PSHE: An opportunity to build an enduring relationship with health and social care or a waste of time

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Abstract
Many 11-16 year old receive an hour or more of focused education of wider health and social care yet many are still unaware of services that can support their physical and mental wellbeing. Evidence has shown how these lessons are not translating the information in a format the young people engage with. During the course of this article some of the reasons for this are discussed.

Keywords: PSHE, Secondary School, Health and Social Care

Introduction
The YEAH! (Young Essex Attitudes on Health and Social Care) Report (Fletcher, 2014) surveyed young people aged 15-19 from across Essex and found that they wanted to know more about health and wellbeing and that although they were given information on smoking and drugs whilst at school most of them were unaware of how to access services for support on these topics. It also found that 9 out of 10 participants wanted to learn about mental health issues as well as physical health issues (Fletcher, 2015). This message was reiterated in the Services We Experience in Essex Today (SWEET) Report (Fletcher, 2016) in which young people from a similar age group and area felt information about health and social care messages were targeted at adults or was given too late after they started to engage in these behaviours (Fletcher, 2016). This raises the question about why these messages are not being translated to our young people. For at least an hour a week, from information collected from three local secondary schools in Essex, a captive audience of 11-16 year olds have a Personal, Social, Health, Economic (PSHE) lesson allocated to look at these subject matters. So why are these messages not being received by this audience or are they being delivered in an inaccessible format.

Key Findings
The curriculum for Personal Social Health Education (PSHE) varies between schools in Britain even down to the name of the lesson. For example, within Essex it is known as either Personal Development, Personal Relationships or Social and Health Education. Some schools do not even separate the subject into its own lesson and just use part of the time dedicated to teach Citizenship or to cover topics relating to health. Other elements covered in PSHE such as sex education and personal relationships are mandatory Department of Education (DOH), (2015) for maintained secondary schools and are either covered in a separate one-off session or as part of a science lesson but everything else is left to the school to decide. New subjects such as this may have to jostle for position with more traditional curriculum topics. So, would this hour a week be better used to cover another topic or could this time be used more usefully for young people. One argument could be that if we are concerned about the health and wellbeing of these young people this hour could be dedicated to additional physical activity. Is the lack of a formal curriculum for PSHE the reason why the value of the topic is undermined or do teachers not value these lessons and is this apathy passed down to the learners. PSHE seems to have no formal curriculum despite being delivered in a secondary school environment which is usually very curriculum driven. Although certain topics are advised (BBC, 2016) the final choice is down to each individual institution or provider. This lack of formal structure thorough a prescribed curriculum could provide one answer as to why the subject is inconsistently delivered or not providing the information our young people need to make informed life choices. Although some models are available these are not standardised.

Health sectors and local authorities across the nation are struggling to meet need and demand in the current health economy (Castle Point and Rochford Clinical Commissioning Group, 2015). Obesity, smoking,
drinking, drugs use, mental health issues and inappropriate use of health services such as hospital Accident and Emergency (A&E) departments are costing the UK dearly. Two-thirds of smokers start before the age of 18 and in Essex we have a particular problem with 6% of 15 year olds smoking regularly and 4.5% smoking occasionally (Health and Social Care Information Centre, 2015). The Future in Mind Report (2015) stressed that ‘failure to support children and young people with mental health needs cost lives and money’ (Lee, 2015, page 13) The knock on effect on individual’s and their families’ emotional wellbeing also carries a heavy burden. There is a captive audience of patients of tomorrow within secondary schools yet it seems by not providing them with the education in these matters to the best of our ability an opportunity is being missed. The Royal Society for Public Health (RSPH) said there is a need for, ‘…radical upgrading in prevention and public health’ (RSPH, 2014, page 1) calling on all those who have knowledge and ability to positively impact on the nation’s public health.

There are 1.29 million teachers and educational professionals in Britain who make up a large proportion of the potential wider public workforce but do not necessarily have the training or experience to take on this vital role (RSPH, 2014). There is evidence in the YEAH! Report (2014) and the need identified by local authorities and health services for improved public health information and positive health messages to be delivered and understood by the next generation of patients. By preventing harmful behaviours such as smoking or drug use before they start should demonstrate a financial cost saving in treating the consequences of these behaviours and an emotional or wellbeing benefit to the individuals themselves who are not damaged by these actions. Delivery of PSHE in schools is the responsibility of all teaching staff (DOE, 2015). Unlike other subjects such as history or maths, PSHE is seen as the responsibility of all teachers but this raises the question: ‘Are these the best placed individuals to teach these lessons? The YEAH! Report (2014) stated “our young participants all suggested that the provision of health and social care information in education settings needs to be adapted to the interactive approach favoured by many young people” (Fletcher, 2014, page 11). This demonstrates that how these messages are delivered is important to these young people as the teaching strategies and techniques should be reflective of the audience they are trying to address.

Wallace (2008) suggests that ‘every interaction with our learners provides us with an opportunity to model for them the communication skills we would wish for them to develop in themselves’ (Wallace, 2008, page 27) and she goes on to explain how important this is in modelling more than just language but also respect and social courtesies. Providing this role model or model behaviour may be a challenge for a teacher in a subject as diverse and wide reaching subject as PSHE. It may be seen as hypocritical if a teacher who is known to smoke is giving information on smoking cessation for example. Another issue to consider is PSHE is a subject that relies on engaging these young people and creating a relationship and environment in which they are comfortable to talk about potentially difficult issues which may be very different from a maths lesson. If teachers are expected to fulfil both of these roles it may prove difficult for both student and teacher as mentioned above. This validity seems to also be important to young people when it came to health messages. The YEAH! Report (2014) found that 29 of the young people spoken to wanted the opportunity to speak to a former drug user about the consequences of drug use (Fletcher, 2014, page 27) as this real life and relevant experience gave a validity to the issues that the young people appreciated.

The methodology for gathering evidence in the YEAH! Report (2014) used people who the participants trusted which could explain why they managed to gather such personal information from them. This was the weakness of previous attempts by schools to engage with this generation. If students are being taught vital health and wellbeing messages by an under prepared members of the workforce, who do not have a passion for the subject, the messages being delivered will be tarnished with this apathy. Another model to consider would be bringing in suitable members of the community such as sexual health nurses or mental health professionals who have training and experience in teaching. This could serve to break down barriers or fears between young people and health professionals and help the school and the students be more inclusive members of the community.

Developing a timetable to include the wider public health work force may prove a challenge too far but using the wealth of knowledge these health and social care professionals have, to train the teachers who have a responsibility to deliver the subject, could be a useful alternative. It may also help to promote community inclusion and empower the teaching staff by giving them adequate training. Some organisations already have tailored programs that teach the messages covered by an effective PSHE program (such as Premier Training International or the PSHE Association).

Could the lack of curriculum in PSHE be a reflection of the seemingly lack of importance placed on it by government. If the patients of tomorrow had better public health knowledge and adjusted their behaviour as a result of this, it could be of benefit to the health economy and beyond. If employer priority is an influencing factor in curriculum development then the benefits of a fitter, healthier workforce should be promoted to them and in turn influence the curriculum of the future.

**Discussion**

**Do teachers require a standardised national curriculum to follow on the subject of PSHE?**

**Do teachers require more training on delivering sensitive subjects?**

**Could health professional provide this information in the school environment?**

Is the subject needed or could this time be better spent?
Conclusion

After reviewing the evidence, I do feel that PSHE lessons in secondary schools are a fantastic opportunity to build an enduring relationship with health and social care. This could be achieved by integrating the education system with the wider public health workforce on a macro level and building stronger communities by linking local services with local educational provisions. By using the health and social care workforce to train teachers or to encourage the health professionals to integrate with the school in a positive way, by either teaching elements of PSHE or being a professional that young people have access to, this could lead to enduring relationships. If nothing changes and outcomes are not measured this could lead to a demotivated workforce and an unenthusiastic generation of people who rely on emergency care and are under prepared for their own futures. If this is not deemed to be of benefit, then using the time allocated for the subject to increase the students’ physical activity could be an alternative that may provide benefits to their health and wellbeing.

Targeting this audience towards the end of their school education is too late and information and support needs to be offered at the earliest opportunity to have real impact. The potentially positive effects of informing and supporting these young people to make well informed choices could save the health economy large sums of money. The emotional cost of avoiding health crises and prolonging healthy lives can have a benefit to the individual and their wider community. The potential value of implementing a more formal structure to how and what is taught in PSHE lessons could be of benefit but proving this is challenging especially in the short term. One of the proven short term benefits to pupils with improved health and wellbeing is that they can achieve better academically (Department for Education, 2014) suggesting that achievement and attainment in all other subjects could be improved. The potential long term benefits are a healthier nation less reliant on health and social care services reducing the physical and financial burden on the rest of the economy.

Competing interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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