence statement 2.12c

There is moderate evidence from two RCTs (both [+]), one NRCT (++) and one CBA study (-) to suggest that HIV and sexual risk reduction programmes may improve personal and social skills, including behavioural prevention skills and condom negotiation skills, in the short-term. There was no evidence to determine the effects of HIV and sexual risk reduction programmes on personal and social skills in the medium to long term. This evidence may be only partially applicable to the UK because the studies were carried out in the USA and Italy, and may not be applicable beyond the populations studied.

Evidence statement 2.12e

There is strong evidence from three RCTs (one [++], one [+], one [-]), two NRCTs (one [++], one [+]) and one CBA study (-) to suggest that HIV and sexual risk reduction programmes can increase condom use or protected intercourse in the short to medium term. However, there was moderate evidence from two RCTs to suggest that the long-term effects of HIV and sexual risk reduction programmes on contraceptive use may be limited. This evidence may be only partially applicable to the UK because studies were carried out in the USA, Norway, and Sweden, and may not be applicable beyond the populations studied.

Evidence statement 2.14

There is moderate evidence from one economic evaluation study to suggest that a sex and relationships education programme, Safer Choices, may be

cost-effective and cost saving. This evidence may be of limited applicability to the UK because cost and benefit estimates were based on data from studies conducted in the USA.

Evidence statement 3.1

There is strong evidence from three systematic reviews (++) to suggest that a family-based programme, Iowa Strengthening Families Program, can produce long-term reductions (greater than 3 years) in alcohol use and heavy alcohol use.

Evidence statement 3.3b

There is moderate evidence from two RCTs (+) to suggest that programmes delivered to families may have short-term positive effects on attitudes and values related to alcohol. Findings may be only partially applicable to the UK as all the studies were conducted in the USA and may not be applicable beyond the populations studied.

Evidence statement 3.3c

There is moderate evidence from two RCTs (+) to suggest that programmes delivered to families that target family interaction may have positive effects on family communication, parental monitoring and parental rules about alcohol. Findings may be only partially applicable to the UK because all the studies were conducted in the USA and may not be applicable beyond the populations studied.

Evidence statement 3.4b

There is moderate evidence from two RCTs (-) and one CBA study (-) to suggest that interventions delivered to parents may have a positive short- to potentially long-term effect on parent-child communication about alcohol. These findings may be only partially applicable to the UK because they were not implemented in a UK setting and may not be applicable beyond the populations studied.

Evidence statement 3.6

There is moderate evidence from one economic evaluation study (+) to suggest that programmes delivered to families may be cost-effective and cost

saving. This evidence may be of limited applicability to the UK because cost and benefit estimates were based on data from studies conducted in the USA.

Evidence statement 3.7a

There is strong evidence from five systematic reviews and meta-analyses (two [++], three [+]) to suggest that interventions and programmes delivered in a range of community settings can have a positive impact on young people's sexual risk behaviours – in particular, condom use and pregnancy.

Evidence statement 3.7b

There is strong evidence from one systematic review (++) to suggest that effective community-based interventions and programmes are: theoretically based; tailored to the target population; implemented by trained facilitators; based on diverse content; and delivered using a wide variety of methods.

Evidence statement 3.7c

There is strong evidence from one systematic review (++) to suggest that effective clinic-based programmes include: a focus on a single gender or ethnic group; HIV and sexually transmitted infection education with skills building activities (for example, condom application); condom negotiation and sexual communication components; and personalised risk assessments.

Evidence statement 3.8a

There is moderate evidence from five RCTs (one [++], four [+]) , one NRCT (+) and one CBA study (-) to suggest that group-based education and/or skills-based interventions, youth development programmes and peer leadership interventions delivered in social and community settings may have a positive short- to medium-term impact on knowledge and understanding related to sexual health. This evidence may be only partially applicable to the UK because these studies were conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.8d

There is moderate evidence from four RCTs (two [++], two [+]) and one CBA study (-) to suggest that group-based education and/or skills-based interventions may have limited effects on sexual activity. Although reductions in the likelihood of sexual intercourse were reported across four RCTs (two

[++], two [+]) there was only evidence from one RCT of intervention effects on frequency of sexual intercourse or number of sexual partners. This evidence may be only partially applicable to the UK because these studies were conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.8f

There is moderate evidence from one RCT (+) to suggest that youth development programmes that target disadvantaged young people may have a positive impact on sexual behaviours among young women, including sexual activity, condom use and pregnancy. This evidence may be only partially applicable to the UK because this study was conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.9a

There is strong evidence from six RCTs (two [++], three [+], one [-]) to suggest that interventions and programmes delivered in healthcare settings may produce short- to medium-term improvements in sexual health-related knowledge. This evidence may be only partially applicable to the UK because these studies were conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.9b

There is strong evidence from three RCTs (two [++], one [+]) to suggest that group-based education and/or skills-based interventions specifically targeting sexually active young women in healthcare settings may have short- to medium-term positive effects on attitudes to condom use. This evidence may be only partially applicable to the UK because these studies were conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.9f

There is strong evidence from four RCTs (two [++], two [+]) to suggest that group-based education and/or skills-based interventions specifically targeting sexually active young women in healthcare settings may have a short- to medium-term positive impact on condom and other contraceptive use, and unprotected intercourse. This evidence may be only partially applicable to the

UK because these studies were conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.10a

There is moderate evidence from five RCTs (one [++], two [+], two [-]) and one NRCT (-) to suggest that interventions and programmes delivered to families may improve knowledge in the short to long term. Findings may be only partially applicable to the UK because all the studies were conducted in the USA and may not be applicable beyond the populations studied.

Evidence statement 3.11a

There is moderate evidence from one RCT (+) to suggest that training for mothers to be their daughters' primary HIV educator may produce short-term improvements in sexual health-related knowledge and understanding. The evidence may be only partially applicable to the UK because this study was conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.11e

There is moderate evidence from one RCT (+) to suggest that delivery of HIV prevention content by mothers may be equally effective as delivery by health experts. The evidence may be only partially applicable to the UK because this study was conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 3.15b

There is moderate evidence from two RCTs (+) to suggest that interventions and programmes delivered to families and parents that target alcohol use and sexual health may improve parent–child communication and family functioning. This evidence may be only partially applicable to the UK because these studies were conducted in the USA and focused on ethnic populations specific to the USA.

Evidence statement 4.2

There is evidence from two qualitative studies (one [+], one [-]) to suggest that young people do not receive consistent, systematic information on alcohol.

Young people would not seek information from teachers because they consider teachers to not care about the subject and to not be trustworthy.

Young people would seek information and advice from youth workers and school nurses because they are considered technically well trained and offer confidentiality on alcohol issues.

Some young people would go to relatives such as parents and older siblings or friends because they are considered experienced and trustworthy.

Young people would not trust the police or go to them for alcohol information.

Young people would not go to their GPs because of a lack of a relationship with them.

Young people want factual, practical information about alcohol that applies to the realities of their lives. This includes information on:

- numbers of units of alcohol in drinks
- the effects of alcohol on their bodies
- harm reduction and where to go for information about this
- how to minimise the influence of the media on their beliefs and behaviour in relation to alcohol.

Young people want the relationship between alcohol and sex to be dealt with in more depth in SRE lessons. They want to understand the influence of alcohol on sexual behaviours and also to know where to get confidential support to manage their emotions if they make a bad decision when drunk.

Young people want the freedom to discuss alcohol-related issues in the classroom. They want professionals, including service staff, school nurses, teachers, learning mentors and social work staff to:

- be good listeners
- be someone they can trust
- be down to earth
- make sessions interesting and fun
- not judge young people and their behaviour

- treat them like adults
- respect confidentiality and be clear when it is not available
- be relaxed and tell the truth, indicating the negatives and the positives
- be understanding
- be interesting and humorous
- not preach
- be accessible, genuine, open, warm, friendly and patient
- not be patronising
- be comfortable talking about sex, relationships, drugs and alcohol
- be sensitive to diversity
- be there when you need them.

Young people feel that a dual teacher/peer education approach to alcohol education would be most helpful. Teachers are considered more knowledgeable and peer educators more understanding, realistic and patient.

Evidence statement 4.3

There is evidence from eight qualitative studies (seven [+], one [-]) to suggest that the main sources of information about sex for young people were:

- schools
- family (parents, older siblings)
- peers (friends)
- media (television, videos, books, magazines, internet)
- pornography.

The sources of information varied with gender, experience of sexual intercourse and ethnicity. Boys and girls (aged 14–17) with no experience of sexual intercourse would seek information from friends who had experienced sexual intercourse. Family members and magazines were popular sources of information for girls. Older peers and pornography were popular sources of information for boys. However, some boys were sceptical about pornography as a reliable source of information.

Young people (aged 17–18) from minority ethnic groups tended to seek information from school and the internet but not from family members.

People with learning disabilities in Northern Ireland aged 13–40 perceived that their experience of SRE was vague or non-existent. They learnt about sex from various sources such as school, media, parents or other family members, front-line staff, professionals and friends.

Young gay men sought information from the gay scene because their formal sex education did not meet their needs or address their realities.

Evidence statement 4.4

There is evidence from 14 qualitative papers (eleven [+], three [–]) that suggests that young people prefer more information in SRE relating to:

- emotions and relationships
- sexual issues related to real life situations
- more explicit or intimate information on sex
- lesbian, gay, bisexual and transgender issues
- issues relating to sex as a pleasure and desire
- sexually transmitted infections.

Evidence statement 4.5

There is evidence from six qualitative papers (+) and incidental data on young people's (aged 13–17) views of the timing of sex education at school. This data suggests that SRE was delivered too late to be of practical use because many had already experienced sexual activity.

Young people who had experienced sexual intercourse believed that school education had started too late.

Young boys from a single-sex school who had not experienced sexual intercourse felt they might feel embarrassed and not be mature enough to learn if SRE was delivered too early.

Incidental data showed that a few young women, who felt their SRE had been delivered too late, were concerned that if sex education is delivered too early it may influence young people's wish to have sex.

Evidence statement 4.7

There is evidence from twelve qualitative studies (ten [+], two [-]) to suggest that young people aged 11–19 of both sexes prefer active over passive teaching methods for SRE. Active teaching methods help young people's learning and participation in SRE.

Young people did not want to be tested in SRE classes. Nor did they want activities that encouraged competition between the sexes.

A combination of single-sex and mixed-sex classes was considered ideal for teaching SRE by both boys and girls.

Young people liked, or wanted, to be taught in smaller groups and this lessened feelings of inhibition.

Setting ground rules in SRE classes helped young people to feel more comfortable.

Evidence statement 4.9

There is evidence from three qualitative papers (two [+], one [-]) that suggests that both boys and girls felt SRE had changed their views, intentions and behaviours regarding sex and relationships.

Boys' changes in behaviour included:

- encouraging their use of contraceptives
- delaying first sexual experience
- the ability to discuss sexual relations with a prospective partner
- waiting until the girl was ready
- feeling more confident about knowing what to expect at their first sexual encounter.

Girls' changes in behaviour included:

- waiting until they were in a long-term relationship before having sex
- enrolling on information courses about contraception.

Expert papers

- Expert paper 1: 'Sex and STI/HIV education programmes for youth: their impact and important characteristics'.

Characteristics of the comprehensive programs that had impact.

The content analysis of these effective curricula led to the identification of 17 common characteristics of the effective programs, including their development, content and implementation. The large majority of the effective programs incorporated most of the 17 characteristics. Also, programs that incorporated these characteristics were much more likely to change behaviour positively than programs that did not incorporate many of these characteristics. Five of the 17 characteristics involved the development of the curriculum; eight involved the curriculum itself; and four described the implementation of the curriculum.

The teams developing the curricula:

- 1) involved multiple people with varied backgrounds
- 2) assessed relevant needs and assets of the target groups
- 3) used a logic model approach that specified health goals, cognitive mediating factors and activities
- 4) designed activities consistent with community values and available resources, and
- 5) pilot tested the program.

Effective curricula commonly:

- focused on clear goals of preventing HIV, sexually transmitted infections and/or pregnancy
- focused on specific behaviours leading to these health goals (for example, abstaining from sex or using condoms or contraception) and gave a clear message about those behaviours

- addressed psychosocial risk and protective factors affecting those sexual behaviours
- created a safe environment for young people
- included multiple activities to change the targeted cognitive risk and protective factors
- employed instructionally sound teaching methods that actively involved the participants and helped them personalise the information
- employed appropriate activities and messages (for participants' culture, age, sexual experience), and
- covered topics in a logical sequence.

When implementing curricula, effective programs commonly:

- 1) secured at least minimal support from authorities
- 2) selected educators with desired characteristics, trained them, and provided ongoing monitoring and support
- 3) recruited young people if necessary and retained them, and
- 4) implemented virtually all activities as designed.

- Expert paper 2: 'Alcohol and sexual health'.
- Expert paper 3: 'Education for all – tackling homophobic bullying in Britain's schools'.
- Expert paper 4: 'Faith ethnicity and cultural issues'.
- Expert paper 5: 'Perspectives of the religious education council'.

Cost-effectiveness evidence

The cost-effectiveness evidence was very limited. There was only one community-based study on alcohol and sex education, and one school-based study.

However, the reviews showed that programmes delivered to families to reduce alcohol misuse dominated a minimal-contact control condition by conferring health benefits (implied and not measured) and by saving more

costs than were spent on the programme. (The programmes considered were the Iowa Strengthening Families Programme and Preparing for Drug Free Years.)

The cost-effectiveness evidence for SRE education delivered in schools suggested that Safer Choices, an abstinence-plus, school-based sex and relationships (SRE) programme dominated a standard knowledge-based HIV curriculum by conferring health benefits (implied and not measured) and by saving more costs than were spent on the programme. The costs saved were in the form of medical costs and smaller losses of employment than in the standard programme.

The economic model for SRE showed that if an intervention produced relatively modest, but genuine, increases in the use of condoms or other contraceptive methods it would be cost effective.

The economic model for alcohol education showed that an effective programme would be a very cost-effective use of public money. For example, a £75 million programme would be cost effective provided it led to at least a 1.4% reduction in alcohol consumption among young people. This assumes that such a reduction would avert long-term adverse health outcomes associated with alcohol consumption and not just have short-term effects.

Fieldwork findings

Fieldwork aimed to test the relevance, usefulness and feasibility of putting the recommendations into practice. The PDG considered the findings when developing the final recommendations. For details, go to the fieldwork section in appendix B and 'Fieldwork Report on School, College and Community based Personal, Social and Health Economic (PSHE) education, focusing on sex and relationships and alcohol education' and 'Testing the recommendations in the draft guidance on PSHE: consultation with young people', available at www.nice.org.uk/guidance/PHxx

Fieldwork participants who work with children and young people were very positive about the recommendations and their potential to help promote PSHE education. Many participants welcomed the link between sex and

relationships and alcohol education, that sex and relationships and alcohol education should start in primary school, that 'abstinence only' education is not effective, and the link to educational attainment. Many participants stated that:

- more emphasis could be given to the relationships element of sex and relationships education in primary schools
- community-based education could be emphasised more throughout the recommendations
- the role of young people in sex and relationships and alcohol education could be enhanced, for example in the planning of education.

Practitioners and commissioners said the recommendations did not offer a new approach, but agreed that the measures had not been implemented universally. They believed wider and more systematic implementation would be achieved if there was:

- greater clarity in specifying who should take action
- a clearer definition of cost effectiveness.

The children and young people consulted disagreed about the importance of PSHE education. However, they were adamant that, when it was delivered, it should be universal regardless of school status. Youth and community groups were seen as an additional outlet for PSHE education; 'doubling up' the key facts to help them remember what they had been taught in school. For those not in education different outlets such as home visits, youth centres, drop in centres and one to ones with teachers were suggested.

Participants thought that if young people want to 'opt-out' of lessons they should be allowed to; however, parents should not be entitled to make this decision for them.

The majority thought that parental input into SRE and alcohol education should be limited. They were unsure about the level to which young people should be involved in planning the curriculum. This was due to recognition of

their inexperience and their lack of awareness of what they think they should be taught.

Participants believed there are benefits to starting SRE and alcohol education in primary school to ensure that children are informed of the changes that will be happening to them before they begin. However, some had fears that this could be of detrimental, for example, prematurely exposing them to information on sexual activity.

There was consensus that young people should have access to one-to-one support. In one-to-one sessions, the level of confidentiality should be established. They felt that teachers should be able to tell young people what services are available to them if they need support in relation to sexual health and alcohol.

Appendix D Gaps in the evidence

The Programme Development Group (PDG) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence. These gaps are set out below.

1. There is limited effectiveness and cost-effectiveness research conducted in the UK in schools, further education and community settings, for all ages of children and young people. This is particularly so for sex and relationships education (SRE) and curricula that jointly address alcohol education and SRE.
2. There is limited evidence evaluating SRE and alcohol education delivered by parents, with either the parents as the primary educator or as a partner in education delivered by an outside agency. There is also limited evidence on working with parents (particularly men) to help them educate their children about alcohol and sex and relationships.
3. There is a lack of studies evaluating SRE and alcohol education for children aged 5–11 years. The studies in this age range lacked age-appropriate outcomes that could provide a basis for education at an older age.
4. The needs of children and young people with specific needs (such as those with physical and/or learning disabilities, those from black and minority ethnic groups, those who are lesbian, gay, bisexual or transgender, those from refugee or traveller groups, those from faith groups, those not in employment, education or training, those who are looked after, or those who are in the criminal justice system) are rarely addressed in the literature.
5. Papers rarely provide enough information about the content of the curricula being evaluated.

6. The impact of teaching methods and school or college infrastructure on effectiveness is rarely explored. For example:
 - different session formats and teaching techniques (such as circle time and active learning)
 - characteristics of deliverers such as teacher confidence and competence
 - the impact of PSHE education training for teachers
 - support from school or college governors
 - the use of extended school provision.
7. The outcomes reported for SRE in the evidence suggest it may be limited in scope, with insufficient coverage of relationship issues. There is also insufficient focus on the broad range of relationships that reflect society today – for example, step parents and siblings, and same-sex relationships and activity.
8. Information about participants' perspectives of the education they received is not collected in a systematic manner.
9. Few studies follow up children and young people for a meaningful length of time to determine whether education has an effect in later life. Most studies continued for only a few months after the end of the education; some did continue for 1–2 years but very few for any longer.
10. Studies are rarely designed to demonstrate causal links between intermediate outcomes such as parent–child communication and sex and alcohol behaviours.
11. There is little evidence about general health approaches to education that cover a range of themes including alcohol and sex and relationships.
12. General outcomes such as self esteem and self efficacy in relation to alcohol and sex and relationships are rarely reported.

The Group made five recommendations for research. These are listed in section 5.

Appendix E Supporting documents

Supporting documents are available at www.nice.org.uk/guidance/PHXX.

These include the following.

- Evidence reviews:
 - Review 1: ‘A review of the effectiveness and cost-effectiveness of personal, social and health education in primary schools focusing on sex and relationships and alcohol education for young people aged 5–11 years’
 - Review 2: ‘A review of the effectiveness and cost-effectiveness of personal, social and health education in secondary schools and further education colleges focusing on sex and relationships and alcohol education for young people aged 11–19 years’
 - Review 3: ‘A review of the effectiveness and cost effectiveness of alcohol and sex and relationship education for all children and young people aged 5–19 in community settings’
 - Review 4: ‘Children and young people’s perspectives on school, family, and community-based personal, social and health education (PSHE), in particular concerning alcohol, sexual health and relationships’.
- Economic modelling
 - ‘A model to assess the cost-effectiveness of sex and relationship education (SRE) developed for NICE public health guidance on personal, social and health education (PSHE)’
 - ‘A model to assess the cost-effectiveness of alcohol education developed for NICE public health guidance on personal, social and health education (PSHE)’.
- Expert papers
 - Expert paper 1: ‘Sex and STI/HIV education programmes for youth: their impact and important characteristics’

- Expert paper 2: 'Alcohol and sexual health'
 - Expert paper 3: 'Education for all – tackling homophobic bullying in Britain's schools'
 - Expert paper 4: 'Faith, ethnicity and cultural issues'
 - Expert paper 5: 'Perspectives of the religious education council'.
- Fieldwork report: 'Fieldwork report on school, college and community based personal, social and health economic (PSHE) education, focusing on sex and relationships and alcohol education'.
 - A quick reference guide for professionals whose remit includes public health and for interested members of the public. This is also available from NICE publications (0845 003 7783 or email publications@nice.org.uk – quote reference number Nxxxx).

For information on how NICE public health guidance is developed, see:

- 'Methods for development of NICE public health guidance (second edition, 2009)' available from www.nice.org.uk/phmethods
- 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' available from www.nice.org.uk/phprocess