Opportunities to promote health to vulnerable male teenagers

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ABSTRACT **Wildbore, A. (2004) Opportunities to promote health to vulnerable male teenagers. *Nursing Times*; 100: 29, 36–37.**

Forty years ago an increase in 'juvenile delinquency' led to a large prison-building programme for young offenders. Today, the emphasis is on community sentencing and a reduction in prison places. The secondment of nurses into youth offending teams makes it possible to offer primary health services to a group of mainly male, vulnerable people.

Teenage boys comprise a vulnerable group who do not usually access health services. In 1959 the government launched a prison-building programme for young offenders – that included eight borstals and eight new detention centres. Borstals were used in the UK for delinquent boys aged 16–21 years, and the detention centres were introduced to give a 'short, sharp shock' to some adolescents.

The abolition of detention centres

Borstals and detention centres were abolished by the Criminal Justice Act 1982. Since the Crime and Disorder Act 1998 there has been a clear focus on training and education. At present, secure training centres cater for young people aged 15–17, and these centres have a high ratio of staff to young people.

Youth offending institutions for 15 to 21-year-olds have a separate block for the under 18s. The majority of these facilities are for males, with very few institutions for females, a reflection of the higher numbers of males than females in the criminal justice system.

Today the emphasis is on reducing the number of prison places for teenagers and increasing community sentences. According to data from the Home Office (2003), two-thirds of young offenders are male and a large majority are excluded from school or have been truanting. As a consequence they not only miss out on access to education but also on the provision of health information and monitoring services.

Young offenders' health needs

Since the implementation of the Crime and Disorder Act 1998, in which multidisciplinary youth offending teams were set up for the first time, there has been an opportunity to assess the health needs of young offenders.

The health officer is a nurse and part of a youth offending team with a background in school nursing, health visiting, or psychiatric nursing, and is usually employed by the health service.

He or she offers health interviews/assessments to each young person entering the criminal justice system and if they wish, parents or carers can be included. In the authors' experience, uptake is about 70 per cent.

The scope of the problem

According to a recent report from the National Audit Commission (2004) there are 3,000 young people in custody at any one time. This is four times higher than in France and 100 times higher than in Finland.

The main reason for the greater numbers is that the UK has the lowest age of criminal responsibility in Europe (now 10 years old but previously eight years old). In addition, the borstals, which were modelled on the public school system (a residential upper-class institution) and have now been abolished, were the first in the history of juvenile crime regimes. This was not replicated by other countries around the world, which have higher ages of criminal responsibility and rely more on community sentences.

While there is health provision within the custody system, there are a wide range of health needs, particularly mental and sexual, which are more appropriately addressed in the community.

The Home Office wishes to build on the success of the Intensive Supervision Surveillance Programme (ISSP) by using it more widely as an alternative to custody, as suggested in the government green paper *Every Child Matters* (Department for Education and Skills, 2003). The ISSP consists of electronic monitoring and the close attention of individuals by supervising officers in the community as the main response to serious and persistent offending. The Home Office document *The Next Steps* (Home Office, 2003) proposes expanding the programme to 4,200 places.

One-third of young offenders interviewed in the document *Speaking Out* (Youth Justice Board, 2003) said they would like help with a health issue. Ten per cent had

BOX 1. COMMON HEALTH ISSUES AMONG YOUNG MALE OFFENDERS

- Outstanding immunisations
- Bereavement issues
- Depression and anxiety problems
- Dietary inadequacies
- Scant knowledge of sexual health
- Dental problems

Alamy

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WEBSITES

Youth Justice Board: www.youth-justice-board.gov.uk

Dads and Lads: www.passport2sport.co.uk

Young Minds: www.youngminds.org.uk

Fathers Direct: www.fathersdirect.com

KEYWORDS ■ Primary care ■ Young offenders ■ Adolescence

BOX 2. HEALTH RESOURCES AVAILABLE FOR YOUNG OFFENDERS NOT ATTENDING SCHOOL

- Youth offending team health worker
- School nurse for excluded children
- Child and adolescent mental health service (CAMHS) link worker
- Sexual health clinics
- Practice nurses in GP surgeries
- Community dentists

deliberately harmed themselves and 50 per cent said that they often felt miserable or sad.

Statistics regarding male suicide are alarming and figures from the Department of Health (2002a) show that suicide rates among men have risen dramatically over the past 20 years. Suicide is now the second highest cause of mortality in men after road traffic accidents.

Teenage pregnancy and a dramatic rise in sexually transmitted infections are also of concern and relevant for discussion with male teenagers entering the criminal justice system.

What do young teenage males want?

Recently there have been major attempts to try to find out what young teenagers want. Previously there have been assumptions about their needs but the document *Listening, Hearing and Responding* (Department of Health, 2002b) outlines that the DoH will be working in partnership with communities and families to make sure children's needs are recognised and met.

In addition, the RCN (2002) found that young fathers want to stay in touch with their children but few fathers' networks or groups exist. The organisation Fathers Direct acknowledges this gap and provides regular newsletters and conferences. Also, Dads and Lads has nationwide groups with opportunities for fathers to involve themselves with their sons through sports activities.

Many teenage males interviewed by the Youth Justice Board (2003) said that the transition from primary school to secondary school was intimidating. This echoes Fyvel (1961) who questioned the rules for divided education after the age of 11. The problem that children face at this transitional stage is recognised by many schools. Many offer pre-term residential holidays and days spent in the secondary school while the pupils are still at primary school. At least one school has encouraged a support group for parents to help them settle their children and address their feelings about changing schools. A parent who experienced problems with her son started this group.

During his interviews with young male offenders in the early 1960s, Fyvel found young males who underachieved in education felt rejected by society. By being a part of a gang, they could achieve a higher status. The Crowther report in 1959 (examining the needs of 15–18 year olds) led to the raising of the school leaving age from 15 to 16.

At present there are 9,000 children who are excluded from schools. Sixty per cent of excluded children have committed a crime – this compares with 26 per cent of children attending school who have committed a crime. Two-thirds of young people entering the criminal justice system are male, and the majority are aged 15–17.

Opportunities for health promotion

The chance to provide one-to-one health interviews to offer immunisations, dietary advice, and information about testicular self-examination, mental health, and sexual health assessments is an important opportunity – not only for informing and empowering young people but also for linking services such as sexual health clinics, practice nurses, GPs, and child and adolescent mental health service staff, as well as dentists and dietitians.

Specialist school nurses, specifically for excluded children, work closely with Youth Offending Team health workers. However, of the young offenders interviewed by the Youth Justice Board, 57 per cent said that they find it difficult to trust anyone, so a trusting rapport is essential for effective results (Youth Justice Board, 2003).

Communication

Communication and providing a trusting atmosphere is crucial to working with teenage males. Bannister (2000) comments that research has shown that children and young people know what their needs are and they can usually communicate their needs if practitioners take time and develop the skills to listen to them.

Many teenage males find it difficult to express their feelings, and school nurses may not always have time to build rapport. However, the practice of joint working with school counsellors (who are increasingly being employed in schools) enables school nurses to share resources with organisations such as Young Minds, a national charity with an information centre. There are useful leaflets on all mental health issues, especially written for young people.

Practice nurses who come across teenage males should adopt a non-judgemental, listening approach. For example, asking too many questions does not build rapport and the aim is to establish communication. Using materials such as plasticine or felt-tip pens and paper to encourage expression can have remarkable results with teenage males, as it can help them to relax.

Bannister (2000) stresses that a written agreement should be made regarding confidentiality. It is also crucial to bear in mind that vulnerable teenage males do not readily express their feelings until they are confident that they will not be judged, denied, or punished.

Conclusion

Due to decisions made by the Home Office to reduce teenage prison places, there will be an increasingly large group of teenage males who would not otherwise come into contact with health services in the community. This is therefore a major opportunity for community health workers to encourage participation and take-up of primary health services. ■

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