

Alcohol and sexual health in young people: the role of PSHE

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ABSTRACT

This paper explores the relationship between sexual health and alcohol in young people in contemporary society, and the role of personal, social and health and economic education (PSHE). This research was prompted by the decision of the Department of Health (DH) not to publish National Institute for Health and Care Excellence (NICE) guidance on PSHE in January 2011. The guidance was requested following a Department for Education internal review into PSHE education. This paper will review qualitative and quantitative research, and data pertaining to the issue of sexual health behaviour and alcohol use among young people in the UK and the role of PSHE education. NICE guidance remains the 'gold standard' for evidence-based healthcare service provision and its implications for sexually transmitted infection and teenage pregnancy rates remains a high priority. Equally, research supports that addressing the issue of alcohol is an increasing priority in young people. This paper will argue that the NICE PSHE review findings should be updated, published and implemented.

KEY WORDS

National Institute for Health and Care Excellence, sexual health, alcohol, young people, PSHE

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Introduction

In November 2010 the National Institute for Health and Care Excellence (NICE) produced evidence-based guidance on school, college and community-based personal, social and health and economics (PSHE) education, including 'health literacy, with particular reference to sexual health behaviour and alcohol' (NICE, 2010: 12).

The guidance was requested by the Department of Health (DH) following a Department for Education (DfE) internal review into PSHE education. Final recommendations were due for publication in January 2011 but this was put on hold while Public Health England (PHE) and other services were reconfigured.

This paper will review the qualitative and quantitative research, and data pertaining to the issue of sexual health behaviour and alcohol use among young people in the UK and the role of PSHE education to argue that the NICE PSHE review findings should be updated, published and implemented.

As the 2013 Chief Medical Officer's (England) report stated, PSHE education is a subject that 'forms a bridge between education and public health' (Davies, 2013: 16).

Background

PSHE is 'a planned programme of learning opportunities and experience, which helps young people develop as individuals and members of families and communities' (PSHE Association, 2014: online). This relates directly to the *Healthy Child Programme* recommendations of access to PSHE content that includes alcohol, tobacco and other drugs, sex and relationships, individual safety and emotional health and wellbeing education' (DH, 2009). This makes PSHE the best opportunity to discuss sexual health and alcohol with young people in a group format from a personal safety and public health perspective.

The overall health, including sexual health, and wellbeing of young people is

of increasing concern in contemporary society. In the UK, children have presented with the lowest wellbeing score among the richest societies (Pickett and Wilkinson, 2007) and countries in the world (UNICEF, 2007). Research from the countries included in the Organisation for Economic Co-operation and Development (OECD) shows that the poorer the general wellbeing scores, the greater presence of risky health behaviours, including binge-drinking and teenage pregnancy (OECD, 2009).

Teenage pregnancy rates have been a public health priority for many years (Department for Education and Skills (DfES), 2006; Department for Children, Schools and Families (DCSF), 2010) and the teenage birth rate is closely correlated to the wellbeing index (Pickett and Wilkinson, 2007). In June 2013, figures from the Office for National Statistics (ONS, 2014) showed teenage pregnancies in under-18s had dropped by 12% to 6,270 when compared to 7,083 in June 2012.

According to the PHE's *Health Protection Report*, the impact of sexually transmitted infections (STIs) remains greatest in young heterosexuals under the age of 25 (PHE, 2014). Overall, numbers of diagnoses in people aged 15 to 24 have risen considerably in the last 10 years, although there has been a decline in cases of genital warts in young females (PHE, 2014).

Levels of alcohol misuse among teenagers are now a recognised public health issue (British Medical Association, 2008; Donaldson, 2009). This was most recently expressed in the government's 2012 alcohol strategy, which included the stated aim of achieving 'a sustained reduction in both the numbers of 11–15 year olds drinking alcohol and the amounts consumed' (Home Office, 2012: 8).

One of the first UK studies to demonstrate a robustly consistent association between sexual activity and alcohol was published by Phillips-Howard et al (2010). This was

followed by a Royal College of Physicians (RCP) report entitled *Alcohol and sex: a cocktail for poor sexual health* (RCP, 2011).

International research into this issue includes studies in the US by Fergusson and Lynskey (1996) and in France by Choquet and Manfredi (1992), which identified associations between alcohol consumption and early sexual activity. Other US research showed a relationship between alcohol and having multiple sexual partners (Ramisetty-Mikler et al, 2004; Cook et al, 2002) and pregnancy (Wells et al, 2004). A further US study by Miller et al (2007) showed a correlation between pregnancy and binge-drinking rates.

Phillips-Howard et al (2010) studied 3,641 school children aged 11–14 who were about to undertake a pilot scheme of sex and relationship education (SRE) across 15 secondary schools in the north west of England. They found that 33% of 11 year olds and 66% of 14 year olds had consumed alcohol, and that there was a strong association between sexual activity and alcohol use. Among 13–14 year olds, sexual activity was found to increase with the amount of alcohol consumed; if a young person was drinking alcohol more than once a week there was a 12 times greater sexual activity risk and a 10 times greater sexual intercourse risk.

The research concluded that the association between sexual activity and alcohol, and therefore sexual health risks, highlighted that public health programmes integrating the two subjects and issues were needed and also that restricting alcohol use policies might limit teenage exposure to sexual activity.

This is supported by a British Youth Council online survey that ran in 2009, entitled *Youth Experiences: Sex and Drinking*. Of the 1,000 responses received, 68% said they believed that alcohol and unprotected sex were strongly linked; 48% of the 59% who had experienced sexual intercourse said they regretted it later and 50% of those had been drinking; and almost one in five respondents would not have had sex the first time they did if they had been sober (British Youth Council, 2009).

Having reviewed the evidence base of sexual health issues related to alcohol in contemporary society it would seem there are both quantitative and qualitative data from researchers and young people themselves that support the need for a

more holistic approach to these issues as part of PSHE.

In the UK, it is illegal to sell, buy or supply alcohol to or for a person under 18, unless they are over 16 and accompanied by an adult within a licensed premises. However, it is legal for a young person under the age of 16 to consume alcohol if it is at home or some other private premises (Drinkaware, 2014). One has to question whether some young people, who are perhaps naïve to the effects of alcohol, are introduced to it as a means of encouraging and allowing abuse and exploitation.

Legal and ethical frameworks governing sexual health and alcohol

A memorandum sent in 2009 by the Family Planning Association (FPA) to UK Parliament summarised that 'there has long been concern about the links between alcohol use and poor sexual health and vulnerability to sexual assault. There is also evidence that some people 'actively use alcohol specifically to facilitate sexual activity' (Parliament Health Commons Select Committee, 2009: 1.3).

A ChildLine report (NSPCC, 2006) cites qualitative data from young people who called and used its service regarding these issues, including, *'I'm pregnant and I need your advice. I had sex when I was drunk, I don't know the father. I feel like a slag'* (Girl, aged 12) and, *'I got drunk at a party, I don't remember having sex, but my friends say I did. Now I'm pregnant'* (Girl, aged 13).

In 2004/2005 around 8% of the calls ChildLine took were from girls of 12 years and under wanting to talk about pregnancy (NSPCC, 2006). Of these, many said that their decision-making was influenced by alcohol. It would be valuable to have more up-to-date data from Childline and the NSPCC to enable us to assess if this is an ongoing issue for their callers but at present this is not available.

Similarly, a Norwegian study showed that, when moderately intoxicated, contraception was less likely to be used by young people and much less likely when strongly intoxicated (Traeen and Kvalem, 1996). Evidence from the *Annual Smoking, Drinking and Drug Use* survey (Natcen Social Research, 2013) showed that 39% of pupils aged 11 to 15 had admitted to drinking at least one alcoholic drink in their lifetime – a decline from 61% in 2003 – and 10%

reported drinking alcohol in the last week, a decrease from 25% in 2003.

Such data are encouraging; but as Professor Sir Ian Gilmore, Chair of the Alcohol Health Alliance and President of the RCP, said when responding to the NICE draft guidance, 'Putting alcohol education together with sex education is also sensible in the light of the importance of alcohol in driving early, often unplanned, sexual experience' (Wilson, 2010).

Psychosocial, cultural and political influences

The need for sex education in schools has long been recognised and was enshrined into law as part of the Education Act (2002), which states that 'the basic curriculum for every maintained school in England shall comprise a basic curriculum which includes: (c) in the case of a secondary school, provision for sex education for all registered pupils at the school, and (d) in the case of a special school, the same provision requirement (Education Act, 2002: 4).

The Education Act was updated and amended in 2011, and Section 2.3 stipulates that all state schools are required to provide SRE to secondary education students (Education Act, 2011). The Academies Act (2010) outlines statutory responsibilities pertaining to PSHE. In September 2013 the DfE published a new National Curriculum which took effect in September 2014. Its guidance document on PSHE education notes that it is 'an important and necessary part of all pupils' education' (DfE, 2013). In addition, whether or not a school has state or academy status, if PSHE lessons are observed as part of a Section 5 Ofsted inspection, the same level of teaching and learning standards are expected as in any other subject (PSHE Association, 2014).

It is estimated that one quarter to one third of all young people are sexually active before the age of 16 (Department for Education and Skills, 2007b) and that 64% of young women and 56% of young men ranked school as the preferred setting for SRE, irrespective of ethnic group (Testa and Coleman, 2006). Among members of the UK Youth Parliament, 40% rated their school's SRE provision as 'poor' or 'very poor' (UK Youth Parliament, 2007).

Alcohol education

The report from the Alcohol and Sexual Health Working Party (RCP, 2011) advised

that school-based programmes for children should have a 'psychosocial approach', where young people are taught the social skills to manage the influences leading to alcohol use and misuse. It suggests that such education should be 'knowledge based' to make those it is aimed at are aware of the consequences (Foxcroft et al, 2002).

It was felt that education about alcohol should form an 'integral' component of a PSHE curriculum. This supports the NICE qualitative research that found that young people requested education on how to minimise the influence of the media on their alcohol beliefs and behaviours (Mentor UK, 2007). The report also recommends greater use of role models and an increased understanding of how society, parents and peers affect, and influence alcohol use and misuse.

NICE felt that a whole-school approach would best support students, staff and parents. Currently, secondary school children receive sexual health and alcohol education as part of their PSHE programme, but the two subjects are taught separately. Rebecca Findlay from the FPA said that 'Healthcare professionals should also be integrating alcohol and sexual health work together and not dealing with them in isolation' (Wilson, 2010). This is something that NICE were supporting and would be a way of moving forward on these issues and their implications for sexual health.

Recommendations following a collaboration between the Sexual Health Policy Team and the Alcohol Policy Team (Sullivan, 2010) to provide a brief for the north-east region commissioners included a recommendation that any future national strategies developed through the DH, DfE and Home Office should make clear links between alcohol, sexual health, teenage pregnancy, sexual violence, community safety and domestic abuse, and should also be implemented locally.

PSHE service provision

Sex and relationships education

Sex and relationships education (SRE) is provided in all local primary and secondary schools, and the quality of teaching is reflected in the Ofsted report of that school. Some settings use their school nursing service to provide or support the school offering, while some use county council

PSHE staff. Some provide the sessions internally from existing teaching staff.

A review of sex education in English schools by the DCSF in 2008 found that SRE was not well taught, particularly by form tutors who were untrained; that it often lacked relevance for young people; and that it was not inclusive of those with disabilities or members of the gay, lesbian, bisexual and transgender community.

The review also felt that many schools did not give sufficient classroom time to developing the skills and confidence required to manage a situation where there is pressure to have unwanted sex or to have a discussion about condom use.

Finally, the report suggested that the assessment of SRE learning was poor, leaving evaluation of influence on attitudes, behaviours and knowledge difficult (Fallon, 2009).

Alcohol education

This is provided as part of the PSHE curriculum, and service provision varies within schools. Some use the school nursing service, some use the Child and Adolescent Substance Use Service (CASUS) or Addaction staff, and some provide the sessions internally from within existing teaching staff.

In Peterborough, the charity Drinksense provides training for contraceptive and sexual health (CASH) professionals to make sure that a consistent message about sexual health and alcohol are made across services (Sullivan, 2010). These services include sexual health providers, youth service, youth offending and probation. In Cambridgeshire, this is supported further within Huntingdon and St Neots, where a Drinksense worker provides sessions and appointments at the young people's clinics (Sullivan, 2010). Community staff who attend local safeguarding children's board (LSCB) training are also taught alcohol brief interventions to deliver within their drop-in clinics alongside sexual health support and education.

Data from the ONS show that, although teenage pregnancy rates under the age of 18 in the UK have fallen by 40.6% since 1998 and between the age of 15 and 17 by 10.3% the under-18 pregnancy rate remains 'one of the highest in Europe' (Community Practitioner, 2014: 5). Research by Blackman (2013: 72) also highlights

that good commissioning may not reduce teenage pregnancy rates as 'bureaucracy arising from the commissioning processes may distract healthcare staff from normal work and from focusing on outcomes'. One has to question whether the pregnancy rate and rates of sexually transmitted infections within young people, could be reduced further if alcohol was discussed alongside sex and relationships with young people raising their awareness of it as an issue.

Key findings of the NICE PSHE final draft qualitative review was that the evidence suggested that young people do not receive 'consistent, systematic information on alcohol' (NICE, 2010:5). It went on to say that young people would not seek information from teachers as they felt they 'did not care about the subject' and 'are not trustworthy'. They would seek information and advice from youth workers and school nurses because they considered them 'technically well trained' and able to offer 'confidentiality on alcohol issues' (NICE, 2010:5).

When considering SRE the young people highlighted that 'continuity in SRE classes (including remaining in the same group and/or continuity in relation to their teacher) was important as this reduced their anxiety levels and aided learning' (NICE, 2010:9). They were happy to be taught by either teaching staff or external staff as long as the lessons were 'fun and confidential' (NICE, 2010:9).

Recommendations

It is clear that the NICE guidelines need to be updated and implemented. The draft qualitative review stated that 'Young people want alcohol and sex to be dealt with in more depth in SRE lessons. They want to understand the influence of alcohol on sexual behaviours and also where to get confidential support to manage their emotions if they make a bad decision whilst drunk' (NICE, 2010: 5).

In addition, the NICE PSHE final qualitative review found that young people prefer external teachers to internal ones to educate on alcohol. As school nurses are already involved in SRE it would make sense for them to deliver both elements either alongside teaching staff, other appropriate professionals or independently within the PSHE curriculum timetable. Finally, the findings suggest that students should remain in the same groups during

Key points

- It is important that the National Institute for Health and Care Excellence (NICE) PSHE guidelines are updated and implemented
- The NICE guidelines have the potential to improve sexually transmitted infection and teenage pregnancy rates, which remain a high priority for government, and address the issue of alcohol, which is an increasing priority in young people
- Implementation of a more holistic approach to PSHE is needed through teaching sexual health and alcohol education together
- Young people want to understand the influence of alcohol on sexual behaviours and where to get confidential support to manage their emotions if they make a bad decision as a result of drinking

these study days to reduce anxiety and aid learning.

Conclusion

This paper has reviewed the qualitative and quantitative research, and data pertaining to the issue of sexual health behaviour and alcohol use among young people in the UK to explore the relationship between sexual health and alcohol within contemporary society and the role of PSHE. The implementation of the NICE guidelines is necessary if we are to tackle the impact of sexual health, alcohol and the relationship between the two for our young people to improve the quality, consistency and holistic nature of PSHE provision within schools today.

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