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

Response Form

The closing date is: 30 November 2011

Department for Education

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Please tick if you want us to keep your response confidential. ☐

Reason for confidentiality:

Name	Philippa Taylor
Organisation (if applicable)	Christian Medical Fellowship
Address:	6 Marshalsea Road, London SE1 1HL

If your enquiry is related to the policy content of the PSHE review you can contact the public enquiry unit on:

Telephone: 0370 000 2288

e-mail: PSHEEducation.review@education.gsi.gov.uk

If you have a query relating to the review process you can contact the Consultation Unit on:

Telephone: 0370 000 2288

e-mail: consultation.unit@education.gsi.gov.uk

Please tick one category that best describes you as a respondent.

☐ Teacher	☐ School Leader	☐ Governor
☐ Parent	☐ Pupil	☐ Local Authority
☐ Teaching Association/Union	x VCS Sector/Charity	☐ Educational Provider
☐ Subject Association	☐ Other	

Please Specify:

About You

Please use this space to tell us about yourself and your job role.

Comments:

Head of Public Policy.

The Christian Medical Fellowship (CMF) is interdenominational and has as members around 4,000 doctors and 1,000 medical students throughout the United Kingdom and Ireland.

We regularly make submissions to governmental and other bodies on a whole range of ethical matters (available on our website at http://www.cmf.org.uk/publicpolicy/submissions/), so we welcome this opportunity to comment to the Department of Health Review of Personal, Social, Health and Economics (PSHE) Education.

Please supply up-to-date evidence to answer any or all of the questions in the review. You may want to focus on only those questions most relevant to you.

Q1) What do you consider the core outcomes PSHE education should achieve and what areas of basic core knowledge and awareness should pupils be expected to acquire at school through PSHE education?

Comments:

Q2) Have you got any evidence that demonstrates why a) existing elements and b) new elements should be part of the PSHE education curriculum?
Your answer should provide a summary of the evidence and where appropriate contain the title, author and publication date of research.

Comments:

Q3) Which elements of PSHE education, if any, should be made statutory (in addition to sex education) within the basic curriculum?

Comments:

No other elements.

We are concerned that should more elements of sex education be introduced this would lessen and weaken the input of head teachers, governors and parents in individual schools and their own control over the materials and used. There should not be any centralisation of the sex education curriculum.

In particular, we do not support making sex education compulsory for primary school aged children (we understand the obligation on primary schools to have a policy for 'SRE' but this does not require that they teach SRE beyond national curriculum science requirements)..

Q4) Are the National, non-statutory frameworks and programmes of study an effective way of defining content?

☐ Yes ☐ No ☐ Not Sure

Comments:

Q5) How can schools better decide for themselves what more pupils need to know, in consultation with parents and others locally?

Comments:

Parenting, especially in moral and religious matters, is very important and highly personal. Parents are ultimately responsible for their children's moral maturity so, within broad limits, they must be free to educate their children on moral matters, as they judge best. The state has a legitimate interest in reducing teenage pregnancy and the spread of sexually transmitted diseases but it is not unreasonable to limit the state's control over what one's children learn and think about sensitive issues of morality, especially when considering the provision of information and services to children below the age of consent.

While primary school governors and head teachers should continue to remain in control of the teaching within their schools, in consultation with parents**, we recommend increasing and strengthening the input of parents on what is included and how it is delivered in schools where their children are taught.**

There are a number of academic studies from the US reviewing the effect of parental involvement. Studies have found that parental involvement laws lead to significant *decreases* both in underage abortion rates (Joyce, Kaestner and Colman, 2006[1]; Levine, 2003[2]) in overall conception rates (Levine, 2003) and, even more encouragingly, to decreases in teenage STIs (Klick & Stratmann, 2006[3]). There is some evidence that parental involvement laws are most beneficial for younger teenagers. For example, Colman, Joyce and Kaestner (2008[4]) find that such a law decreased both abortions and births amongst girls aged 17 at the time of the birth or abortion. However, amongst a slightly older cohort (girls aged 17 at the time of conception) abortions decreased by a lower amount whilst births

[1] Joyce, T., Kaestner, R. and Coleman, S. 'Changes in Abortions and Births and the Texas Parental Notification Law'*, New England Journal of Medicine.* 2006. 354. pp.1031-8.
[2] Levine, PB. 'Parental involvement laws and fertility behavior', *Journal of Health and Economics*, 2003.22. pp. 861-78.
[3] Klick, J and Stratmann, T. 'Abortion access and risky sex among teens: parental involvement laws and sexually transmitted diseases', *Journal of Law, Economics and Organisation.* 2008. 24. pp.2-21.
[4] Colman S., T. Joyce and R. Kaestner, 'Misclassification Bias and the Estimated Effect of Parental Involvement Laws on Adolescents' Reproductive Outcomes' *American Journal of Public Health*, 2008. 98. pp 1881-5.

increased slightly (albeit the increase was statistically insignificant).

In the UK research has found that parents feel strongly that there would be fewer teenage pregnancies if more parents were involved in talking to their child(ren) about relationships, sex and contraception. Among the first wave of the BMRB tracking survey sample of 600 parents of 10–17 year olds, 86% agreed with this statement. Moreover, just over three-quarters (78%) of parents surveyed felt it was easy to talk to their child about sex and relationships.[5] There is research evidence that **including teenagers' parents in information and prevention programmes is effective**. Further, young people whose parents discuss sexual matters with them are more likely to use contraception at first intercourse.[6]

Despite this, the Teenage Pregnancy Unit has consistently emphasised that the role of confidentiality is crucial when providing family planning and abortion services to young people, especially those below the age of consent. The rationale behind this is that if parents do not have to be informed then uptake of services by young people will increase and this will in turn contribute to lower underage conception rates.

However, this has disempowered parents and made it difficult for parents who object to this approach, or who are ambivalent to it, and whose children attend state schools. They have had to face situations where school-based clinics have been set up with the ability to provide contraception and emergency birth control to young people under the age of consent with no requirement that parents be informed. **At the same time, approaches based on encouraging young people to exercise self-control or chastity tend to attract little support, and sometimes outright opposition, from official sources**.

If research shows that access to such services does not reduce conception rates, then the case for guaranteeing confidentiality is weakened. In fact, there is very little evidence to support many of the measures that have been put in place with the intention of cutting teenage pregnancy rates. Very few studies have actually examined the impact of removing (or enforcing) confidentiality for

[5] BMRB International (2001). Evaluation of the Teenage Pregnancy Strategy. Tracking survey. Report of results of benchmark wave. January 2001. www.teenagepregnancyunit.gov.uk

[6] Swann, C., Bowe, K., McCormick, G. and Kosmin, M. (2003).
Teenage pregnancy and parenthood: a review of reviews. Evidence briefing. London: Health Development Agency. www.hda.nhs.uk/evidence

contraception on pregnancy rates (rather than just on the uptake of services). Those that have (eg Paton, 2002[7]) have failed to find a significant impact on underage conception rates, although there is some evidence of an impact on births relative to abortions.

Overall, the evidence base for this policy is mixed. We suggest that government should actively encourage the involvement of parents in their children's decision-making and not undermine it through such a strong emphasis on confidentiality.

Faith sensitive teaching is also essential. A significant proportion of the UK population has a faith background, therefore adopting a faith sensitive approach will increase relevance, promote understanding and capitalise on common ground and common goals. The experience of *The Alternatives Education* Team working in the London borough of Newham,[8] is that faith sensitive relationships education engages hard-to-reach groups. Government should be careful not to force (overtly or indirectly) parents to send their children to classes that may contradict their moral and religious values on matters of intimacy and personal conduct. Such policies violate parents' rights, whether they are Muslim, Jewish, Christian, Hindu, Buddhist or of no religion at all.

To cite a practical illustration, The *Alternatives Education* team reported that in one school their lesson was the first time that one group of (Muslim) girls had engaged in the health and social care classes about relationships and sexual health, **because all lesson content was put within a faith context**.[9]

A report by Ofsted in July 2010 found that too many schools are failing to consult parents in this important area of education. It also seems that many parents are confused by sex and relationships education in primary schools. Both these concerns need rectifying by increased communication with parents.

We also support the continued right of parents to withdraw their child(ren) from sex education lessons that they consider inappropriate for their child(ren).

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[7] Paton, D. 'The Economics and Abortion, Family Planning and Underage Conceptions', *Journal of Health Economics*. 2002. 21. pp.27-45.
[8] http://www.alternativesnewham.org.uk/home/AlternativesEducation
[9] Faith, Relationships and Young People: Report of a Conference in Newham, 2008, p48. http://www.newish.org.uk/836%20Report%20Pages%20(4).pdf

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

6 a) Strengthening the priority given to teaching about relationships?

Comments:

a) strengthening the priority given to teaching about relationships,

CMF's view on teaching about relationships is that we cannot deal effectively with teenage sex and its legacy of sexually transmitted disease, illegitimacy and abortion without challenging the widely promoted idea that teenage relationships are incomplete without sex. Teenagers need help and support in crossing the border between childhood and adulthood; affirmation from peers, family and friends, accurate information about sex and its consequences and assurance that virginity is good and that saying 'No' is OK.[10]

If the desire from government is truly to prioritise relationships, we recommend using the term **'Relationships and Sex Education'**, instead of the usual 'Sex and Relationships Education' (SRE), because it puts relationships first and places sex in the context of relationship.

RSE should be about the physical, intellectual, emotional, social and spiritual aspects of the person, not just the mechanics of reproduction.

The *Sex and Relationship Education Guidance* from the DfEE (2000[11]) states that sex and relationship education:
'It is lifelong learning about physical, moral and emotional development. It is about understanding of the importance of marriage for family life, stable and loving relationships, respect, love and care. It is also about the teaching of sex, sexuality and sexual health. It is not about the promotion of sexual orientation or sexual activity – this would be inappropriate teaching.'

We support this balanced approach, which includes a strong emphasis on marriage and stable relationships.

[10] Triple Helix, 2002. CMF. http://www.cmf.org.uk/publications/content.asp?context=article&id=1183
[11] SRE guidance, DfEE 0116/2000, page 5, para 9.

6 b) The importance of positive parenting?

Comments:

'Within the context of talking about relationships, children should be taught about the ***nature of marriage and its importance for family life and for bringing up children***.'[12] (our emphasis).

We support the teaching of the responsibilities of parenthood to young people, and the important roles played by both mothers and fathers, along with the need for both to be involved with children for the long-term. The bringing up of children is best achieved within a stable, committed, long-term relationship, ideally marriage.

Teenage sexual activity is more widespread among children of divorced, broken and single parent homes, as this can create an environment in which positive parenting is much more challenging.[13] Those least likely to have experienced a loving, intact home are least likely to be able to have open and constructive communication with their parents about relationships and sex, and are more likely to continue the cycle of poor parenting.[14] Hence the importance of teaching on marriage and family life.

6 c) Teaching young people about sexual consent?

[12] SRE guidance, DfEE 0116/2000, page 11, para 1.21.
[13] Family breakdown as risk factor and consequence of teenage parenthood is referred to extensively in SEU, 1999, Social Exclusion Unit Report on Teenage Pregnancy Cm 4342, HMSO
[14] Analysis of a cohort of children born in 1970 (BCS70) showed that, after taking into account many other factors, women whose mother was a teenage mother are about twice as likely to have a teen birth as those born to older mothers. Ermisch, J. and Pevalin, D. (2003). Who has a child as a teenager? ISER working paper 2003-30. Colchester: Institute for Social and Economic Research, University of Essex. www.iser.essex.ac.uk/pubs/workpaps/pdf/2003-30.pdf

Comments:

Relationship and sex education guidance should have the goal of preparing young people for healthy adolescence and long-term, committed, exclusive adult relationships (see our comments above). **This can be achieved by developing their self-esteem, values, life skills and knowledge so that they are able to consider media messages and the impact of actions and choices on themselves and others** (see our comments at the end). A number of research studies have shown that teenagers often regret the age when they started having intercourse. And over 40% of teenagers in the UK give peer pressure as the reason for first intercourse.[15]

Despite spending over £250 million on measures to cut teenage pregnancy rates since the start of the Teenage Pregnancy Strategy in 1999, the impact on teenage pregnancy rates has been negligible. Indeed, '*overall teenage sexual health in the UK is far worse today than ten years ago despite the millions of pounds invested in sex education*.'[16] The Government was not able to reach its modest 2004 target of a 15% cut in the under-18 rate. Meanwhile, diagnoses of sexually transmitted infections amongst teenagers have continued to increase over the period of the Strategy.

Paton (2009[17]) suggests that there is, in fact, little or no evidence that current school SRE reduces pregnancy rates amongst teenagers. Recent random control trials (for example Henderson *et al*,[18] 2007; Stephenson *et al*, 2008[19]) report a lack of impact of sex education schemes on unwanted pregnancy rates, although one exception is Cabezon *et al* (2005[20]) who find evidence that an abstinence-based programme had a statistically significant impact in reducing both early sexual activity and pregnancy rates.

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[15] Triple Helix 2002, http://www.cmf.org.uk/publications/content.asp?context=article&id=1183
[16] 'Teenage Sex', Trevor Stammers, *CMF File* 37, 2008. http://www.cmf.org.uk/publications/content.asp?context=article&id=2184
[17] Paton, D. Nursing Times. October 2009. pp 22-25
[18] M.Henderson, D. Wight, G.M. Raab, C. Abraham, A. Parkes, S. Scott *et al* , "Impact of a theoretically based sex education programme (SHARE) delivered by teachers on NHS registered conceptions and terminations: final results of cluster randomised trial", 2007. *BMJ* 334, pp. 133-137.
[19] Stephenson J., V. Strange, E. Allen, A. Copas, A. Johnson, C. Bonell, A. Babiker, A. Oakley et al, 'The Long-term Effects of a Peer-Led Sex Education Programme. (RIPPLE): a cluster randomised trial in schools in England', *PLoS Medicine*, 2008. 5. pp.1579-90.
[20] Cabezon C. Vigil, I. Rojas, M.E. Leiva, R. Riquelme, W. Aranda and C. Garcia, 'Adolescent pregnancy prevention: an abstinence-centered randomized controlled intervention in a Chilean public high school', *Journal of Adolescent Health. 2005. 36. pp. 64-9.*

The majority of studies examine a particular 'SRE' programme relative to existing SRE models, i.e. they are not testing the impact of school sex education relative to *no* school sex education. The few exceptions to this rule present conflicting evidence. For example, Oettinger (1999[21]) finds that, amongst some sub-groups, teenagers who were exposed to school-based 'SRE' experienced slightly higher pregnancy rates than those who were not exposed. In contrast, Kohler, Manhart and Lafferty (2008[22]) find that SRE is associated with lower self-reported pregnancy rates amongst teenagers. Sabia (2006[23]) concludes that SRE has no measurable impact on pregnancy rates. A CMF paper (2008[24]) concluded that there is considerable recent evidence that simply increasing the availability of contraception without accompanying education on the importance of saving sex may lead to **more** sexually transmitted infections and unplanned pregnancies rather than fewer.

With regard to research on abstinence education and results in relation to reducing teenage pregnancy rates, it appears that the findings on abstinence education are mixed. Some studies suggest that some abstinence programmes have only limited effects, but the results of such studies are often exaggerated. Other studies have found that abstinence-focused education may have beneficial impacts. Jemmot et al (2010[25]) compare an 'abstinence only' intervention with both 'abstinence-plus' and 'contraception-based' interventions. They found that youngsters who experienced the 'abstinence only' approach had significantly later sexual initiation than those in the other programmes.

Policy makers need to be careful in drawing firm policy conclusions from the results of studies. On some issues (for example the impact of abstinence-based education), the evidence relating to conception rates is still limited and more research is needed. Without doubt there are good and not so good abstinence education programmes. **Rather than dismissing them all, the right approach**

[21] Oettinger, G.S. The effects of sex education on teen sexual activity and teen pregnancy', *Journal of Political Economy. 1999.* 107. pp. 606-44.
[22] Kohler P.K., L.E. Manhart and W.E. Lafferty, 'Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy' *Journal of Adolescent Health*, 2008. 42. pp. 344-51.
[23] Sabia J.J. 'Does Sex Education Affect Adolescent Sexual Behaviors and Health?', *Journal of Policy Analysis and Management*, 2006. 25. pp. 783-802.
[24] 'Teenage Sex', Trevor Stammers, *CMF File* 37, 2008.
http://www.cmf.org.uk/publications/content.asp?context=article&id=2184
[25] J. B. Jemmot, L.S. Jemmott and G.T. Fong. 'Efficacy of a Theory-Based Abstinence-Only Intervention over 24 Months: a randomized controlled trial with young adolescents', *Archives of Pediatric Adolescent Medicine.* 2010. 164.2, pp.152-159.

would be to try to find out which ones are more effective.

Kirby's (2007[26]) report on SRE concludes that:

'In general, encouraging teens to postpone the initiation of sex or to become sexually abstinent should be important goals of many comprehensive pregnancy and STD prevention initiatives, not just those that advocate abstinence alone.'

'Abstinence is the most effective way to avoid teen pregnancy and STD…'

It is important that practitioners and those involved in policy formulation avoid giving the impression to stakeholders (such as parents and school governors) that particular measures **need** to be introduced so as to cut teenage pregnancy when the evidence does not back this up.

The DfEE guidance *Sex and Relationship Education* clearly states the value of delaying sexual activity and the benefits to be gained from delay. **We support their policy that knowledge of sex education should include: '*learning the reasons for delaying sexual activity, and the benefits to be gained from such delay.*'**[27]

In summary, we believe that the arguments for delaying sexual activity should be a key part of a comprehensive sex education, as should the use of appropriate teaching material relevant to age, culture and religion.

[26] Kirby D. Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and sexually transmitted diseases. Washington, DC: National Campaign to Prevent Teen Pregnancy, 2007, pages 46-7

[27] SRE guidance, DfEE 0116/2000, page 5, para 9.

Q7) Have you got any examples of case studies that show particular best practice in teaching PSHE education and achieving the outcomes we want for PSHE education?
Your answer should be evidence based and provide details of real-life case studies.

Comments:

Q8) How can PSHE education be improved using levers proposed in the Schools White Paper, such as Teaching Schools, or through alternative methods of improving quality, such as the use of experienced external agencies (public, private and voluntary) to support schools?

Comments:

Q9) Have you got any examples of good practice in assessing and tracking pupils' progress in PSHE education?

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

Comments:

Q10) How might schools define and account for PSHE education's outcomes to pupils, parents and local people?

Comments:

Q11) Please use this space to provide us with your views and any other comments about PSHE.

Comments:

As will be apparent from our answers to these questions, we wish to uphold the general principles that parental input to schools on this topic should be strengthened, and that children should be protected from sexualisation in the classroom. We believe that the most important information young people should be given is the importance of **love, commitment and self-esteem**,[28] alongside empowerment to delay sexual activity, which is all too often later regretted.[29]

However we also take the opportunity to express a note of caution regarding the context of this consultation and the findings.

First, the impact of any outcomes from sex education will be heavily influenced by wider cultural and socio-economic factors that cannot be ignored. The conflicting pressures of family, peer groups, media, society at large and emotional needs of young people, work to influence them into taking actions that they may later regret.[30] As CMF has noted elsewhere, it is *adults* who have exposed children of all ages to a society which is obsessed by sex, putting them under enormous pressure to conform.[31]

There is a normalising of sexual activity in younger people, driven by those in the media and parts of the business and advertising world[32]: '*Young people live in a highly sexualised culture and are sexualised by companies wanting them to buy their products*.' (Simon Blake, Brook[33]). The Bailey Review[34] found that parents are

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[28] A review of the literature on the link between teenage pregnancy and self-esteem concluded that the risk of teenage motherhood is raised – possibly by up to 50% – among teenage girls with lower self-esteem than their peers. Emler, N. (2001). Self-esteem: the costs and causes of low self- worth. York: Joseph Rowntree Foundation. www.jrf.org.uk/knowledge/findings/socialpolicy/pdf/N71.pdf

[29] Wellings et al state that earlier (than age 16) first intercourse is less likely to be an autonomous and a consensual event, and more likely to be regretted and unprotected against pregnancy and infection. Wellings K. Nanchahal K., Macdowall W., McManus S., Erens R.,et al, 2001, "Sexual behaviour in Britain: early heterosexual experience," *Lancet* Vol. 358, pp. 1843-50

[30] Research carried out in 2002, showed that 60% of boys and 80% of girls regretted the first time they had sex. Faith, Relationships and Young People: Report of a Conference in Newham, 2008. http://www.newish.org.uk/836%20Report%20Pages%20(4).pdf

[31] Triple Helix, 2002. http://www.cmf.org.uk/publications/content.asp?context=article&id=1183

[32] Bailey Review of the Commercialisation and Sexualisation of Childhood, 2011. http://www.education.gov.uk/inthenews/inthenews/a0077662/bailey-review-of-the-commercialisation-and-sexualisation-of-childhood-final-report-published

[33] Faith, Relationships and Young People: Report of a Conference in Newham, 2008. http://www.newish.org.uk/836%20Report%20Pages%20(4).pdf

particularly unhappy with the increasingly sexualised culture surrounding their children, which they feel they have no control over. They singled out sexually explicit music videos, outdoor adverts that contain sexualised images, and the amount of sexual content in family programmes on TV. **The Bailey Review findings should therefore be considered as part of this exercise, along with the recommendation to make parents' voices heard.** As Christians, we at CMF consider that the commoditisation of sex outside of permanent relationship is a much-distorted view of sex, and that many sexual images in popular culture are negative or manipulative, usually self-centred and focused upon 'what I can get out of it'.[35]

Second, whilst research findings are important and instructive, the limitations in the quantity and/or quality of research means there should be caution in relying heavily on them for policy conclusions. In particular, the academic evidence that direct interventions such as more explicit school sex education and confidential access to family planning services help to lower teenage pregnancy rates is mixed, and at best weak. Moreover, there are naturally variations in the quality of programmes and interventions which must also be taken into account.

[34] Bailey Review of the Commercialisation and Sexualisation of Childhood, 2011. http://www.education.gov.uk/inthenews/inthenews/a0077662/bailey-review-of-the-commercialisation-and-sexualisation-of-childhood-final-report-published

[35] Triple Helix, 2002. http://www.cmf.org.uk/publications/content.asp?context=article&id=1183

Thank you for taking the time to let us have your views. We do not intend to acknowledge individual responses unless you place an 'X' in the box below.

Please acknowledge this reply ☐

Here at the Department for Education we carry out our research on many different topics and consultations. As your views are valuable to us, would it be alright if we were to contact you again from time to time either for research or to send through consultation documents?

☐ Yes ☐ No

All DfE public consultations are required to conform to the following criteria within the Government Code of Practice on Consultation:

Criterion 1: Formal consultation should take place at a stage when there is scope to influence the policy outcome.

Criterion 2: Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

Criterion 3: Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

Criterion 4: Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

Criterion 5: Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Criterion 6: Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Criterion 7: Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

If you have any comments on how DfE consultations and reviews are conducted, please contact Carole Edge, DfE Consultation Co-ordinator, Tel: 01928 438060 / email: carole.edge@education.gsi.gov.uk

Thank you for taking time to respond to this request for representations

Completed questionnaires and other responses should be sent to the address shown below by 30 November 2011

Send by post to: Department for Education, Consultation Unit, Area 1C, Castle View House, Runcorn, Cheshire WA7 2GJ

Send by e-mail to: PSHEEducation.review@education.gsi.gov.uk