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**MRC/CSO Social and Public Health Sciences Unit Consultation Response**

**Title of consultation**

Delivery of relationships, sexual health and parenthood (RSHP) education in Scottish schools - draft statutory guidance

**Name of the consulting body**

Scottish Government

**Link to consultation**

<https://consult.gov.scot/learning-directorate/teaching-guidance-for-relationships-sexual-health/>

**Why did the MRC/CSO Social and Public Health Sciences Unit respond to this consultation?**

We conduct high quality research that has a real impact on health and wellbeing, and on reducing health inequalities – both at home and across the globe.

We have a particular focus on developing and using cutting-edge methods to understand how social, behavioural, economic, political and environmental factors influence health. We work with decision makers, practitioners and the public to identify interventions and policies that can have an effective and sustained impact on health and wellbeing, particularly among those most in need.

**Our response**

## **Question 1: Introduction**

### Is the draft introduction clear on the status and application of the guidance? No

The guidance could be clearer in how to manage conflict between 1.6: Parents and carers have the right to have their children educated in conformity with their own religious and philosophical convictions and 1.9 UNRC: for the best interests of the child to be primary consideration / for the right of children and young people to express a view and have that view taken into account.

1.6 The guidance that “teachers should work closely with parents in its delivery, by discussing proposed lessons and resources with them in advance” may not be realistic. Evidence indicates parental engagement with schools regarding RSHP is generally very low. In a UK-wide trial of a school-based pregnancy prevention and sexual health promotion intervention (the “If I Were Jack” resource), when schools contacted parents (n=4097) by email asking them to complete a brief survey on their perceptions of a short video that would be shown in RSHP lessons in their child’s school, only 3% of parents responded (Lohan *et al.*, 2023). While teachers should notify parents of content in advance of teaching sensitive RSHP topics, “working closely” with parents may not always be feasible.

1.10: Children have a right to privacy, safety, dignity and respect. In line with Getting It Right For Every Child, children and young people should be central to decision-making. The guidance could be clearer on how children and young people (CYP) can be involved in developing the guidance, with reference to key recommendations for conducting meaningful involvement of young people in decision-making relating to sexual health policy and practice (Lewis *et al.*, 2023). For instance, efforts to involve CYP must consider how to include CYP with a range of different perspectives, how to address power dynamics between adults and CYP, and how to protect CYP in these processes.

Guidance could also be clearer on school’s role in protecting CYP’s privacy, dignity and respect when supporting young people who wish to change gender identity/ name/pronouns.

This is probably assumed, but guidance could make it clear that all students should receive RSHP education together not split by male/female/special topics e.g. menstruation.

Gender inclusive education: whole school guidance – as with gender stereotypes, are heteronormative assumptions about relationships to be challenged across curriculum?

**References**

Lohan M, Gillespie K, Aventin A, Gough A, Warren E, Lewis R, *et al.* School-based relationship and sexuality education intervention engaging adolescent boys for the reductions of teenage pregnancy: the JACK cluster RCT. *Public Health Res* 2023;11(8)

Lewis R, Boydell N, Blake C*, et al.* Involving young people in sexual health research and service improvement: conceptual analysis of patient and public involvement (PPI) in three projects. *BMJ Sexual & Reproductive Health*2023;**49:**76-8

Aventin, Á., Gough, A., McShane, T. *et al.* Engaging parents in digital sexual and reproductive health education: evidence from the JACK trial. *Reprod Health* **17**, 132 (2020). https://doi.org/10.1186/s12978-020-00975-y

## **Question 3: Parental engagement and ability to withdraw from RSHP learning**

1. Is the guidance sufficiently clear in relation to the rights of parents and carers Unclear
2. Is the process for withdrawing a pupil sufficiently clear? Unclear

The flowchart is useful as it illustrates withdrawal process, however it does not cover what should happen if a parent/carer wishes to withdraw the young person but the young person wishes to continue – the document insinuates that there is agreement from both parties, or if not, that a parent’s wish overrides that of a young person’s.

The Schools’ Health and Wellbeing Improvement Research Network (SHINE) offers a mental health survey to network member schools. Over 85,000 responses have been received since 2020. During this time, only 58 parents have contacted the SHINE team directly about the survey. However, 85% of these queries have been from parents/carers asking to vet the questions on behalf of their children, with 18% of those parents specifically wanting assurance that there are no sexual health or gender identity questions in the survey. Those parents said they would opt out their children from the survey if sexual health questions are included, however, pupils can opt in on the day. Guidance should clarify what action schools should take in these types of situations.

2.11 - discusses UNCRC article 12 but there is no mention of UNCRC article 28 (right to education) within document. Surely this would be relevant when discussing withdrawal?

## **Question 4: Embedding RSHP Education as a Whole School Approach**

## How effective is the guidance in explaining the key issues to be highlighted to teachers in delivering RSHP education? Effective

We agree on the importance of taking a whole school approach to gender inclusive education, as delivery of programmes can be undermined if there is not sufficient school engagement, staff involvement and building of content into lessons (Meiksin *et al.*, 2020).

**References**

Meiksin, R., Campbell, R., Crichton, J., Morgan, G.S., Williams, P., Willmott, M. *et al.*  (2020) Implementing a whole-school relationships and sex education intervention to prevent dating and relationship violence: evidence from a pilot trial in English secondary schools, Sex Education, 20:6, 658-674

## **Question 5: Consent and healthy relationships**

1. Is the guidance sufficiently clear in supporting consent and healthy relationships having a greater focus in RSHP education? No

The guidance should clarify the definition of “consent”. Willis *et al*. (2021) defines consent as: “voluntary, sober, and conscious willingness to engage in a particular sexual behaviour with a particular person within a particular context.” pg.3. However, we understand and agree that the definition of “consent” should be adapted based upon the age of the young people to ensure age-appropriate discussions on consent and healthy relationships throughout schooling. Those delivering messages on consent should recognise that young people’s sexual activity may be unplanned; that young people may be ambivalent about whether they want it to happen; and that there is rarely verbal communication (Mitchell and Wellings, 2002). It is important that educators giving guidance on consent avoid simplistic messages that negate these realities.

3.4 – While emphasising consent laws and the consequences of negative behaviours (in-person and online) is important, consent education should also encourage and support young people to feel comfortable advocating for themselves, band should avoid messages that provoke anxiety for young people (e.g. messages about enthusiastic verbal consent that are unrealistic for most young people). Mitchell *et al.*’s (2021) model of sexual wellbeing highlights comfort with sexuality (i.e., “Experience of ease in contemplation, communication, and enactments of sexuality and sex”, pg. 610) and sexual self-determination (i.e., “Free choice or rejection of sexual partner(s), behaviours, context and timing without pressure, force, or felt obligation”, pg. 610) as essential parts of positive sexual wellbeing. Educating young people on these aspects could include techniques on how to articulate healthy boundaries and how to handle the pushing or overstepping of those boundaries. Discussions around boundary setting are something which can be introduced at a young age, and which can develop into discussions on sexual consent.

Section 3.6, 3.7 and 3.10 In terms of resources for whole school approaches to consent and healthy relationships, we recommend the inclusion of the Equally Safe at School intervention (led by Rape Crisis Scotland and funded under the Equally Safe strategy - see <https://www.equallysafeatschool.org.uk/>). Equally Safe at School takes a whole school approach in tackling the roots of gender-based violence (gender inequality) and complements bystander approaches. Equally Safe at School is currently being rolled out in Scotland and is undergoing a national evaluation led by University of Glasgow (and funded by the National Institute for Health and Care Research). Whether or not schools undertake Equally Safe at School, there are useful resources for schools on the website, including a systems map which explores the challenges of reporting and addressing incidents of sexual harassment in school (<https://www.equallysafeatschool.org.uk/research/>) and an animated video for discussion with students (<https://www.equallysafeatschool.org.uk/>). Recent research finds that sexual harassment is common in Scottish secondary schools and there is need to address the ambiguities in ‘what counts’ as sexual harassment (Sweeting *et al.*, 2022)

We note from meetings with schools taking part in Equally Safe at School, concern about a rise in misogynistic attitudes among male students, potentially stemming from exposure to online influencers such as Andrew Tate. In terms of future-proofing the guidance, it might be good to include to recognise and include guidance on this issue, particularly since it strongly underpins gender-based violence.

On 3.7 we note that the current list of resources are all focused on risk and adverse outcomes. Our research finds that sexual function problems are common in young people – approx. 10% of 16 to 21 year olds report a distressing sexual problem lasting 3 months of more in the last year (Mitchell *et al.*, 2016). A risk-focused approach may neglect to answer pressing questions for older adolescents around more positive aspects of sexuality, and may ignite anxieties that contribute to sexual problems in adult life.

Section 4.7 – We agree that the bystander approach is a useful technique to encourage community responsibility to reduce sexual harassment/violence. However, the bystander approach only infers the involvement of those not directly involved in instances of sexual harassment/violence. Such an approach does not consider or include those who are directly involved in an encounter they are uncomfortable with or do not like. Equally, a bystander approach is only useful in scenarios where there are bystanders present.

Through the STASH (Sexually Transmitted infections And Sexual Health) intervention, Purcell *et al*. (2023) established a need to prioritise young people’s development of direct communication around sex, and to improve the self-efficacy of children aged 14-16 regarding sexual health and wellbeing. This is particularly important when it comes to evidence which suggests that young people may not always have the skills to communicate effectively about sex (Mitchell *et al*., 2020; Patterson *et al.*, 2020). Comparatively, Tanton *et al.* (2015) suggested that older adolescents want their school to provide them with information on psychosexual matters pertaining to sexual feelings and navigating risky sexual behaviours, in which consent communication plays a crucial role.

**References**

Willis, M., Marcantonio, T. L. and Jozkowski, K. N. (2021) Internal and external sexual consent during events that involved alcohol, cannabis, or both. *Sexual Health, 18*(3), pp. 260-268.

Mitchell K, Wellings K (2002). The role of ambiguity in sexual encounters between young people in England. *Culture, Health and Sexuality, 4(4) 393-408.*

Mitchell, K., Lewis, R., O'Sullivan, L. F. & Fortenberry, J. D. (2021). What is sexual wellbeing, and why does it matter for public health? *Lancet Public Health, 6*(8), e608-e613. (doi: 10.1016/S2468-2667(21)00099-2) (PMID:34166629)

Sweeting H, Blake C, Riddell J, Barrett S, Mitchell KR (2022) Sexual harassment in secondary school: Prevalence and ambiguities. A mixed methods study in Scottish schools. PLoS ONE 17(2): e0262248. <https://doi.org/10.1371/journal.pone.0262248>

Mitchell, K. R., Geary, R., Graham, C., Clifton, S., Mercer, C. H., Lewis, R., Macdowall, W., Datta, J., Johnson, A. M., & Wellings, K. (2016). Sexual Function in 16- to 21-Year-Olds in Britain. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, *59*(4), 422–428. https://doi.org/10.1016/j.jadohealth.2016.05.017

Purcell, C., McDaid, L., Forsyth, R., Simpson, S. A., Elliott, L., Bailey, J. V., Moore, L. & Mitchell, K. R. (2023) A peer-led, school-based social network intervention for young people in the UK, promoting sexual health via social media and conversations with friends: intervention development and optimisation of STASH. *BMC Public Health, 23*, 675. (doi: 10.1186/s12889-023-15541-x)

Mitchell, K. et al. (2020) A peer-led intervention to promote sexual health in secondary schools: the STASH feasibility study. *Public Health Research, 8*(15), (doi: 10.3310/phr08150)

Patterson, S., McDaid, L., Hunt, K., Hilton, S., Flowers, P., McMillan, L., Milne, D. & Lorimer, K. (2020) How men and women learn about sex: multi-generational perspectives on insufficient preparedness and prevailing gender norms in Scotland. *Sex Education, 20*(4), pp. 441-456. (doi: 10.1080/14681811.2019.1683534)

Tanton, C. et al. (2015) Patterns and trends in sources of information about sex among young people in Britain: evidence from three National Surveys of Sexual Attitudes and Lifestyles. *BMJ Open, 5*(3), e007834. (doi: 10.1136/bmjopen-2015-007834)

## **Question 7: Gender Inclusive Education**

### Is the guidance sufficiently clear in ensuring gender inclusive language is used to deliver RSHP education? Yes

We agree that children receive multiple limiting gendered messages and that these are important to tackle. A randomised trial found that, compared to standard RSE, a gender-transformative relationships and sex education intervention focused on engaging men in pregnancy prevention (the If I Were Jack resource) increased the use of reliable contraception (Lohan *et al.* 2023).

We additionally agree on the importance of taking a whole school approach to gender inclusive education, as delivery of programmes can be undermined if there isn’t sufficient school engagement, staff involvement and building of content into lessons (Meiksin *et al.*, 2020).

Although later referred to in 3.21, there appears to be no specific guidance here on data sharing with parents. This includes managing data sharing with young people whose parents are separated, and the practicalities of managing reporting systems such as SEEMIS with more than one address. To protect young people’s wellbeing, where one parent is aware of a change in gender identity but the other isn’t, clear guidance is essential to support school staff and systems to act in the best interests of the child.

**References**

Lohan M, Gillespie K, Aventin A, Gough A, Warren E, Lewis R, *et al.* School-based relationship and sexuality education intervention engaging adolescent boys for the reductions of teenage pregnancy: the JACK cluster RCT. *Public Health Res* 2023;11(8)

Meiksin, R., Campbell, R., Crichton, J., Morgan, G.S., Williams, P., Willmott, M. *et al.*  (2020) Implementing a whole-school relationships and sex education intervention to prevent dating and relationship violence: evidence from a pilot trial in English secondary schools, Sex Education, 20:6, 658-674

## **Question 9: LGBT inclusive RSHP education**

1. Is the guidance sufficiently clear in ensuring RSHP education is is LGBT inclusive? Yes

It is important to proactively tackle homophobia in school environments (Buston and Hart, 2001). We agree on the guidance’s suggestion to embed LGBT+ education across the curriculum. This will help tackle LGBT-phobia contributing to the visibility and positive representations of LGBT+ people. Unit research highlights how social climates in which LGBT+ people are seen as other or different contribute to health inequalities between LGBT+ people and their cisgender and heterosexual counterparts (Marzetti *et al.*, 2022).

We agree it is important to let LGBT+ children share information on their own terms and that a child coming out as LGBT+ should not, in itself, be seen as a safeguarding concern. The guidance goes on to clarify that there might related safeguarding concerns that come up with that disclosure. We recommend the guidance adds a point to section 3.21 stating that when possible, the child should be involved in the decision making process of how that safeguarding concern is addressed, as this can minimise feelings of distress.

We agree on a whole school, LGBT+ inclusive approach to RSHP. This approach benefits all children, including heterosexual and cisgender youth, as it teaches them about diversity and results in more comprehensive RSHP learning.

In the CONUNDRUM study (Lewis *et al.,* 2021), which involved over 2000 young people aged 16-24 across Scotland, young people of all sexualities (including heterosexual young people) were critical of the heteronormative focus of information delivered in RSHP, including either total lack of information on STI and pregnancy prevention that is inclusive of LGBT+ young people, or deprioritisation of this content (e.g. reports of teachers skipping over particular slides or examples within lessons). Young people also critiqued focus on some forms of diversity but not others (e.g. discussion about STI prevention between men who have sex with men, but not between women who have sex with women).

**References**

Buston, K. and Hart, G. (2001) Heterosexism and homophobia in Scottish school sex education: exploring the nature of the problem. Journal of Adolescence, 24(1), pp. 95-109.

Marzetti, H., McDaid, L.  and O'Connor, R.  (2022) “Am I really alive?”: understanding the role of homophobia, biphobia and transphobia in young LGBT+ people's suicidal distress. Social Science and Medicine, 298, 114860.

Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people’s use and non-use of condoms and contraception: A co-developed, mixed-methods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONtraception UNDerstandings: Researching Uptake and Motivations). MRC/CSO Social and Public Health Sciences Unit: University of Glasgow.

# **Section 4: Key Learning Points for RSHP Education**

4,3 “All children and young people, including those who require additional support, should co‑design the RSHP education they receive, where appropriate”. Guidance should be clearer here so that this is not misinterpreted by practitioners as simply asking young people to decide the content of their RSHP education. The addition of a subordinate clause to express how young people should be involved in this co-design would be helpful ie. by providing opinions and suggestions related to the content, accessibility and methods of delivery of the various resources and topics. It is essential that there is careful consideration regarding what meaningful involvement looks like in this sphere, involvement processes must consider power relations, privacy and multiple perspectives involved in the process (Lewis *et al.,* 2021)

4.4. We agree it is important that RHSP lessons are inclusive and provided to all pupils. However, guidance on how ASN pupils will be supported in these lessons would be helpful for schools to allocate the required provision of support staff as with other curricular subjects.

4.5 The suggestion that teachers need to “be creative in finding ways to adapt the curriculum” to make the content age and stage appropriate for ASN learners is vague given the nature and sensitivity of the topics, it is even more important that teachers are provided with differentiated materials as part of the RSHP curriculum to ensure that ASN pupils are confidently catered for. There are differentiated materials and programmes on the RSHP website which should be signposted here: https://rshp.scot/learners-with-additional-support-needs-asn/programmes-resources-to-support-learning/

4.6 We agree with this premise but again feel that appropriate resources should be signposted here, given the potential for causing confusion and upset.

4,10 We agree with the premise of this guidance but feel that the phrasing “consult with parents” is vague. Clarity around providing notification to parents/carers of the timeframe and content of RSHP lessons to allow for consultation if required would be more helpful.

4.12 is very clear and helpful.

**References**

Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people’s use and non-use of condoms and contraception: A co-developed, mixed-methods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONtraception UNDerstandings: Researching Uptake and Motivations). MRC/CSO Social and Public Health Sciences Unit: University of Glasgow.

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