NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH DRAFT GUIDANCE

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

NICE public health guidance x

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 literacy[1], 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, commissioners and managers in children's trusts and children's services, local authorities and primary care trusts.

It is also for practitioners who work with young people and who have a direct or indirect role in, and responsibility for, school, college and community-based personal, social, health and economic (PSHE) education focusing on sex and relationships and alcohol. This includes 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, their parents and carers and other members of the public.

The guidance complements, but does not replace, NICE guidance on: community-based interventions to reduce substance misuse; alcohol and

[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

schools; reducing sexually transmitted infections and teenage pregnancy; and social and emotional wellbeing in primary and secondary education (for further details, see section 7).

The Programme Development Group (PDG) has considered the evidence reviews, cost effectiveness, commissioned reports and expert testimony

This document sets out the Group's preliminary recommendations. It does not include all sections that will appear in the final guidance. NICE is now inviting comments from stakeholders (listed on our website at: www.nice.org.uk).

Note that this document does not constitute NICE's formal guidance on school, college and community-based personal, social, health and economic education focusing on sex and relationships and alcohol education. The recommendations made in section 1 are provisional and may change after consultation with stakeholders and fieldwork.

The stages NICE will follow after consultation (including fieldwork) are summarised below.

- The Group will meet again to consider the comments, reports and any additional evidence that has been submitted.
- After that meeting, the Group will produce a second draft of the guidance.
- The draft guidance will be signed off by the NICE Guidance Executive.

For further details, see 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' (this document is available at www.nice.org.uk/phprocess).

The key dates are:
Closing date for comments: 15 July 2010
Next PDG meeting: 16–17 September 2010.

Members of the PDG are listed in appendix A and supporting documents used to prepare this document are listed in appendix E.

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

Contents

1 Recommendations

When writing the recommendations, the Programme Development Group (PDG) (see appendix A) considered the evidence reviews, evidence of cost effectiveness, commissioned reports and expert testimony. Note: this document does not constitute NICE's formal guidance on this programme. The recommendations are preliminary and may change after consultation.

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

The evidence reviews, supporting evidence statements and economic modelling report are available at http://guidance.nice.org.uk/PHG/Wave12/77

PSHE education – what this guidance covers

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

This guidance focuses on two PSHE education topics – sex and relationships and alcohol, and the links between them – within schools, colleges and in the wider community. It also takes into account the need to promote inclusion and tolerance and to reduce health inequalities.

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

In primary schools, personal, social and health education is integrated with citizenship. There is no formal economic component. The subject was renamed as personal, social, health and economic education in secondary schools and incorporates the study of economic wellbeing and financial capability. There is no requirement for further education colleges to provide

[2] PSHE Subject Association (2010) 'About PSHE' [online]. Available from www.pshe-association.org.uk/content.aspx?CategoryID+1043

personal, social and health education (with or without an economic component).

The majority of the recommendations cover children and young people of all ages in primary and secondary schools, colleges and other educational institutions such as pupil referral units.

Recommendations 1–9

Whose health will benefit?

All children and young people, including those who are looked after or leaving care and those with a learning disability.

Recommendation 1 Entitlement to PSHE education

Who should take action?

- Directors, commissioners and managers in local authorities, children's trusts, children and young people's services, primary care trusts (PCTs), and children and young people's strategic partnerships.

- All those involved in the design and planning of PSHE education in schools, special schools, sixth form and further education colleges, pupil referral units, young offender institutes and secure accommodation for young people, young people's services, and voluntary and community services.

What action should they take?

- Raise awareness among the whole school and college community, including parents, of the positive impact that effective education on sex and relationships and alcohol can have on children's and young people's health and wellbeing. Explain that it helps them to understand the risks and consequences of their actions and to gain the knowledge and skills they need to be healthy and safe. Emphasise that it can help to increase educational attainment.

- Assess the need for, and existing provision of, education about sex and relationships and alcohol within PSHE education. This should be carried out as part of the joint strategic needs assessment which informs the local children and young people's plan. Pay particular attention to children and young people who may not be in regular contact with education, health and social services. This includes, for example, looked-after children and young people and those who are (or whose families are) homeless, travellers or asylum seekers. In addition, children and young people from certain black and minority ethnic communities may have particular needs.

- Ensure all children and young people are taught effectively about sex and relationships and alcohol. This should take place within a planned programme of PSHE education in schools, special schools, pupil referral units and colleges. It should start in primary school and continue through all the key stages of their educational career, until early adulthood.

- Provide information, advice and support so that young people's services and community-based organisations can offer children and young people the opportunity to learn about sex and relationships and alcohol in a way that will contribute to their personal and social development. The information, advice and support should be consistent with PSHE education provided in schools and colleges.

- Commissioners and managers of young people's services should ensure groups of children and young people with particular needs receive good quality education about sex and relationships and alcohol, consistent with PSHE education provided in schools and colleges. Groups with particular needs could include children and young people with physical, learning or communication difficulties, those who do not attend school or college regularly, those from families whose first language is not English, those from certain black and minority ethnic groups, those who are coping with difficult circumstances (for example, young carers), and young people who are lesbian, gay, bisexual or transgender. Education should promote tolerance and understanding of diversity.

- Commissioners, educators, parents and local voluntary and community groups should be aware that research evidence does not support use of an approach to sex and relationships education that only teaches abstinence. Evidence shows that this does not help prevent the initiation of sex, or reduce the frequency of intercourse or the number of partners a young person may have. Rather, such an approach may increase early sexual activity and its consequent risks.

Recommendation 2 Involving parents

Who should take action?

- School and college governors, head teachers, college principals, teachers, college lecturers and tutors.
- Faith and cultural organisations and other voluntary and community groups.
- Nurses working in schools and colleges and other professionals who contribute to PSHE education.

What action should they take?

- Ensure pupils, students and parents help to develop school or college policies on sex and relationships, alcohol and other personal, social and health issues, such as homophobic bullying.
- Provide parents with information and practical support to help them develop the confidence to talk to their children about emotions, relationships, parts of the body, sexual health and alcohol.
- Explain to parents that sex and relationships education helps children and young people understand their own physical and emotional development. Also explain that, combined with education on the effects of alcohol, it helps them to take increasing responsibility as they get older for their health and wellbeing and that of others. This includes giving them the skills and confidence to know when and how to seek advice and help from health services.

- Reassure parents that sex and relationships education does not promote early sex, increase rates of sexual activity or increase the likelihood of sexual experimentation. Rather, it helps children and young people to resist pressure to get involved in activities that might damage their health. It also gives them the skills and confidence to delay sex until they are ready to enjoy a responsible and mutually loving relationship.

- Offer parents the opportunity to attend a course in parenting strategies and effective communication skills in relation to sex and relationships and alcohol. This should include advice on how to help their children develop communication, decision-making and negotiation skills. Provide them with ongoing support throughout the programme, and tell them where they can get support after the programme has ended.

Recommendation 3 Planning

Who should take action?

- All those involved in the design and planning of PSHE education in schools, special schools, sixth form and further education colleges, pupil referral units, young offender institutes and secure accommodation for young people.

- School and college governors, head teachers, college principals, teachers, lecturers and tutors.

- Local and regional coordinators of the Healthy Schools programme.

- PSHE education coordinators and advisers.

What action should they take?

- Consult and involve the whole school and college community in the development of a comprehensive and complementary curriculum on sex and relationships and alcohol. This should be integrated within a planned programme of PSHE education.

- Schools and colleges should obtain advice and support to inform the development of a comprehensive and up-to-date programme of education about sex and relationships and alcohol within PSHE education that meets the needs of all pupils and students. They should obtain this advice from heads of children and young people's services, drug and alcohol action teams and teenage pregnancy and sexual health advisers in local authorities and PCTs.

- Ensure teaching and non-teaching staff, pupils and students, school and college governors and parents support the programme and that it is consistent with the school or college's ethos and values.

- All PSHE education coordinators and advisers, head teachers, college principals and school and college governors should work together to ensure continuity and progression between key stages of the PSHE education curriculum. This is particularly important during the transitions from primary to secondary school, and from secondary school to college.

- Link the PSHE education plans on sex and relationships and alcohol with health services in schools and colleges and the wider community. Also anticipate and develop links with other areas of PSHE education (for example, emotional health) and encourage consistent links with other subjects across the wider curriculum.

- Head teachers and college principals should designate a lead teacher or lecturer with responsibility for planning and coordinating 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 or the Healthy College initiative.

- Ensure education about sex and relationships and alcohol starts in primary school. Topics should be introduced and covered in a way that is appropriate to the maturity of pupils and is based on an understanding of their needs and is sensitive to diverse cultural, faith and family perspectives. The lead teacher or lecturer should coordinate the design of

a scheme of work that is developmental and allows topics to be expanded and revisited in subsequent years, in secondary school and college.

- Allocate discrete time for teaching PSHE education so that planned and assessed learning can take place. 'Drop-down' or occasional themed days are not effective when used in isolation but may enhance planned and timetabled provision.

- Find practical ways of including young people who may be experiencing difficulties (for example, bullying) or who are unhappy in their relationships with peers and adults at school or college, as part of a whole-school and inclusive approach to improving wellbeing.

Recommendation 4 Achieving PSHE education objectives

Who should take action?

All those involved in the planning, provision and teaching of PSHE education including:

- PSHE education coordinators and leads, teachers, college lecturers and tutors
- 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 primary school children to develop and sustain relationships and friendships. Ensure they understand the importance of valuing and having respect for others, as this will provide a foundation for later teaching about alcohol, sex and relationships.

- Increase children and young people's knowledge and understanding of their social, emotional and physical development, and self-respect and empathy for others.

- Enable children and young people to identify and manage risks, recognise and avoid exploitation and abuse, and make and carry out decisions. Give them the confidence to make responsible, healthy and safe choices.

- Cover a broad range of topics in a way that is factually accurate, unbiased and non-judgmental. Teaching should help pupils and students to distinguish between facts and opinions.

- Introduce topics (for example, homophobic bullying) in a timely manner, based on an understanding of pupil's needs and in consultation with parents. Teaching should be appropriate to children and young people's maturity and experience. Education about sex and relationships is more effective if it is introduced before young people first have sex.

- Promote awareness of and sensitivity to diverse faith and cultural beliefs, and encourage understanding of different beliefs and practices, for example, in relation to alcohol use, sexual orientation and abortion. Discrimination and prejudice should be discussed and challenged.

- Offer children and young people with particular needs personalised help to learn about sex and relationships and alcohol. This could include tailoring information to meet their particular needs.

- Help children and young people to develop negotiation skills, to understand their rights and responsibilities – to themselves and others – and to understand what 'consent' means. This includes learning how to resist pressure to do things they are not comfortable with – and that it is wrong to put pressure on others to do something they don't want to do.

- Use up-to-date, high-quality, age-appropriate and factually correct resources that help to develop children and young people's personal, emotional and social skills and that support active and participatory learning styles. Resources should be flexible enough to meet the needs of different children and young people and reflect the realities of their lives. For example, they may refer to social networking websites. They should

also address developmental risk factors that could lead to misuse of alcohol or risky sexual behaviour.

- Teaching should be coordinated with, and supported by, confidential and welcoming young people's health and advisory services.

Recommendation 5 Support for PSHE education

Who should take action?

- Directors of public health and specialists in public health observatories and PCTs.

- Heads of children's services in local authorities, children's trusts and children and young people's strategic partnerships.

- Head teachers, PSHE education coordinators and lead teachers, college principals and lecturers, and local and regional coordinators of the Healthy Schools programme.

- PSHE education advisers, drug and alcohol advisers, teenage pregnancy and sexual health advisers in local authorities and PCTs and nurses in schools and colleges

What action should they take?

- Public health directors and specialists in public health observatories and PCTs should offer PSHE education coordinators and lead teachers relevant local information on, for example, rates of under-18 conceptions and alcohol-related injuries. They should also help them to interpret local data so that they can develop a PSHE education curriculum that reflects local circumstances and helps meet local needs.

- PSHE education advisers and coordinators and public health specialists should offer training days, resources and opportunities to network and share good practice.

- Public health specialists, nurses in schools and colleges and PSHE education advisers and coordinators should provide accurate, up-to-date

and unbiased information about the sexual health and alcohol services available to young people. This includes explaining that these services provide free, confidential and non-judgmental information, advice and support and, if needed, testing and treatment, without the need for an appointment[3].

- Teachers and lecturers should plan and manage the contribution made by members of external organisations and ensure it conforms to the school or college policy on PSHE education, and is consistent with the objectives of the PSHE education programme as a whole.

Recommendation 6 External contributors and visitors to schools and colleges

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 PCTs, nurses and counsellors in schools and colleges.

- Faith and cultural organisations and other voluntary and community groups.

What action should they take?

- Teachers and lecturers should encourage and support health professionals, members of other agencies (for example, specialist alcohol advisers) and members of local community groups (such as faith or cultural organisations) to contribute to the teaching of PSHE education. This may

[3] For more details about contraceptive services see 'Contraceptive services for socially disadvantaged young people' (NICE public health guidance – publication expected October 2010).
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
Department of Health (2009) Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical officer. London: Department of Health

include working with children and young people by providing information on and explaining beliefs about sex and relationships and alcohol, and encouraging discussions.

- Ensure external contributors have the skills and confidence to handle questions. Before they start, agree boundaries on any personal questions that may arise during their sessions.

- Teachers and lecturers should always be present to monitor and evaluate the contribution made by health professionals and members of external organisations. Individuals and representatives of external organisations should always conform to the school or college policy on PSHE education and their contribution must be consistent with the objectives of the PSHE education programme.

- Head teachers, PSHE education coordinators and lead teachers and college principals and lecturers should ensure that everyone who contributes to PSHE education (including sex and relationships and alcohol education) in schools, colleges and the community is confident and competent. Where possible, they should have received accredited training which covers a wide range of strategies and approaches, including interactive and participatory techniques (see recommendations 7 and 8). Those who should receive training include, for example, nurses in schools and colleges and Connexions personal advisers.

- Nurses in schools and colleges and counsellors who work with children and young people on an individual basis (for example, by providing school-based or college-based sexual health advisory services) should conform to health service consent and confidentiality guidance[4]. All young people should be made aware that one-to-one consultations with health professionals and counsellors in school or college will be confidential unless there are serious professional concerns about their safety, health or welfare.

[4] Department of Health (2009) Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical officer. London: Department of Health

Recommendation 7 Trained teachers and lecturers

Who should take action?

All those involved in the planning, provision and teaching of PSHE education including:

- school and college governors, head teachers and college principals
- PSHE education coordinators and leads, teachers, college lecturers and tutors
- directors and managers of local authorities, PCTs and children's services.

What action should they take?

- Ensure all teachers, lecturers and tutors who are willing to teach about sex and relationships and alcohol have received accredited training. They should have the skills and competence to fulfil the role and the support they need to improve their knowledge and teaching skills (see recommendation 9).

- Ensure PSHE education is only taught by those who have received accredited training. Non-teaching staff, teaching assistants, counsellors and personal tutors who have not received this training may provide support. They can advise students on how to obtain specialist confidential advice on sex and relationships and alcohol, but they should not be expected to teach these topics.

- Provide all those teaching, or contributing to, PSHE education with the time and resources to receive accredited training. Encourage staff who have received training to share the lessons they have learnt with colleagues. Offer support as they apply their new skills and enable them to evaluate the impact of the training on their own teaching.

Recommendation 8 Teaching approaches

Who should take action?

- All those involved in the planning and teaching of PSHE education in schools, special schools, sixth form and further education colleges, pupil referral units, young offender institutes and secure accommodation for young people.

What action should they take?

- Use a range of evidence-based teaching methods to suit different learning styles, including skills-based programmes, interactive techniques, and combined school- or college-based and family-based learning opportunities.

- Set clear health goals – for example, to prevent sexually transmitted infections (STIs), delay the start of alcohol use or prevent homophobic bullying. Be clear about the specific behaviour needed to achieve these goals (for example, using condoms and reducing the number of sexual partners to prevent STIs, or reducing alcohol consumption to prevent alcohol-related injuries).

- Build on existing knowledge and provide information that helps children and young people to develop their knowledge, understanding, attitudes and skills and to appreciate the benefits of responsible, healthy and safe choices. Include information about alcohol and sexual health that:

    - clarifies misconceptions about the use of alcohol, contraception and the prevention of STIs
    - increases children and young people's understanding of the short-term and long-term effects of alcohol on physical and mental health and on sexual behaviour

  - explains the right to say no, including advice that not drinking alcohol is the safest and healthiest option for children and young people[5]
  - explains the responsibility not to put others under pressure to drink alcohol or engage in sexual activity before they are ready
  - explains rules and laws relating to alcohol use and to sex and relationships, such as consent and confidentiality
  - increases children's and young people's knowledge of where to get confidential advice and support.

- Provide combined school- and family-based learning opportunities that have been shown to improve school achievement 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 school of topics that have been discussed at home
  - setting homework that encourages dialogue between parents and their children
  - lending books and teaching resources to parents and carers.

- Adopt active learning techniques that build on pupils' and students' existing knowledge, encourage them to explore their attitudes and allow them to practise their personal and social skills. (This could include, for example, working in pairs and small groups to reach a consensus on a particular issue and to provide shared feedback to the rest of the class.) Include activities that they can do with their parents and family. This might include preparing questions for a visitor to the class, such as a teenage parent.

[5] Department of Health (2009) Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical officer. London: Department of Health

Recommendation 9 Training

Who should take action?

- Higher education institutions.
- School Centred Initial Teacher Training (SCITT) providers.
- Universities Council for the Education of Teachers (UCET).
- Training and Development Agency (TDA) for schools.
- Children's Workforce Development Council (CWDC).
- Other training agencies that provide initial teacher training and support for continuing professional development for teachers and other professionals.

What action should they take?

- Provide specialist accredited training for PSHE education as part of initial teacher training. This includes sex and relationships and alcohol education.
- Improve the quality of continuing professional development in PSHE education, including sex and relationships and alcohol education. Ensure teachers, lecturers and tutors, health professionals, young people's practitioners (such as youth workers) and those who work with parents and carers have access to continuing professional development.
- Ensure training enables teachers, lecturers and tutors in schools, colleges and the wider community to:
    - conduct a needs analysis to inform curriculum content 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 and carers, community groups including faith 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 act as peer educators, contingent on the provision and uptake of training and support for the students involved.

Recommendation 10 Community-based education on sexual health and relationships and alcohol

Whose health will benefit?

All children and young people, including those:

- who are looked after or leaving care
- who have physical or learning disabilities
- from specific faith, cultural or ethnic groups
- who are homeless or are asylum seekers
- who are lesbian, gay, bisexual or transgender
- who are not in education, employment or training
- who are at risk of exclusion from school or college.

Who should take action?

- Commissioners of children's services, children's trusts and local authority services.

- Social workers and family support workers and all those providing support for parents and carers in children's services, health services, local authorities and voluntary sector organisations. This includes those developing training for parents, as well as youth workers, drugs and alcohol advisers, sexual health advisers and counsellors, and Connexions personal advisers.

What action should they take?

- Commission community-based education about sexual health, relationships and alcohol for groups of young people who may have missed some of their school- and college-based education, or who did not feel it met their needs. Groups could include both those who are already sexually active and those who are not.

- Provide community-based programmes of sex and relationships and alcohol education for parents and their children (rather than just for parents). These should start before the child reaches 13, because it is important to establish strong communication in the early years of a child's life. Programmes should reflect the principles set out in recommendations 1, 2 and 3.

Recommendation 11 Children and young people who are at risk

Whose health will benefit?

Children and young people who are involved in risk-taking behaviours. This includes those who:

- binge-drink alcohol, regularly get drunk or have behaved in an antisocial manner as a result of drinking alcohol
- have had a number of sexual partners
- have experienced physical or sexual abuse or violence.

Who should take action?

- GPs, nurses, drugs and alcohol advisers and sexual health advisers.

- PSHE education coordinators and leads, teachers, college lecturers and tutors, nurses in schools and colleges, counsellors and health advisers, and others who may help to teach PSHE education.

- Youth workers, social care and educational welfare officers, including those working with socially disadvantaged young people.

- Teachers in pupil referral units and those working with youth offenders.
- School and college governors, head teachers and college principals.
- Community and voluntary organisations that work with and support socially disadvantaged young people, including those who are homeless or who are asylum seekers.

What action should they take?

- Ensure vulnerable children and young people receive PSHE education (including education on sex and relationships and alcohol). This should include individually tailored information and advice. It should also include help to identify and manage risks and make responsible, healthy and safe choices.
- Base alcohol advice on the Chief Medical Officer's recommendations on drinking[6] and inform children and young people about the potential harms associated with early alcohol use and binge-drinking. Also point to the links between alcohol use and risky sexual behaviours (such as regretted sex or not using a condom).
- Use every opportunity to inform children and young people about specialist services where they can get personalised advice and support.

The PDG considers that all the recommended measures are likely to be cost effective.

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

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 opportunities and

[6] Department of Health (2009) Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical officer. London: Department of Health

experiences. It equips children and young people with the knowledge and practical skills to live healthy, safe, capable and responsible lives and to grow and 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 PSHE education to help meet their statutory obligations to promote both the wellbeing of pupils and community cohesion, and to provide sex and relationships and drugs and alcohol education.

Pupils' needs have not always been sufficiently identified or addressed within PSHE education and some sensitive issues, including sex and relationships education (SRE), are not taught well (Ofsted 2007). In a national survey, 40% of young people rated the SRE they had received as 'poor' or 'very poor' (UK Youth Parliament 2007). Expert reports on SRE and on drugs and alcohol education agree that these topics are given insufficient priority (Department for Children Schools and Families 2008a; 2008b).

In primary schools PSHE education consists of the non-statutory personal social and health education with citizenship framework, at key stages 1 and 2. The secondary school programmes of study for PSHE education at key stages 3 and 4 are also non-statutory. However, some biological aspects of SRE and alcohol education form part of the statutory national curriculum programmes of study in science and are taught in all secondary schools (Qualifications and Curriculum Authority 2007).

In addition, schools are required to have an up-to-date policy that describes how SRE is provided outside the National Curriculum Science Order. This should be available for parents to inspect. Schools are also expected to have a drug policy that includes alcohol and which states how the school will manage all drug-related matters.

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

Despite an increase in participation in education and training, the proportion of young people aged 16–18 not in education, employment or training in 2008 was 10% (Department for Children, Schools and Families 2009a). This group may experience greater difficulties accessing sex and relationships and alcohol education.

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 familiarise young people with local services, including sexual health services.

A mapping survey of further education provision of sexual health services showed that most (72%) further education and sixth form colleges provide some level of on-site student services, but provision varies between and within regions (Emmerson 2008). Inequality of access to services is apparent. 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 over half of young men aged 15–18 years (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 of them do so (Ofsted 2002). Recent inspection evidence suggests that many schools are consulting with parents as part of reviewing or developing their SRE programme and this reduces the likelihood of parental withdrawal (Macdonald 2009)

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

Since the government's teenage pregnancy strategy began in 1998 the national under-18 conception rate has fallen by 13% and there has been a 23% decrease in the under-18 birth rate (Office for National Statistics 2010). Although rates have dropped, England's teenage pregnancy rate remains one of the highest in western Europe, with over 40,000 conceptions for under 18s in England and Wales in 2008 (Office for National Statistics 2010). Furthermore, 20% of under-18 conceptions are repeat pregnancies (Teenage Pregnancy Independent Advisory Group 2009).

About half of under-18 conceptions end in abortion, demonstrating that many of these pregnancies are unwanted (Department for Children, Schools and Families 2010b).

There is a link between alcohol consumption and teenage conceptions. The conception rate in girls aged 15–17 years in electoral wards with the highest levels of alcohol-related hospital admissions was 41 per 1000, compared with 34 per 1000 in wards with the lowest levels of alcohol-related hospital admissions, when deprivation was controlled for in the analyses (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) (Department for Children, Schools and Families 2010c). 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 years (drinking, even at age 15 or older, can be hazardous to health). If young people aged 15–17 years 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).

Although the proportion of young people between 11 and 15 years reporting they have never drunk alcohol has risen from 39% in 2003 to 48% in 2008, those who do drink seem to drink more. Between 2007 and 2008 mean alcohol consumption among young people aged 11–15 who drank in the last week increased from 12.7 units to 14.6 units (Fuller 2009). Of those who drank in the last week, 55% had done so on 1 day only, which when considered with the amounts drunk suggests that they are binge drinking (Fuller 2009). The proportion who 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 last 4 weeks, 28% of those aged 11–12 and 63% of those aged 15 reported having been drunk in the last 4 weeks. In addition, 12% of drinkers aged 11–12 and 42% of drinkers aged 15 reported having deliberately tried to get drunk in the last 4 weeks (Donaldson 2009).

A survey of nearly 10,000 young drinkers aged 15–16 years 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 Personal, social, health and economic (PSHE) education aims to equip children and young people with the knowledge, understanding and practical skills to deal with real-life issues they face in their lives both now and in the future as they move through puberty and adolescence and into adulthood.

3.2 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 the same way. Effective teachers of PSHE education monitor the progress of every pupil and student, take into account their varied circumstances, experiences and needs, and offer them personalised learning opportunities.

3.3 Providing PSHE education for children and young people with particular needs (for example, those in care, with disabilities, from faith groups, from black and minority ethnic communities, or who are lesbian, gay, bisexual or transgender) was not addressed in the evidence reviews. However, the PDG's view was that the formal PSHE education curriculum should be augmented by specialist provision for children and young people who have particular needs.

3.4 As they grow up young people extend their relationships beyond their immediate family and friends and begin to explore their own sexual identity. This is a normal part of human development.

3.5 A planned programme of sex and relationships education (SRE) that includes information and opportunities for discussion about sexual health, sexually transmitted infections, methods of contraception, pregnancy and abortion can help children and young people to delay sexual activity until they are ready. It does not cause them to have sex at an earlier age, or to have more sex, or sex with more partners, and nor does it increase the number of unwanted or teenage conceptions and abortions.

3.6 The PDG noted that an overemphasis on concerns about 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.

3.7 Social attitudes towards alcohol and the age at which most people would find it socially acceptable for young people to begin to drink small quantities of alcohol vary. However, the Chief Medical Officer's advice, based on medical evidence of the impact of alcohol on brain and physical development, means there is no safe level of drinking for those under 18 years.

3.8 Most adults drink alcohol, and in the UK it can be legally purchased by anyone over 18 years. Images of, and references to, alcohol and its consumption are pervasive. However, much of the research evidence comes from the USA, where the social context is different. 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.

3.9 An early introduction to education about sex and relationships is sometimes believed to 'destroy children's innocence'. However, children and young people are exposed to sexual imagery in the media and advertising, which can give them a distorted view of sex,

relationships and sexuality without any consideration of possible outcomes such as sexually transmitted infections and unwanted pregnancy. A trained and confident teacher will work with parents to give children and young people appropriate and accurate information to help them make sense of the imagery that surrounds them.

3.10 Exposure to graphic sexual images and sexually explicit language and content on the internet and TV and in films, magazines and pornography can result in children and young people forming inaccurate views and negatively influence their expectations about sexual behaviour and relationships. 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.

Role of parents

3.11 Parents are children's 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. Children's attitudes to alcohol consumption and to relationships are often formed in early childhood within the family.

3.12 Although most parents wish to communicate with their children about sex and alcohol and drug use, they often feel ill-equipped to do so, and value support and information that increases their confidence and knowledge.

3.13 Most schools recognise that good communication with parents about the provision of PSHE education is important, to ensure accurate information is provided that is consistent between home and school. They may not be aware that PSHE education which also involves the family can have a positive impact on primary school children's attitudes to school and on their attainment. The PDG considered that

this would also apply to children and young people in secondary schools and colleges. 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. It is likely to decrease for older age groups and in more informal community settings (for example, youth clubs).

3.14 The views of parents about what constitutes education that is relevant to their children's age and maturity will differ. Parents may want schools to introduce sensitive topics earlier than some teachers might assume. Children are likely to want information earlier than their parents might consider appropriate.

Schools and colleges

3.15 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.

3.16 Children and young people acquire information and develop their values and attitudes from what they see around them in their families and communities and in the media. Schools and colleges will vary in the way they recognise and respond to the realities of children's and young people's lives and the values of the different ethnic and faith groups within their community.

3.17 Schools and colleges will have their own values and ethos within which SRE and alcohol education is provided. 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 perspectives and the religious, secular and cultural perspectives on different behaviours.

3.18 The mix of full time and part time students at further education colleges poses challenges for the teaching of PSHE 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.

3.19 For some children and young people, school or college provides an environment in which they have contact with trusted adults and where they can feel safe. Both teaching and non-teaching staff might be unaware of their potential effect as role models and mentors for these children and young people.

3.20 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-based 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.

Education programmes

3.21 Many of the educational programmes reviewed were short and the follow-up period to access outcomes was often limited. 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.

3.22 Adherence to all aspects of an educational programme that has been shown to be effective is important if the expected outcomes are to be achieved. 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 documented and outcomes assessed. Using exercises from several

programmes or initiatives brought together in an untested format is unlikely to have positive outcomes.

3.23 As children and young people grow and develop their educational needs develop too. Therefore, a progressive and developmental curriculum is required throughout their school and college career to ensure that their PSHE education keeps pace with their development.

3.24 The PDG recognised that short-, medium- and long-term effects of an educational programme can all be of value. For example, a short-term reduction in alcohol consumption may lead to a reduction in alcohol-related injuries.

Needs of children and young people

3.25 Different children and young people may prefer different settings and types of initiatives for their SRE and alcohol education. Some children and young people prefer community and informal settings rather than the classroom. Those who attend the former do so voluntarily and may have different characteristics from those in school or college, which are likely to be compulsory.

3.26 There may be children and young people with particular needs, for example those in care, with disabilities, from faith groups, from black and minority ethnic communities, or who are lesbian, gay, bisexual or transgender. They may want to have at least part of their education in less traditional settings and from educators who have more experience of their particular needs. There was little evidence about most of these groups, or about children and young people who are excluded from school or college, and the PDG members drew on their experience when making recommendations.

Limitations of the evidence

3.27 Most of the evidence is from the USA, based on evaluations of identified educational programmes. These studies provided little information about teaching methods. The evidence generally lacked

detail about comparators, which were referred to as ‘usual practice’. The PDG was aware that this could potentially affect applicability to the UK, but considered that the evidence was sufficiently applicable to the UK context to inform the recommendations.

3.28 Effective programmes tended to be based on theory, but there was no evidence to support valuing one theory over another.

3.29 Few of the studies of educational programmes, interventions and activities 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. Most studies focused on changes in knowledge and attitudes, or the development of personal and social skills. In general, outcome measures were not clearly specified.

3.30 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.

3.31 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 necessary to gain those benefits, or else the resources used were known but not the level of benefits. For that reason, a method called ‘threshold analysis’ was used. In this method, the level of resources is given and the size of the effect needed for the intervention to be cost effective is estimated. The PDG considered whether an effect size of that amount or more would be attained in each scenario modelled.

3.32 Where 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 'Operating framework for 2008/09' and 'Operational plans 2008/09–2010/11'.
- NHS organisations, social care and children's services meet the requirements of the Department of Communities and Local Government's 'The new performance framework for local authorities and local authority partnerships'.
- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.
- Local authorities fulfil their remit to promote the economic, social and environmental 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 multi-sector partnerships for health, such as local strategic partnerships.

NICE will develop tools to help organisations put this guidance into practice. Details will be available on our website after the guidance has been issued (www.nice.org.uk/guidance/PHxx).

5 Recommendations for research

This section will be completed in the final document.

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

6 Updating the recommendations

This section will be completed in the final document.

7 Related NICE guidance

Published

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

School-based interventions on alcohol. NICE public health guidance 7 (2007). Available from www.nice.org.uk/guidance/PH7

Interventions to reduce substance misuse among vulnerable young people. NICE public health guidance 4 (2007). Available from www.nice.org.uk/guidance/PH4

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

Under development

Contraceptive services for socially disadvantaged young people. NICE public health guidance (publication expected October 2010)

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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.

Tariq Ahmed Project Director, Brent Education Action Zone

Professor Mark Bellis Director, Centre for Public Health, Liverpool John Moores University

Dr Kate Birch Healthy College Co-ordinator/Student Welfare Adviser, Huddersfield New College & NHS Kirklees

Simon Blake Chief Executive, Brook

Jonathan Cooper Teacher Advisor PSHE and Citizenship, Wakefield Family Services

Laura Cottey Young Person Representative, Community Member

Aylssa Cowell Manager, Streetwise Young People's Project

Kathryn Cross Sexual Health Nurse, Lewisham PCT

Chris Gibbons Senior Education Officer, Stonewall

Richard Ives Education Consultant, *educari*

Professor Anne Ludbrook Professor of Health Economics, University of Aberdeen

Anna Martinez Co-ordinator Sex Education Forum, National Children's Bureau

Colleen McLaughlin Senior Lecturer, University of Cambridge, Faculty of Education

Jasmin Mitchell Community Member

Tracey Phillips Policy Consultant and School Governor, Community Member

Terri Ryland Director of Practice Development, Family Planning Association

Clare Smith PSHE Advisor, Southwark Children's Services

Anne Weyman OBE LLD (Hon) (Chair)

Co-opted member

Paula Pearce Teacher and subject leader for PSHE at Rockingham Primary School, Corby, (one meeting)

Expert testimony

Douglas Kirby Senior Research Scientist, ETR Associates

NICE project team

Mike Kelly CPHE Director

Tricia Younger Associate Director

Hilary Chatterton Lead Analyst

Louise Millward Analyst

Peter Shearn Analyst

Una Canning Analyst

Alastair Fischer Technical Adviser, Health Economics.

Rachael Paterson and **Sue Jelley** Senior Editors

Alison Lake Editor

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)’ was 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)’ was carried out by the National Collaborating Centre for Women and Children's Health. The principal authors were: Leo Nherera and Paul Jacklin

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.

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 http://guidance.nice.org.uk/PHG/Wave12/77

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

Three 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 against a no intervention control or against 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.

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

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

- In terms of analyses, very few studies reported that an intention-to-treat analysis had been conducted, 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.

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).

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.
- 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.

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: http://guidance.nice.org.uk/PHG/Wave12/77

Fieldwork

This section will be completed in the final document.

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).

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 three 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. **EP1** indicates that expert paper number 1 is linked to the recommendation.

The reviews, expert reports and economic analysis are available at http://guidance.nice.org.uk/PHG/Wave12/77

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, 2.8a, 2.8b, 2.8c, 2.10c, 2.14, 3.1, 4.3; EP1, EP3

Recommendation 2: evidence statements 2.8b, 2.9d, 2.10c, 3.1, 3.3c, 3.6, 3.15b, 4.3

Recommendation 3: evidence statements 1.6a, 1.6b, 1.6c, 1.6d, 2.8c, 2.9d, 2.9e, 3.9a; EP2; EP3

Recommendation 4: evidence statements 1.6a, 1.6b, 1.6c, 1.6d, 2.7, 2.9a, 2.12c, 2.14, 3.8f; EP3

Recommendation 5: evidence statements 2.8c, 3.9a, 2.14, IDE

Recommendation 6: evidence statements 2.8c, 3.9a, 3.9b, 3.9f, 4.2

Recommendation 7: evidence statements 2.8b, 2.8c, 3.7b

Recommendation 8: evidence statements 1.1, 1.6a, 1.6b, 1.6c, 1.6d, 2.2a, 2.2e, 2.12a, 2.12c, 3.7b, 3.9f, 4.2, 4.7; EP1, EP2

Recommendation 9: evidence statements 2.8b, 4.2; IDE

Recommendation 10: evidence statements 2.14, 3.1, 3.3b, 3.3c, 3.3d, 3.4b, 3.6, 3.7a, 3.7b, 3.7c, 3.8a, 3.8d, 3.10a, 3.11a, 3.11e, 3.15b, 4.3

Recommendation 11: evidence statements 2.2d, 2.2e, 2.3f, 2.8b, 2.9d, 2.9e, 2.12a, 2,12c, 2.12e, 3.7c, 3.8f, 3.9a, 3.9b, 3.9f

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 trials (RCT) (+), three non-randomised controlled trials (NRCTs) (+) and one case control study (CSS) (+) to suggest that programmes, which target social development and combine school and family-based components, may positively impact on 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 generalisible 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, which 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 generalisible beyond the populations studied.

Evidence statement 1.6c

There is moderate evidence from three NRCTs (+) to suggest that a social development programme, which combined 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 generalisible 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 of 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 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 2.2a

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 as studies were implemented within Australia, Germany and the USA and may not be generalisable 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 as this study was conducted in Australia and may not be generalisable 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 as studies were implemented outside the UK and may not be generalisable 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 as studies were implemented in Spain and the USA and may not be generalisable beyond the populations studied.

Evidence statement 2.7

There is inconsistent evidence from two economic evaluation studies to determine the cost-effectiveness of school-based interventions that aim to prevent or reduce alcohol use in young people under 18 years old. This evidence may be of limited applicability to a UK context because cost and benefit estimates were based on data from studies conducted in the USA.

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: (1) a theoretical basis; (2) use of trained adult health educators as providers; and (3) 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 STIs 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 as 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 as the studies were conducted in the UK.

Evidence statement 2.9e

There is mixed evidence from three RCTs (all [++]) on the effects of comprehensive SRE programmes on outcomes relating to pregnancy. There is moderate evidence from one RCT (++) of the peer-led RIPPLE programme to suggest that this programme may reduce rates of teenage pregnancy, but not abortion, in the long-term, and strong evidence from one RCT (++) of the teacher-led SHARE programme to suggest that this programme has no long-term effects on rates of conception or termination. This evidence is directly applicable as 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 as five of the studies were conducted in the USA, one in Italy and one in the Netherlands, and they may not be generalisable 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 as the studies were carried out in the USA and Italy, and may not be generalisable 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 as studies were carried out in the USA, Norway, and Sweden, and may not be generalisable 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 (ISFP), 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 generalisable beyond the populations studied.

Evidence statement 3.3c

There is moderate evidence from two RCTs (+) to suggest that programmes delivered to families which 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 as all the studies were conducted in the USA and may not be generalisable beyond the populations studied.

Evidence statement 3.3d

There is moderate evidence from 11 RCTs (seven [+], four [−]) to suggest that programmes delivered to families may have mixed effects on health outcomes related to alcohol use. Three RCTs (one [+], two [−]) showed no effects of the intervention on alcohol use. One RCT (+) of a brief, family-focused intervention (Iowa Strengthening Families Program) showed long-term reductions in alcohol use, initiation of alcohol use and drunkenness, and one RCT (+) of a culturally tailored family-based programme showed a long-term effect on initiation of alcohol use. In addition, one RCT (+) of a CD-ROM intervention with parental involvement showed long-term reductions in monthly alcohol use. Findings may be only partially applicable to the UK as all the studies were conducted in the USA and may not be generalisable 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 as they were not

implemented in a UK setting and may not be generalisable 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: (1) theoretically based; (2) tailored to the target population; (3) implemented by trained facilitators; (4) based on diverse content; and (5) 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: (1) a focus on a single gender or ethnic group; (2) HIV and STI education with skills building activities (for example, condom application); (3) condom negotiation and sexual communication components; and (4) 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 females, 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 as all the studies were conducted in the USA and may not be generalisable 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 as 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 as 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 as 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, as their formal sex education did not meet their needs or address their realities.

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 were 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.

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'.

Cost-effectiveness evidence

The cost effectiveness evidence was very limited.

However, the reviews showed that programmes delivered to families to reduce alcohol misuse can be cost effective and cost saving when compared with a minimal intervention approach – and when considered from a societal perspective. (The programmes considered were the Iowa Strengthening Families Programme and Preparing for Drug Free Years.)

The cost-effectiveness evidence for alcohol education delivered in schools was inconsistent.

It was suggested that Safer Choices, an abstinence-plus, school-based sex and relationships (SRE) programme, may be cost effective and possibly cost saving in comparison with a standard, knowledge-based HIV curriculum.

Costs and consequences were considered from a health and societal perspective.

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 the long-term adverse health outcomes associated with alcohol consumption.

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 about 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 only continued for 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 topics 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.

Appendix E Supporting documents

Supporting documents are available at http://guidance.nice.org.uk/PHG/Wave12/77. 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'.

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