LIFE submission to the PSHE Consultation, November 2011

Question 1. What do you consider the core outcomes PSHE education should achieve and what areas of basic core knowledge and awareness should pupils be expected to acquire at school through PSHE education?

We are primarily interested in the Relationships and Sex Education (RSE) area of PSHE. This is our chief area of expertise and experience. We have two decades' experience of work in schools. We have a long history of close contact with teachers and schools and sensitive ground-level adjustment to their needs. We understand the importance of sensitivity to changing needs in different groups and different areas and grassroots feeling among parents. We are sometimes viewed as being outside the RSE mainstream, but we are in touch with other providers and we have shown ourselves willing to enter mutually beneficial relationships with others and co-operate to achieve shared goals in arenas such as the Sexual Health Forum and the Sex and Relationships Education Council.

In our view, the core outcomes for RSE are improved public health outcomes, specifically the reduction of STI infection rates, teenage pregnancies and the possible emotional damage that can be associated with premature sexual activity. Pupils should acquire knowledge about basic sexual biology; respect for themselves and others, including respect for others' bodily integrity and autonomy; and accurate information about sexually transmitted infections and contraceptive methods. Pupils should be prepared for the complexity of sexual relationships, and have realistic expectations and perspectives concerning their consequences. An additional important component, in our view, should be challenging pupils to have a critical approach to prevailing cultural expectations concerning sexual behaviour, and being equipped to resist the trends towards sexualisation of society identified in e.g. the Bailey review. Pupils should be equipped with reasons and resources to delay first sexual activity, and be aware of the benefits associated with doing so.

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

(a) Existing parts of the RSE curriculum that should remain include: full and accurate information about STIs and other health consequences (the Health Protection Agency statistics on STIs and the government statistics on teenage pregnancy show that this is an ongoing public health problem).

(b) There is good evidence to support the new elements which we think ought to be part of RSE, e.g. closer parental involvement in content, context and timing (see evidence cited in question 7, particularly Kirby), more focus on relationships and behaviour change, and adult-led rather than peer-led interventions[1].

LIFE's own experience in schools suggests that there continues to be a great deal of ignorance and confusion about sexual health, and about integrating sexual activity into adult relationships. It would also appear from our feedback and experience that many pupils are experiencing significant emotional disruption following premature sexual activity, and are feeling pressured into early sex for various reasons. As early as 1999, it was recognised in the teenage pregnancy strategy that one of the key requirements was for teenagers to be equipped to say no to sexual activity. Almost all studies of early sexual activity show that a significant number of teenagers report intoxication or

[1] (see the work of Prof JB Jemmott, e.g. Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months: A Randomized Controlled Trial With Young Adolescents John B. Jemmott III, PhD; Loretta S. Jemmott, PhD, RN; Geoffrey T. Fong, PhD Arch Pediatr Adolesc Med. 2010;164(2):152-159. Also Abstinence and Safer Sex HIV Risk-Reduction Interventions for African American Adolescents: A Randomized Controlled Trial, John B. Jemmott III, PhD; Loretta Sweet Jemmott, PhD, RN, FAAN; Geoffrey T. Fong, PhD JAMA. 1998;279(19):1529-1536

coercion in their early sexual activity. This clearly suggests a need for a self-esteem and self-assertion element in RSE, as well as encouraging pupils to think about values and responses before they find themselves in pressured situations.

Question 3. Which elements of PSHE education, if any, should be made statutory (in addition to sex education) within the basic curriculum?

We do not believe that any elements of PSHE should be statutory, and RSE in particular should become statutory within the general PSHE curriculum. This is in line with the government's professed aims of promoting localisation and respect for schools' and parents' independence. If the government's Big Society agenda is to mean anything, surely it means allowing as much independence to local institutions and families as possible.

Question 4. Are the National, non-statutory frameworks and programmes of study an effective way of defining content?

The non-statutory frameworks are useful as a means of defining approaches and contexts. But inevitably there are limitations to how far a non-statutory approach can go in defining content. This, however, does not mean that we should define the actual content of RSE on a statutory basis, and we would oppose any such proposal. This would add considerable layers of bureaucracy to existing guidelines and schemes of work and would go against the grain of streamlining and localism that is the cornerstone of other aspects of government education policy.

Question 5. How can schools better decide for themselves what more pupils need to know, in consultation with parents and others locally?

The key here is for schools to be aware of local trends in RSE-related public health, e.g. local rates of STI infections, teenage pregancies, teenage abortion rates. This way they are free to tailor their responses and curriculums to the specific needs of local communities. This is one of the strengths of localism and decentralisation ï it enables greater flexibility and responsiveness in how schools approach the whole question of RSE, and indeed PSHE more broadly. It may be, for example, that if an area has a particularly serious problem with STI infections, a strong focus on teaching pupils how to avoid infection may be necessary, whereas a national curriculum may force schools to focus on issues that are not especially important in particular areas. Outside providers are a useful resource in this context, due to their expertise and experience and their closeness to particular needs. Smaller organisations at ñground levelò can respond flexibly and appropriately in a way that statutory bodies and national bodies often fail to.

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, b) the importance of positive parenting and c) teaching young people about sexual consent?

The current guidelines are quite open-ended. Simplification may prove problematic because it removes the leeway given to individual providers within the currently loose guidelines. As things stand, most providers can interpret the guidelines in the way they think most appropriate or can emphasise different aspects of the guidelines. This is actually a strength, as it enables and encourages localism and common-sense approaches.

(a) It is highly important for pupils to be informed of the evidence that marriage provides a more secure basis for child-rearing and relationship stability than other forms of relationsip.
(b) Information about positive parenting is in most need of more emphasis. If by positive parenting, we mean that the guidelines ought to stress the irreplaceable role of parents and guardians in RSE, and their right to have input on the content and context of RSE then that would be an excellent step. This concept could perhaps be extended to stress in the guidelines the links between sexual activity and parenthood, i.e. pupils should be encouraged to consider whether they are ready for possible parenthood before beginning sexual activity, given the inextricable ink between sex and reproduction.
(c) The guidelines already seem to have plenty of material relevant to consent and to relationships, although it would be better if the relationships sections were to emphasise in a more authoritative way that relationships are the ideal and normal place for sexual activity rather than simply one option among many. The guidelines clearly emphasise the need not just for consent, but for respect and consideration in sexual relationships. Pupils should be reminded of other considerations around consent:

- That consent is just one criterion for healthy sexual activity and does not legitimise all forms of sexual activity. For instance, research suggests that early sexual intercourse, even when consented to, is often regretted[2]. Pupils should be made aware of this.
- That the UK maintains an age of consent for sexual activity - 16.
- Sometimes ñnegotiationò of contraception is discussed as part of consent. Pupils should not be given the mistaken idea that contraception represents a magic bullet solution to STIs, pregnancy etc.

Question 7. Have you got any examples of case studies that show particular best practice in teaching PSHE education and achieving the outcomes we want for PSHE education?

Your answer should be evidence based and provide details of real-life case studies

There is good evidence to show the success of what is sometimes called ñabstinence-plusò RSE ï i.e. providing pupils with full and accurate information about sex and relationships, and not relying on a simplistic ñjust say noò approach, but giving reasons and resources to delay first sexual activity, ideally until a lifelong committed relationship. It is easy to write off this kind of approach, and to compare it unfavourably with the so-called ñcomprehensiveò approach (which is actually no more factually comprehensive that such models, but does not go as far as abstinence-plus in placing relationships in context).

The work of Dr JB Jemmott in the US proves the efficacy of carefully applied abstinence-plus approaches that focus on behavioural change[3].

British researchers such as David Paton are also questioning the effectiveness of the techniques and assumptions associated with ñcomprehensiveò RSE in achieving good public health outcomes[4].

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[2] Wright D, Henderson M, Raab G, Abraham C, Buston K, Scott S, et al., ôExtent of regretted sexual intercourse among young teenagers in Scotland: a cross sectional surveyõ, BMJ, 2000;320:1243ï1244; Sabia J J, Rees D I, ôThe effect of adolescent virginity status on psychological well-beingõ, Journal of Health Economics, Volume 27, Issue 5, September 2008, Pages 1368-1381.

[3] http://www.annenbergpublicpolicycenter.org/Bio.aspx?myUsername=jjemmott

[4] *Paton, D.(2009), "Does access to contraception raise teenage pregnancy rates?", Nursing Times, Vol.March, E:professional journals.* **See also** *Paton, D.(2009)., "Exploring the evidence on strategies to reduce teenage pregnancy rates", Nursing Times, Vol.105(42, 22nd Oct), pp. 22-25,* **and** *Girma, S.; Paton,*

There is of course some disagreement over what the evidence in this area actually shows, and there is actually not a great deal of evidence that any currently used approach to RSE has a significant effect in improving sexual health outcomes[5].

Even those who are wary of an abstinence-plus approach should note that it is not always straightforward to measure the success of RSE interventions ï for instance, pupils who have experienced a negative outcome, such as an STI infection or pregnancy, thus counting as a data point against a particular approach, may have actually developed a mature and considered approach to sexuality as a result, whereas a pupil considered a ñsuccessò by the standards of conventional ñcomprehensiveò RSE may be yet to develop such a successful and mature attitudes.

It is also the case that researchers in sexual health fields related to RSE ï such as AIDS prevention ï are increasingly finding that merely providing information and contraception without seeking behavioural change does not work as a long-term solution[6].

As an organisation involved in RSE, LIFE receives consistently excellent feedback from schools, individual teachers and pupils concerning our programme. One of the key aspects that is widely praised is that we hold up an ideal of sexual activity as belonging properly within the context of long-term committed relationships. 83% of schools who invite a LIFE RSE speaker into their school ask for a return visit.

Question 8. How can PSHE education be improved using levers proposed in the Schools White Paper, such as Teaching Schools, or through alternative methods of improving quality, such as the use of experienced external agencies (public, private and voluntary), to support schools?

Our experience is that organic individual feedback between schools and providers is the key mechanism for improving our services and maintaining quality. To some extent, it is difficult to

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D.(2011), "The Impact of Emergency Birth Control on Teen Pregnancy and STIs", Journal of Health Economics

[5] See, for instance, DiCenso A., G. Gordon, W. Andrew and L. Griffith (2002), ĂInterventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trialsą British Medical Journal, 324(15, June): 1426-34.

Henderson M., D. Wight, G.M. Raab, C. Abraham, A. Parkes, S. Scott et al (2007), ĂImpact of a theoretically based sex education programme (SHARE) delivered by teachers on NHS registered conceptions and terminations: final results of cluster randomised trial, BMJ, 334(Jan): 133-137.

Stephenson J., V. Strange, E. Allen, A. Copas, A. Johnson, C. Bonell, A. Babiker, A. Oakley et al (2008),The Long-term Effects of a Peer-Led Sex Education Programme (RIPPLE): a cluster randomised trial in schools in Englandą PLoS Medicine, 5(11, Nov): 1579-90.

Wilkinson P., R. French, R. Kane, K. Lachowycz, J. Stephenson, C. Grundy et al (2006), Teenage conceptions, abortions and births in England: 1994-2003, and the national teenage pregnancy strategyąLancet, 368 (Nov): 1879-86.

[6] Cassell MM, et al. (2006). "Risk compensation: the Achilles' heel of innovations in HIV prevention?" BMJ 332(7541): 605-607.
Richens JJ, et al. (2000). "Condoms and seat belts: the parallels and the lessons." Lancet 355(9201): 400.
Kajubi P, et al. (2005) "Increasing condom use without reducing HIV risk: results of a controlled community trial in Uganda." J Acquir Immune Defic Syndr: 40:77-82.
Rethinking AIDS Prevention: Learning from Successes in Developing Countries (2003), Edward C. Green

measure the outcomes of RSE interventions, so we depend closely on co-operation with those close to pupils who are best-placed to judge their needs and what has worked with pupils of particular levels of age and maturity. This usually means teachers and parents ï another reason why localism and freedom of individual schools are useful in this context.

Question 9 Have you got any examples of good practice in assessing and tracking pupils' progress in PSHE education?

Your answer should be evidence based and provide details of real-life case studies

We do not have formal evidence-based examples of such good practice; as an outside provider of RSE we do not have means of tracking long-term outcomes or development of RSE and PSHE within schools. However, we can and do respond to schools' changing priorities, needs and wishes, so to that extent we are responsive to changing practice and attitudes within the broader RSE context. As noted above, our good feedback suggests that our programmes are desirable and appropriate for schools, and that we are changing and evolving our RSE programmes where necessary.

There is some good evidence that parental involvement in RSE, both in supporting schools and in forming curricula, can improve outcomes[7].

Question 10. How might schools define and account for PSHE education's outcomes to pupils, parents and local people?

Looking at the kind of feedback mechanisms available in other subject areas, there are many avenues for how schools can show themselves to be in touch with these key stakeholders. The obvious ones, of course, are availability of all curriculum materials, full and honest consultation on request for those with concerns, retention of the parental right to withdraw from RSE, and for co-operation with other community institutions.

Local schools are the most appropriate and accessible forum for parents and teachers to come together and discuss the needs and priorities of particular children and communities. For instance, a parent who has concerns is more likely to be able to discuss those concerns frankly and sensitively and constructively with a teacher with whom s/he has an existing relationship than with someone who is not actively involved in their childrenôs education. Parents have already been excluded from many areas of meaningful decision-making concerning their childrenôs sexual health ï their under-16-year-olds can access abortion and contraception without their knowledge or consent, which amounts to the state being complicit in systematic deceit. They should not be further alienated from the moral education of their children. Central government and education authorities have a long record of promoting materials for RSE which are unacceptable or unsuitable.

Whether or not particular children are ready for any kind of RSE is a judgment call that only those closest to those children can really make. It is best handled on a local level where those who are most involved and most knowledgeable about the situation can co-operate. There is a particular potential problem here for schools that serve faith communities, in that if the government is to

[7] http://www.guttmacher.org/pubs/journals/3014398.html

ñDeconstructing the Dutch Utopiaò, http://www.famyouth.org.uk/pdfs/DDU.pdf;

also ñEmerging Answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseasesò ; D Kirby, National Campaign to prevent Teen and Unplanned Pregnancy, 2007

respect the particular faith commitments of schools, it is contradictory for them to compel a certain curriculum content or context to those schools.