

Royal College of Psychiatrists Consultation Response



DATE: 28 November 2011

SUBMISSION FROM: THE ROYAL COLLEGE OF PSYCHIATRISTS

COMMENTS ON: The Review of Personal Social Health and Economics (PSHE) Education

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation, which was prepared by the Faculty of Child and Adolescent Psychiatry at the College with additional contributions from a College member with expertise in public mental health.

This consultation was approved by: Dr Ola Junaid, Associate Registrar

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Submission to the Review of Personal Social Health and Economics (PSHE)
Education

General comment

The College has focused its response on those questions with most relevance to mental health issues.

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

Whilst there are many different desirable outcomes, those pertinent to psychological well being and mental health promotion include the following:

- Improved wellbeing
- Reduced prevalence of mental health problems
- Improved awareness and recognition of what good mental health is and how mental health problems can present
- Improved awareness of ways to promote mental health.

Areas of basic core knowledge and awareness pupils should be expected to acquire at school through PSHE education:

- Increased awareness of the variety of an individual's emotional responses to stress and life events, and how to encourage coping mechanisms and the development of resilience and mental well-being;
- how to support peers when facing emotional challenges or mental health difficulties, which includes accessing support from teachers or other appropriate adults when necessary;

- to encourage students to work towards a whole school ethos of tolerance, problem-solving and a stigma-free environment; and
- recognition of common expressions of mental health problems.

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

In a report published in 2009 the UK was ranked 24th out of 29 European countries in a survey of children's well-being (Bradshaw & Richardson, 2009). Personal, Social, Health and Economic Education can make an important contribution to improving children's well-being, as follows:

- Improved well-being has a range of important health benefits such as:
 - Improved resilience to broad range of adversity
 - Reduced emotional and behavioural problems in children and adolescents including persistence of such problems (Adi et al, 2007; NICE, 2008; NICE 2009; Parry-Langdon et al, 2008)
- Improved well-being also has a range of important non-health benefits, including:
 - Improved educational outcomes (NICE, 2008; NICE, 2009)
 - Healthier lifestyle/ reduced health risk behaviour (Lyubomirsky et al, 2005) including reduced smoking and harmful levels of drinking .
- It is important to note that half of lifetime mental illness arises by the age of 14 (Kim-Cohen et al, 2003; Kessler et al, 2005). Interventions to promote mental health, prevent mental disorder and intervene as soon as it arises are therefore particularly important during childhood and adolescence.

- Preschool and early education programmes result in improved cognitive skills, school readiness, improved academic achievement, positive effects on family outcomes including for siblings (Anderson et al, 2003; Sylva et al, 2007; Sylva et al, 2008) and can prevent emotional and conduct disorder (Tennant et al, 2007)
- A range of school-based interventions which can promote mental well-being and prevent mental health problems is outlined in the Royal College of Psychiatrists position statement on public mental health (RCPsych, 2010), available at: http://www.rcpsych.ac.uk/pdf/PS04_2010.pdf.
- More effective school based approaches are long term, whole school, focusing on promotion and including teacher training and parental participation (Durlak et al, 2011; Weare and Nind, 2011)
- Peer mediation effective in promoting pro-social and behavioural skills in the long term (Blank et al, 2009)
- Secondary school curriculum approaches to promote pro-social behaviours and skills can also prevent development of anxiety and depression (NICE, 2009)
- A good example of an effective, evidence-based intervention is the US Social and Emotional Learning programme which focuses on children being able to develop self-awareness, self-management, social awareness, relationship skills and responsible decision making. A meta-analysis of 213 studies of school-based, universal SEL programs involving 270,034 students found that children and young people receiving SEL had 25 per cent improvement in social and emotional skills (ES 0.57), attitudes (ES 0.23), behaviour (ES 0.24) and 11 per cent improvement in academic performance (ES for test grades 0.33) (Durlak et al, 2011). The intervention also resulted in reduced conduct problems (ES 0.22) and

emotional distress (ES 0.24). The economic modelling work by Knapp et al (2011) highlighted net savings of £84 for each pound invested in the intervention.

- A number of different programmes can prevent different types of violence:
 - School based violence prevention programmes (Mytton et al, 2006)
 - School based sexual abuse prevention programmes (Zwi et al, 2009)
 - School based bullying prevention programmes (Ttofi et al, 2008)

Campaigns initiated by the Royal College of Psychiatrists have involved the development and delivery of workshops for teachers, in which common conditions prevalent in adolescence are explained, alongside local services available from other agencies. (Stoke; Dudley 2007, among others) These workshops have been enthusiastically received and filled to capacity. Exercises from the workshops have been used in the classroom setting, prompting discussion about many conditions, including psychosis, and the extent of alcohol use and misuse from the age of 12 upwards.

Individuals from the Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists, regularly teach at INSET days for teachers, and invariably experience an enormous interest in psychological issues that either prevent a young person from learning, or need to be addressed by teachers. Such liaison and involvement of other professionals in training of frontline staff raises teachers' awareness and ability to deal with the very challenging issues that confront them daily. They are then able to use the knowledge gained to improve the ethos of the school and raise standards.

Service users (older adolescents and young adults) comment that whilst sex education and drug education is taught, there is very little in the curriculum about common mental health problems such as depression, eating disorders and psychosis, even though they themselves would have benefited from this, and peers commonly have these conditions. This is particularly important

during childhood and adolescence since half of lifetime mental illness has arisen by the age of 14 (Kim-Cohen et al, 2003; Kessler et al, 2005). We know that if early intervention were in place in the adolescent years, the reduction in adult mental health disorders would be:

- 26% for anxiety
 - 23% for depression
 - 24% for substance misuse
 - 32% for mania
 - 46% for eating disorders
 - 25% for schizophreniform disorder
 - 41% for antisocial personality disorder
- (Kim-Cohen, Caspi and Moffitt, 2003)*

These conditions have long-term effects both on the ability of an individual to make the most of their education and on their future employment, so prevention by increasing awareness and stigma reduction is important, and could be enabled by an appropriately delivered PSHE curriculum.

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

Emotional health and well-being is part of the curriculum but it is non-statutory. Furthermore, programmes to promote social and emotional literacy, such as the Social and Emotional Aspects of Learning (SEAL) have recently ended, despite the extremely high level of evidence on which such programmes are based, particularly if having good programme fidelity (Durlak et al 2011).

However, mental health difficulties also need to be addressed since 10 per cent of all young people will have significant problems requiring intervention and a

larger proportion of children and adolescents have sub-threshold mental health problems which both have significant impact and increase the risk of developing threshold disorder. Mental health problems affect a wide range of health, social and educational outcomes during childhood and adolescence which then continue to impact across the life course. Immediate impacts of mental disorder are highlighted in the table below which show increased risk of a wide range of outcomes in those with conduct disorder (6% of 5-16 year olds) and emotional disorder (4% of 5-16 year olds).

Relative risk of health and social skills outcomes, school outcomes and risk-taking behaviours in children and young people, with and without mental disorders (Green et al, 2005)

		Emotional disorder	Conduct disorder	Hyperkinetic disorder	Whole survey prevalence
	Age	RR*	RR*	RR*	
Health and social skill outcomes					
Health is fair or bad (parent report)	5-16	4.6	3.4	2.6	7%
Found it harder than average to make friends	5-16	3.9	2.7	3.2	10%
No friends	5-16	6.0	8.0	5.0	2%
School outcomes					
Two or more years behind in intellectual development	5-16	1.4	4.0	4.4	10%
More than 15 days absence in the previous term	5-16	4.3	3.5	2.2	5%
Ever been excluded from school	5-16	3.0	16.5	9.7	4%
Self-reported risk-taking behaviours					
Regular smoker	11-16	3.8	6.0	2.5	5%
Regular drinker	11-16	1.4	2.1	1.4	9%
Drinks twice a week or more	11-16	1.7	4.0	2.3	3%
Taken drugs, mainly cannabis	11-16	2.5	3.5	2.9	9%
Taken drugs excluding cannabis	11-16	4.0	2.5	5.0	2%
Self-reported self-harm	11-16	4.7	3.5	2.6	7%

*RR = relative risk compared with those without disorder

- There is much research evidence (for example *Knapp, McDaid and Parsonage, 2011* and *Kessler, 2007*) showing that early intervention at this stage can prevent the development of significant mental health problems in adult life. Therefore work which promotes the prevention and detection of conditions such as depression, eating disorders and psychosis should be included. This would be likely, in turn, to lead to more early interventions, enhance children's learning and increase the

possibility that children and young people will be able to make a positive economic contribution when they become adults.

- As there is comparatively little knowledge of mental health issues, and the subject remains stigmatised, it is likely that if it continues to be a non-statutory aspect of the PSHE curriculum, it will not be delivered. We strongly urge the government to consider making it a statutory element of PSHE.
- Parenting: research evidence shows that young people and adults growing up in families where there is ineffectual parenting are more likely to develop conduct disorder and poorer outcomes (*Scott S, Knapp M et al, 2001*). Parent training courses have been found to be cost-effective, but engagement of adults for group therapy is difficult and the attrition rate is high. Good parenting skills can be taught and could be part of the PSHE curriculum. This would be cost-effective and potentially result in considerable financial gain both for the individual and society as a whole.

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