Medical Students in Youth Corrections: A Community Service Learning Opportunity

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ABSTRACT

Four medical students conducted a community service program at a local youth custody centre. The program included cooking, exercise, and health-oriented educational discussions. The experience enforced the CanMEDS competencies and allowed the students to develop a greater appreciation of specific health care needs of marginalized populations. This may better prepare students to care for marginalized patients in the future as physicians. Community service learning opportunities are a valuable adjunct to conventional medical education.

KEYWORDS: *marginalization, incarceration, adolescent, recidivism, medical education*

The second year medical curriculum at the University of British Columbia (UBC) includes a course titled 'Doctor, Patient, and Society' (DPAS). In addition to weekly lectures, students have the option of attending tutor-led small-group discussions and developing our own community-based research study, or engaging in a community service learning opportunity (CSLO). The CSLO option is meant to provide community service in response to community-identified health concerns. This article is meant to highlight a CSLO experience at a local youth custody centre.

We visited the youth custody centre weekly to run a program involving cooking, exercise, and education to incarcerated youth. Basic cooking skills were taught to the youth along with healthy, affordable, and easily reproducible recipes. An exercise component involving fitness training and team sports helped teach the youth sportsmanship and fair play, in addition to encouraging an active, healthy lifestyle. Education was integrated into these programs; topics discussed included diabetes mellitus, sexually transmitted infections, nutrition, contraception, bullying, and drug/alcohol awareness.

Marginalization and Recidivism

A common theme taught to medical students is that of marginalization—a population considered to be vulnerable or at high-risk for being underserviced by the health care system. A study in 2004 found that youth in custody have high rates of mental illness (72%), physical abuse (64%), homelessness (32%), and sexual abuse (11%).[1] Additionally, Aboriginals constitute 47% of youth in custody.[1] It is therefore fair to consider incarcerated youth at the custody centre as a uniquely marginalized population.

Despite lectures describing marginalized populations, we had felt unprepared for the difficulties facing these youth. Many youth described a life of poverty, a household with parents engaging in substance abuse, or foster care after release. One young male had no goals for the future because he stated, "I'll be dead before I'm 30." Other youth would not celebrate their release because they said, "We'll be back soon"—they weren't lying. These youth faced challenges that simply could not be conveyed in a simple lecture. Along with substance abuse, lack of income—especially if it leads to homelessness—has been identified as a major risk factor for recidivism in incarcerated individuals.[2,3] Interactions with the youth identified a distinct lack of skills necessary to obtain employment, and studies have shown that incarcerated youth are nine times more likely to be under-qualified compared to their peers.[4] Unsurprisingly, over 80% of incarcerated youth are repeat offenders.[1]

Our experience with this population raised some valuable questions amongst our group. Originally, it was not well understood why these youth would continue to offend. We learned that once the youth are released, they return to a similar socio-economic situation as before and are never given an opportunity to succeed. These youth are essentially set up for failure. One medical student reflected how "... many parallels can be drawn between these youth and patients who engage in high-risk behaviours ..." A greater focus on the treatment of substance abuse and post-release supports for these youth would likely be beneficial in reducing the high recidivism rate in this population.

What We Learned

As medical students, developing the skills and competencies to practice as a medical expert comes from experiences both inside and outside the classroom. These competencies, also known as the CanMEDS roles, include medical expert, communicator, collaborator, manager, health advocate, scholar, and professional.[5] This program exposed us to an environment which provided many opportunities to develop these roles.

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Many youth upheld a "reputation" upon initial visits to the facility. Such reputations made it difficult for us to engage in meaningful discussions with the youth. We were forced to adapt our communication style in order to better connect with these youth. One strategy was isolating an individual from the group—not unlike conducting a patient interview with an adolescent and having the parent leave the room. Another effective communication technique involved using the youth's personal experiences and interests to help relate certain topics. For example, over the first six months we learned about the inmate's interests, work experiences, and plans upon release. The statistics report a high incidence of homelessness (32%) in youth in custody and our experience corroborated that.[1] Having learned the importance of income in reducing recidivism, we catered a presentation to their career goals to help interrupt this cycle. Providing personalized information (such as pamphlets to specific programs of interest) was also valuable and helped build rapport.

In another instance, there was a situation where an inmate had assaulted another youth. We used this opportunity to engage in a discussion on bullying. We posed an open-ended question on whether anyone in the room had been bullied; everyone (guards, medical students, and inmates) raised their hands. This created a safe environment and led to an interesting discussion on the types, effects, and prevention of bullying. Relating personal experiences and interests to a specific topic was an effective way to engage the youth in an interactive discussion.

Strong communication skills are the cornerstone of the medical interview and the doctor-patient relationship. Physicians are required to develop these skills to interact with a wide variety of individuals, and the CSLO experience with this marginalized population allowed us to foster these skills in a subset of marginalized populations. Although the interactions at the youth custody center were not that of doctor-patient, the learning outcomes and strengths developed will translate into skills used in the medical setting.

CONCLUSION

The opportunity for students to develop community-based programs over an academic year gives them a unique perspective about the healthcare needs of specific individuals, communities, and populations. Working with community service organizations can be a valuable adjunct to medical education. Exposure to marginalized populations in a social setting may be a more effective way to understand concerns specific to these populations and ultimately lead to better care. The CSLO component of the DPAS course is a valuable option for students in the UBC medical curriculum.

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How to Make It in Medical School: Pearls of Wisdom from Dr. Salloum

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