ISSN 1363-8394

Journal of Adolescent Health and Welfare

Volume 10 - No 2 - Summer 1997

Incorporating the Newsletter of the International Regional Chapter of the Society for Adolescent Medicine

Letter from the editor -

Dear Colleagues,

Planning for the 1998 conference is proceeding apace - the response from speakers, particularly on an International front has been truly amazing. Looks like it's going to be a really great occasion - so book up soon!

The appraisal forms from the 1996 conference have given us some guidelines for future planning - although some comments are difficult to respond to when diametrically opposite views are given. The general response was excellent - discussion groups were variable and highly dependant on the leader. Some people felt they wanted a break and did not want academic discussion over lunch - hence in our next conference we are going to have an alternative of - free lunch break or meet the professor lunches. Some people complained about the quality of lunch which was sandwiches - but since it was basically free, that seemed rather wingey to me. Where else can you have an all day conference for only £15 including lunch and coffee! Give us a break! I did take exception to the comment that the conference was 'male dominated and self indulgent' - as the female leader of a conference where half the speakers were female - maybe the comment related to a particular speaker? So far as self indulgent - I make no apologies if it referred to the emphasis on Youth Support's achievements since it was after all a celebration of our tenth anniversary.On a score of 0-5 the ratings were as follows-

Pre-conference booking - 4.1
Displays - 3.7
Mental Health Plenary - 3.6
Discussion Groups - 2.9
Sexuality Plenary - 4.4
Keynote lecture - 4.5
Registration - 4
Opening address - 4
Health - 4.1
Refreshments - 3.5
Social and Behavioural - 4.1
Dinner 4.8

Reminders -Oct 23 meeting Royal Society of Medicine: Oct 1998 International conference Royal College of Physicians; seminars at YSH; articles for journal.

Diana Birch
Director Youth Support

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Youth Support are pleased to invite you to attend our

Twelfth Forum Meeting

At - The Royal Society of Medicine
1 Wimpole Street, London WC1

Thursday 23rd October 1997 - 6-9pm

Self Harming Behaviours and Eating Disorder

Name .... Designation ....
Address .... Tel no ....
.... Fax no ....

Please reserve .... places at the Forum meeting for myself and colleagues (attach list of names please). Please ring category below and enclose appropriate payment.

Non member - £15 per person.
Forum member free (plus free guest). Students free. Young People free.

OR - I wish to apply for forum membership and enclose £20 in payment.

Please send to :- Youth Support Conference Administration
13 Crescent Road, London, BR3 2NF. FAX 0181 659 3309

* CONFERENCE ROUND UP *

- Personal views of those attending recent conferences -

"Youth - Our Resource for the Future"

Our conference on 24th October 1996 marked the tenth anniversary of 'Youth Support'. The charity began from a small idea - that of providing help and support for pregnant schoolgirls and young mums and grew to include services for young people with many differing needs. Forum meetings have formed a vital part of our work - Adolescent Health has been a neglected area in the UK and 'spreading the word', supporting and teaching colleagues is vastly important.

The first meeting of our 'Forum on Adolescent Health and Welfare' attracted approximately 50 people to the Royal Society of Medicine one evening - this last conference had us turning delegates away as numbers went over the 450 mark -the maximum possible at the Royal College of Physicians and resulted in us having to hold parallel plenary sessions using the just opened new lecture theatre with a video link between the two. Our prayers were answered when the builders finished on time!

This was a really proud moment for those of us who had struggled so hard to obtain some recognition for adolescent services and the need of young people to have a medical service in their own right. Colleagues travelled from across the world at their own expense to take part - Roger Tonkin from Vancouver opened the conference with a balanced view of 'Youth Empowerment - Illusion or reality?' - bringing some common sense to the latest 'buzz word' in adolescent health - *empowerment*.

Parallel plenary sessions on 'Mental Health and Behavioural problems' chaired by Eric Taylor with contributions on teenage suicide by Patrick Alvin from Paris, therapy by Ueli Buhlmann from Zurich and a moving personal story read by Laura, a young 'Youth Supporter'; and a plenary on 'Health and Physical Challenge' chaired by Neville Butler raised complaints from delegates who found it hard to choose. Such is the dilemma of adolescence - learning to make choices!

The afternoon choices were no easier - 'Teenage pregnancy and sexuality' chaired by Pramilla Senenayake (IPPF) and including the youth support experience of fifteen year longitudinal survey of school girl pregnancy, exciting presentations by Fay Hutchinson and other colleagues from the Brook, Pamela Gilles from Nottingham to name but a few - vied with 'Social and Behavioural challenges' including Christine Ferron from Lausanne presenting a study of school drop outs, Dr Aggrey Burke on the challenge of race and Leon Polnay on the needs of young people in care.

The day ended with a keynote presentation 'Looking to the future'. Dick MacKenzie (Los Angeles) had the audience visualising youth

wandering through the 'shopping malls of life' picking and choosing experiences, risks and positive growth when they are ready - putting what you want in your own trolley.

We learned a great deal from the conference and perhaps the biggest lesson was that more people do have an interest in considering the needs of young people, there is a lot to learn , a lot to discuss and we need much more time! Hence our next conference will extend to two days and have alternative plenaries, workshops, posters and free paper sessions. Dates are 22nd and 23rd October 1998 at the Royal College of Physicians, London. I encourage your attendance. Youth Support has flourished in the last ten years and the conference was a celebration of the energy, commitment and dedication of all our staff and friends - and particularly of our youth. Let us hope that we will continue to grow and serve young people for the next decade!

- International Chapter News -

News of the **International Regional Chapter (IRC)** of SAM
(Society for Adolescent Medicine)

Co Chairs -	Diana Birch	Gustavo Girard	Treasurer	Aric Schichor
	London	Buenos Aires		Connecticut
	England	Argentina		USA

We have just had our SAM meeting in San Francisco. As usual a very full meeting which seems more crammed with material every year. Our institute was the most adventurous project we have undertaken to date with a number of chapter members, new faces and prominent SAM members giving of their time and joining in - quite a heartening milestone for us all - and hopefully something for the chapter to grow on.

It does seem that after a somewhat difficult period of 'role confusion' during the birth pains of the IAAH, the Chapter has emerged with a distinct identity - a fully fledged part of SAM. While at the same time IAAH has forged it's own identity outside of SAM - even though there is a considerable overlap in membership. This healthy parallel growth feels much more comfortable than what could have been perceived as competition for the same 'market'. Gustavo and I defined the IRC in our '94 newsletter - this definition is reiterated below for the benefit of new members.

The write up of the institute will feature in the next journal - however this edition does include articles by chapter members Daniel Hardoff (Israel) and Onno Sijperda (Netherlands).

What is the IRC SAM?
The International Regional Chapter of SAM.

The IRC (International Regional Chapter) is a chapter of SAM (The Society for Adolescent Medicine) which has been in existence since 1987 to provide a forum for both non USA members and US members with an interest in International affairs. In common with other chapters, not all chapter participants are full SAM members - but we encourage colleagues to join SAM wherever possible.

Our principal objectives are to :-
Encourage International participation in SAM and at SAM meetings.
Increase awareness in International issues among SAM members.
Provide a forum via our newsletters and annual workshop for interchange of ideas and for professional 'networking'.

The IRC has to date been the only chapter of SAM to run a workshop at the annual SAM meeting and this activity has been a successful focus for the chapter.

There is naturally some overlap in membership of IRC SAM and IAAH - but this constitutes a very small proportion of individuals and the ethos and structure of the organisations are quite distinct.

At our chapter business meeting - We decided that we should collect chapter dues from members since the cost of keeping in touch, producing the newsletter and postage is high for a chapter so widely dispersed geographically. Aric will be contacting members to request chapter dues of a minimum of 10 US dollars (reduced from 20) and a suggestion of a donation to boost chapter coffers which are currently in the red.

One of the reasons - in fact the main reason for this deficit - is the fact that this year a number of SAM members signed up for our international dinner and then did not show up. Since the dinner was on a Friday night and had to be booked at short notice - we had to prepay for the set number of meals - and this money was lost when the 'no showers' did not contribute. For all other SAM dinners a sum of $40 is paid up front at booking - so you would think that people would realise that signing up for an event does bear some responsibility to pay for it. Aric is contacting these individuals to exact payment.

Next years meeting will also hopefully include an international institute and we will be working on the theme of exploitation of youth - particularly via sexual exploitation , pornography, prostitution of young girls and boys and 'sexual tourism'. We will also include child labour. Please get in touch if you would like to present on this theme.

Eating Disorders - Cultural and Religious Considerations

Daniel Hardoff - Division of Adolescent Medicine
Bnai Zion Medical Centre Haifa Israel.

The definitions of both anorexia nervosa, bulimia and also of the eating disorders not otherwise specified include the fear of being fat [1]. This intense feeling is involved in the development of the pathological eating behaviour However, beside internal factors that influence the adolescent to achieve weight control, cultural aspects have a significant contribution to eating patterns and weight control of teenagers in particular and need to be considered in the evaluation of persons with suspected eating disorders. The role of culture in eating disorders is of interest to physicians and psychologists as well as to sociologists and anthropologists.

There is an extensive literature dating back to Darwin [2] on cross-cultural differences in the idea of beauty and within a given culture a consensus of opinion and taste prevails regardless of age,socio-economic status, ethnic differences and standards [3]. Throughout history, ideals of feminine beauty have changed in accordance with aesthetic standards of the particular time and women have attempted to alter themselves to match the current societal demands [4]. The societal pressure to stay slim in western countries increases with the socio-economic status and the overall wealth of the country [5,6] whereas in the less affluent countries there is a direct positive correlation between body weight and socioeconomic status [7] The perception of body shapes and aesthetic values of overweight are culturally related so that the stigma of fatness as ugly is far from a universal value [8]. Indeed in some cultures obesity is valued as a symbol of success and economic security [7]. It has been shown that Kenyan Asian females tended to perceive thin female shapes more negatively and fat female shapes more positively compared to British females [9] However both Kenyan British and UK females ratings demonstrated a linear relationship between increase in obesity and increase in negative evaluation [9]. In a recent study of Ugandan and British males and females in England who had to rate health and attractiveness of figures, the Ugandan subjects of both sexes tended to rate the more heavy obese figures as much more attractive and healthy than did the British subjects[8] Still, that study showed that there is a pan-cultural preference for midrange body shapes.

Adolescent girls in North America have perception of attractiveness that does not conform to biologic reality[10] A survey of adolescents of both sexes in the US showed a striking disparity between self-perception of obesity and actual weight for height in girls but not in boys[11] A literature review of children's attitudes toward thinness and fatness [10] revealed that at age 7 years and possibly earlier children have acquired adult cultural perceptions of attractiveness. By 6 to 9 years of age children already express dislike to the obese body build and the role of television in obtaining such attitudes has been suggested since, a message is delivered through TV programs and advertisements equating thinness to beauty and good life. These

cultural predispositions may be regarded as contributing factors to the development of eating disorders in pre-adolescent children who are now more frequently diagnosed compared to the previous decade[12]
Cultural factors in development of eating disorders have mainly been studied in Western civilizations.Despite recognition that socio-cultural factors influence disordered eating, the important sociocultural factor of ethnicity has been previously overlooked[13]. Within the United States white adolescents were more likely to exhibit bulimic behaviours than were Black, Hispanic or Asian adolescents[14,15] In a recent study comparing Greek Australian and Anglo Australian adolescent girls regarding risk factors for the development of eating disorder no difference was found in body image variables indicating dissatisfaction [16] Since previous studies have shown low levels of eating disorders in Greek girls living in Greece[17] and similar risk levels of Australian compared to US girls[18] it was hypothesised that first generation Greek Australian girls had assimilated Australian attitudes regarding ideal body size and eating behaviours [16] When Turkish & Greek adolescents in their native countries were compared to Greek females in Western Germany a higher rate of anorexia nervosa in the offspring of migrated families was found[17] suggesting migration to Western culture as a risk factor for the development of eating disorders. Cultural changes that include identification with Western ideals of slimness are therefore followed by an increase in weight and shape consciousness leading to the development of eating disorders[19] This hypothesis of over-identification was supported when a transcultural comparison of eating disorders was performed in the former East and West Berlin [20] A cross-cultural study of the prevalence of eating disorders in Central Europe before the political changes of the 90's, has shown that eating disorders represented at least as a common problem in Eastern as in Western Europe[21]. It has been suggested that the process of identification with Western values existed before the political changes through the mass media, and that further increase in eating disorders in these countries might be possible following the recent changes[21]

Conflicting data exists in regard to the relative prevalence of eating psychopathology among Asian women compared to Caucasian women in the US and in the UK. While in British studies women[22] and school girls[23] with an Asian background (from the Indian subcontinent) had more abnormal eating attitudes, American Asian women not from the subcontinent had lower levels of eating psychopathology [2] Other surveys have demonstrated differences within the same ethnic group across nations[25,26].Recent study[27] shows that perceived control by family members is not important in determining the relatively unhealthy eating attitudes of Asian adolescents of Indian origin 14-15 years old.When girls of a broader age range(12-16 yrs) were studied the effect of perceived parental control was particularly strong among the older girls [28].Parents are likely to attempt to ensure that their children conform to the values that the parents themselves hold as important. These efforts may conflict with the child's attempt to identify with Western cultural influences

causing the child to gain internal control manifesting as disturbed eating patterns and eating disorders[29]. Interestingly, with parental control excluded it turned out that the Asian girls were more satisfied with their bodies than the Caucasian girls[27]

While cultural factors may change eating behaviours of migrating adolescents, religious traditions regarding food restrictions have prevailed thoughout generations in different cultures. Fasting days in the Jewish tradition such as Yom Kippur and food avoidance during the day in Ramadan month in the Moslem tradition are typical examples. There is no place for individual variations within these traditions and the time limit for food restrictions is clear and precise. The paucity of literature describing anorexia nervosa in the Jewish context suggests orthodox Judaism may protect against the illness [30] Judaism does not consider aesceticism very highly, and strongly refuses to see God-pleasing act in self inflicted abstention from the permitted pleasure of life[30]. There is a long-standing connection between Christian aesceticism and food refusal, where the human body was considered secondary to the human will and spirit[31] In medieval times self starvation was sometimes considered as a heroic behaviour inspired by God and Christendom's patriarchy defined it as a saintly sacrifice[32] But in the thirteenth and fourteenth centuries holy anorexia became a positive expression of self by a woman in response to the world that attempted to dominate her[32]. Anorexia nervosa emerged as a new and distinct medical entity in the late 1800s when food refusal was considered a disease symptom rather than an act of personal piety[31]. In modern times ascetic behaviour involves a wish to make radical statements such as hunger strikes for political purposes or for personal protect. However "fasting girls" at the turn of the twentieth century sometimes reacted against antimodernist impulses by joining traditions of Spiritualism which is a religious movement stressing transcendence of spirit over body and flesh[33] Contemporary fundamentalist tradition extends an asceticism about secularity to control of the appetite and consumption of food. Many diet books published by fundamentalist church-affiliated presses equate the spiritual realm and God's Kingdom with bodily thinness and lack of fat[31] Although there has been little actual research on religiosity in contemporary anorexia some published reports suggest that religion does play a role in the lives of present time anorectics. Thus in ancient times socio-cultural issues including religious affiliations were the sole influencing factors in determining restrictive eating behaviour. In our times these factors still contribute to the development of eating disorders. Therefore, migration, family tradition, religious affiliation and beliefs should be included in the assessment of eating disorder before finalising the clinical diagnosis.

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Youth Support Conference '96

Youth - Our Resource for the Future

you enjoyed the conference

- now buy the proceedings -

available spring '97 advance orders £5

AND - book the next one!

join us again in 1998

see over for details!!

The 'Group Game'
Group Therapy / Group Leadership workshop

How about using one of our Youth Support training games in your staff group? The following is a role play designed to bring out some of the dynamics of group interactions. It can also be a useful exercise to try out with patient groups and young people. Initial instructions and explanations should obviously be varied dependant on the type of participants.

One member is allocated the role of group leader and is given appropriate instructions such as the following - Themes can vary to deal with topical issues.

Group Leader -

You are leading a mixed group of fairly disturbed people.
You want the group to discuss ways of being assertive without using violence and aggression.
One of the group members has recently been expelled from the treatment unit for striking a member of staff - so there is this undercurrent of anxiety to deal with.
Find ways of facilitating the group process while maintaining a measure of control and protection for the 'weaker' members. Make appropriate interpretations and challenge when necessary.

The other group members are each assigned a role card which can be made by photocopying the sheet overleaf and cutting out the sections. They can be stuck on card or laminated.

Role Cards

Powerful , PAT silent type who sits in back of group and refuses to be drawn in.	**'Mr Normal' NORMAN You think groups are great for people with problems - but you don't have any!**
Garrulous GERT person who talks a lot about inanities and not really relevant to group	**DAISY Denial is your forte. You can participate well in group discussions but cannot apply it to yourself.**
Passive/aggressive PETE type - you appear to be participating and doing what the leader wants but really you are undermining the group.	**Rubbish .... RALPH You think groups are rubbish and that the therapist is stupid.**
'Helpless' - HELENA attract attention to yourself by being weak and helpless and sniffing and 'getting upset' if challenged.	**'Seasoned' SUZIE -you have been through therapy before and are very good at challenging the others and telling them what they are doing but not so good at looking at yourself.**
Pained PAULA you are a 'good' group member, you share your feelings but nobody has suffered as much pain as you have - you play one upmanship in the pain stakes.	**Shocking SARAH - you get attention by waiting your turn and making outrageous remarks or trying to shock the others.**
Disruptive DORA You try hard to concentrate on the group but you make sure that you attract attention by doing something physical to disrupt - fall off our chair - have a coughing fit, feel faint, make a noise etc.	**Intense IRMA You have a real problem you want sorted out and have come to this group to work hard. You are irritated by others diverting you from your purpose and with the therapist for not controlling the group.**

Observation of group -

It is sometimes useful to include a group of observers who are invited to comment on the group process - otherwise group members should discuss their perceptions after approximately 15 minutes of role play.

Look for power struggles
- **who is in control**
- **how do they control?**

Allegiances and sub-groupings
- **group members 'using' others in their game play.**
- **who is 'with the therapist' and who 'against'**

Attention seeking ploys

Avoidance mechanisms
- **how do they avoid, tactics**
- **why?**

The leader / group therapist
What tactics do they use?
- **interventions**
- **challenging**
- **interpreting**

Group member

How does it feel to be part of group?
What do groups members mean to you?
Could you draw parallels between the way the group worked and felt for you and the way you have felt in other groups? For example in your family? In your school? In your work place?

Risinghill: Death of a Comprehensive School

This was the title of a book written in 1968 by Leila Berg regarding the short life of a secondary school - born in 1960 and died in 1965. The problems of Risinghill are not unique and it is salient to look back on some of the comments and findings of this enquiry and the demise of a well meaning headmaster who attempted to achieve 'democratic' leadership. In working with young people we tread a thin line between allowing freedom of thought and behaviour, youth empowerment on the one hand and giving direction and containment on the other. This is often even more important when we consider managing and directing staff who work with youth! Quotes from the Risinghill report will I am sure strike resonances with many of us.
-

Apart from keeping his day as clear of paper work as possible, so that he always had time to see his teachers the head organised very frequent staff discussion meetings so that everyone would be free to come at some time. At first sixty teachers used to turn up to each discussion. One teacher said she went over to the lavatories and found some girls there smoking, and when she told them off they said ... something .. well she couldn't repeat it. 'But what was it?' The head asked. She said 'No, I couldn't possibly tell you' He sensed it was really something which she wanted to say through their mouths and he said 'Was it something about me? If it was, say it - I'm used to hearing rude comments.' So she said 'They said "That silly bugger won't mind!"' He laughed; he was genuinely pleased because he was getting some truth, and because the teacher had found a way to release some hostility.

But one of the senior members of staff became very distressed and anxious and would not stay at meetings where junior members of staff were permitted to say whatever they liked, and this teacher gave very emotional reports on such meetings to County Hall (the management body), who did not like it either. County Hall did not have to worry. The discussions were broken up by the teachers themselves. A group of men teachers pushed corporal punishment as the solution to every problem, at every meeting and after weeks of this incessant drumming, the rest of the staff was bored and angry and refused to come any more. The discussions had been broken up by imposed force of which corporal punishment is after all merely another facet. From then on the only discussions that could be held were casual spontaneous ones in the head's study with only the already sympathetic teachers The others were so embarrassed and disturbed by informality in surroundings that they felt should be august, that they kept as far away as possible.

I was very puzzled to hear staff complain that the head did not give them leadership. I had never come across a school where the head initiated, or tried to initiate, both spontaneously and with specially duplicated papers, so much discussion about policy and methods. Afterwards I realised that many of the staff did not want discussion - they wanted to be 'told'; and they wanted to be led in a completely different direction from the way the head was going. This is what they meant by 'no power of leadership' - a phrase which later County Hall, pulling determinedly in the opposite direction, was to use too.

The head himself had also been brought up by authoritarians. But unlike most of them he had not succumbed, and had preserved his honesty. He was resolved that no child should experience the humiliations, the violence, the undermining of integrity that he had experienced, but should instead be allowed and encouraged to grow from his own inner source. All this made him a person of enormous value to growing children, and to education in practice. But from his own fight with authoritarianism, he still retained a weakness. He was over concerned that adults should understand what he was doing and concede that it was good.

Youth Health Profiles

Onno Sijperda

I am a school doctor in the Youth Department of the Regional Health Service in Zwolle, Netherlands. I shall try to inform you about a new approach in our Health Service in which co operation with our direct clients, schools and local authorities is essential. I shall show you how epidemiologic inquiries can make this part of the whole policy cycle for schools and local authorities. I am in charge of the health care for about 10,000 children and adolescents from four to about 20 years old. It is our duty to achieve optimal health of young people through periodical examinations and consultation hours for adolescents but also by stimulating network activities and co operation of various disciplines and professionals and by Health Education activities, sometimes in specific projects. Interdisciplinary co operation is necessary to cope with the often complicated problems young people have to deal with today. Especially in the small, mostly rural towns in the eastern part of our country there has been a relatively fast increase of behaviour problems amongst adolescents in the past ten years as reported by many authorities and confirmed by epidemiological inquiries in various fields of health. For many years in our region the local alcohol abuse problems among young people have been significantly higher than in the rest of Holland ('87 Regional Health Service Inquiry). Traffic accidents and casualties are more common. Juvenile delinquency has grown fast, gambling problems have become very common and especially the use of drugs has increased from about 1-2% among adolescents in 1987 to 15% now! It seems that this process has been accelereated considerably by, on the one hand, the loss of traditional firm family-ties, the decrease of the role of the church in the community and the loss of microsocial control in this rural society, and on the other hand the denial of the real problem and lack of professional infrastructure in the region (police, social work, etc) In the past years we have developed three projects to approach this problem:

- a regional project for young dropouts, in which collaboration links are being established with the secondary schools, especially in the fields of school dropoutss and absence-administration and abuse and addiction problems.
- A local addiction prevention project for drugs, gambling and alcohol which started six months ago; and finally
- A project on bullying and social competence in the whole area of the Health Service

Communities and schools show interest in establising a more integrated way of approaching these problems thus Health Services are forced automatically to start new procedures and processes. In the field of Public Health we developed two main approaches in the past four years. An important basis for these new approaches is a more systematic way of collecting data (youth) health profiles, the inquiry with 2000 adolescents. The two approaches are:

1. **School Health Policy** In the past few years the cooperation between schools on the one hand and the Youth Department and youth assistance services on the

other has been concentrated on four areas:

- signalling and assistance of problem youths
- health education and health promotion
- network activities / co operation of professionals
- care of a healthy environment

It turned out that schools were very satisfied with the more structured co coperaiton with the Health Service and also that projects such as the "bullying" project and the "addition" project were much more effective when these four areas were taken as starting point. A variety of organisations in Holland (Health education, Health services) at this moment try to conceptualise this overall vision on school health policy. The European Association of Health promoting Schools is a good ambassador in this field.

Until now a broad implementation project for elementary schools has been carried out by some thirty regional Health Services in co operation with the Institute for Applied Social Sciences of the University of Nijmegen in the past five years. Recently the same institute started an implementation project for secondary schools with our health service as a pilot institute. Both questionnaires of this enquiry and the whole school health policy cycle are an important part of this implementation project.

2. Healthy Cities Approach

In our country, as in our region, it is increasingly important to develop a Health Policy for any community or even any part of a city. One tries to develop a local health policy in this way with participation of the population, with direct lines to the local authorities especially directed to social-economically determined health differences. Practical consequences of this approach are in general:

- specific projects for the young (criminality/ social dropouts)
- special projects on a subject (safety,traffic security, damp housing)

special investigations: in addition to the regional database centre, we made several inquiries by key figures to stimulate the local health policy.In our Health Service we already have a long history in this field ("Public Health for young drop outs" Turku 1991) Since 1994 we have tried to develop a healthy Region approach in which all 21 communities of our Health Region can participate The first activities the several communities asked us to cooperate in are "accident prevention" for the aged, drugs prevention and social isolation. The whole local health policy cycle in this respect will start next year so the communities are already looking anxiously forward to the first results of our inquiry

The investigation; its origin

1 *cardiovascular risks*

From the available national data our health service tried to establish some preliminary communal health profiles, which were the first basis for the Regional Data Bank to develop in the years to come. It soon turned out that cardiovascular diseases both in morbidity and mortality were more prevalent in our region Therefore in 1993 we started a cardiovascular epidemiologic project for the whole population in which participated about 3200 inhabitants aged 20 to 70. For the young we wanted to start an inquiry on life style to be carried out in 1994.

2. *Socio-economically determined health differences*

For many years there has been a good co operation with the department of Social Medicine of the University of Groningen. Some investigations have been carried out together so when we were asked to participate in the longitudinal study of 2000 adolescents in the northern part of the Netherlands, similar to the twenty-07 inquiry in Glasgow (Patrick West e.a.) in which socio-economically determined health differences were the main target (cf also Black Report 1984) we were happy to do so. We decided to use the same questionnaires as Groningen for both their study and our life style study and completed the questionnaire this way. Finally we added 1500 to the existing 500 students who already participated in our region in the Groningen investigation and thus made our own inquiry with this 2000 students population

3 *School health policy*

The Health Promoting Schools Approach is growing very fast in Holland and since our service is involved in the implementation project for secondary schools it was very natural to incorporate the questionnaires and the whole investigation in this project. It can be one of the instruments in the information stage of the school health policy. Moreover the projects based on this approach (bullying, drugs and stimulants use) needed a baseline measurement

The investigation, the method

Procedure

Eighteen schools were approached in 1994-995 to co opeate in the investigation. After an explanatory meeting with the management and interested teachers within school an invitation for joining the inquiry was sent to the form IV students (15-16 years of age) of the four types of secondeary school education in our country. On the day of the inquiry a team of epidemiologists, a school nurse and medical assistant introduced the questionnaire in the class and where necessary assisted the students in filling it in during one period of 50 minutes. Results were collected and were analysed with the help of SPSS

The questionnaire

The questionnaire consists of the following categories:

A personal factors (family structure parents education and profession)

B Health determinants; life style (stimulants, food, sports) cultural factors; social network /social support; coping behaviour and coping style

C State of health ; somatic experience complaints; psycho-social wellbeing (loneliness, self esteem etc); medical consumption

The population

For the Groningen investigation there were three schools in Zwolle. For the health service investigation the schools were in Zwolle (100,000 inhabitants) and in the other cities in the neighbourhood Kampen, Hattem, Steenwijk, Dedemsvaart,Ommen and Hardenberg (all about 20,000 to 30,000 inhabitants)

General results

The number of male and female students was nearly equal

The average age was 16.6 years

The majority of the young came from traditional family structures (89%).

Lifestyle - Lifestyle and general behaviour influence short term and long term health. In the next table the results for tobacco, alcohol and drug use are given as

well as the results for sports and breakfast

Lifestyle results for the whole region:

		number	%
Smoking (now)	No	1256	63
	Yes	732	37
Alcohol use (last 4 weeks)	No	327	19
	1-5 times	1036	52
	6-19	431	22
	20 or more	137	7
Drugs	never	1345	75
	1-5 times	271	14
	6 or more	360	11
Sports	No	572	29
	Yes	1416	71
Breakfast	0-2 days	353	18
	3-4 days	162	8
	5 days	1470	74

The results for smoking (yes or not) are very much the same as those of the NIAD survey of 1992 which concerned the whole Dutch youth population. Looking at the same age in this inquiry one can see that the group of non ever drug users has diminished from about 85% in 1992 to 75% now. That means that more children are willing to experiment with a so called soft drug like cannabis, a good reason for a prevention programme. Alcohol use is rapidly increasing from 72% drinking in the last 4 weeks as mentioned in 1992 to 81% in this inquiry. As for sports and eating habits the results are more hopeful. More important seems the difference in substance use for the 17 schools. Drugs use for instance ranges from 7.5 to 15.4%

General health Only 57% of the students felt healthy.

% Complaints in the last 4 weeks	
Headache	68
Stomach aches	51
Nausea	41
Sore throat	43
Cold	75
difficulty concentrating	43
learning new things	30
Sleeplessness	52
Truancy	28
Problems menstruation	70

Although all complaints score reasonably high differentiating the results for the different schools and education types is very important in setting up prevention activities. As for the degree of cheerfulness 89% felt more or less cheerful and 11% did not. For this part as also for the General Health Questionnaire (GHQ) there are only slight differences between the various schools and regions but there is an interesting difference between boys and girls.

I must admit that I showed here only some results of the whole inquiry. Other results will have to be worked out and analysed further but I think it is enough for the purpose of this lecture the use of these data for school health policy and local health policy

Health policy - what next?

In order to give a better basis to both the school health policy and the local health policy it is very useful to collect health data more systematically on various levels and from different sources. We call this systematic health profiles. For both fields these profiles will yield a different policy cycle.

School health policy

In the Implementation project for high schools (ITS Nijmegen) four main instruments for data collection about school health have to be developed:

- one instrument on the student level; this questionnaire, adequately modified and shortened, can be a good one
- one questionnaire for the sociology, biology and health care teachers about the health education programmes they are using
- one questionnaire for mentors and counsellors about the

student problems they come across in their work.

- finally a checklist on safety and hygiene within the school

All the instruments have to be evaluated and validated in the years to come but they can already serve to initiate the policy cycle we are going to start with the schools. Standardised interviews will be carried out with all the 17 schools involved in the enquiry. A specific report with the first data about the students in the school compared with the regional and if possible national averages for each type of education will already have been presented to the school. At this meeting we can discuss the results, collect special demands for further analysis and make further suggestions for intervention, programmes and projects for the school. In November 1995 a contract with each school will be made with a specific program for the next years. Possible interventions have to be as standardised as possible. National projects on a certain subject (bullying criminality stimulants etc.) are preferred but specific interventions for the school are possible, if required. The programmes will run in 1996 and at the end of 1997 a final evaluation will be made in which both the interventions and the co-operation between school and health service can be discussed in order to make a new contract for the years after that. This way the whole Policy Cycle can start again.

Local health policy-Only after the consent of the schools about using their data can we start the policy cycle for the local health policy. In the healthy region project we have the next activities for the years to come. Three pilot communities will have their first interview about their specific problems and needs and demands; they will be able to decide about the specific approach in their community in December. The first results of the interviews with these pilot communities can be used to make a specific scenario for these interviews in general. Results refer to communities where students attend school further analyses will be made starting from the town, village or quarter where the students are living if communities for specific results. Consequently for the whole population just as for the young people a local health policy cycle can start which will be evaluated every two years

Conclusion In this presentation I have tried to inform you about a new approach in our health service in which co-operation with our direct clients, schools and local authorities is essential. I told you about epidemiology as a very important part of the whole policy cycle. I showed you some results of our adolescent investigation. Further analyses will be made from the results and I hope to present them more comprehensively in due course.

A brief psychological analysis of some common sex offender profiles, behaviour patterns and models of treatment

Daniel Anderson - Dip SW Year One
(Daniel was one of our social work students at Youth Support)

Working within the field of child protection and vulnerable adolescents, sexual abuse is often a predominant factor, where clients have suffered, and continue to be emotionally scarred throughout their lives. It is therefore essential for those professionals working within this area to have an understanding of both victim and victimiser, where an understanding of offender behaviour and related therapies can aid and enhance a more knowledgeable and effective approach to work with the victims of such abuse.

This essay will attempt to address some common profiles of the offender, a psychological analysis of offending behaviour, and provide the reader with an outline of treatment models.

The major focus of this essay will deal with the child sexual offender, within the framework of paedophilia, incest and child molestation.

Such psychological factors as 'social isolation', 'role reversal', 'marital discord', 'the seductive child', 'unsatisfactory marital sexual relationship', 'alcoholism', 'sex punitive mother' and 'family dysfunction', have all been well researched in determining offender characteristics. Transference of non sexual problems into sexual behaviour, is another key psychological patter in relation to the profile of the offender. IN the argument of a quest for 'immediate gratification', a Freudian analysis sees the offender as 'continuing into adult life with infantile sexual desire'. with the likes of 'unresolved oedipal conflicts, castration anxiety and repression of the oedipal wishes'. These conflicts all act as contributory factors of regression states of psychosexual development stemming from childhood, thus leaving the adult in a state of 'neuroses / life crises', which can then develop into a state of 'perversion'. It has been argued that socialisation is a further element adding to the make up of the sexual offender. With exposure to pornography and being the recipient of molestation, deviant sexual behaviour as a child can be evidenced within research / practice findings, the result of being inappropriate sexualised behaviour instilled within the child. With these primary external stimuli modelling the child's behaviour, a framework of 'generalisation' can result in a transference of promiscuous behaviour to all who the child interacts with, (imitation). In relation to interfamilial sexual abuse, incest has been defined as an 'erotic form of hatred'. Offenders characteristics are key pointed on the whole toward a member of the family unit, and encompass such antecedents as 'depression, low self esteem, and difficulties in maintaining sexual relationship with adult

women'. These contributory factors can thus result in 'recreational, tactical and physiological forms of abuse' A modern recognition in relation to sexual offender profiles brings gender into the argument and dispels the myth that males abuse and females do not abuse. This next section dealing with major patterns of offending behaviour will address the psychological explanations of behaviour, incorporating gender issues.

Sexual offender behaviour is steeped in 'Freudian regression', 'Kleinian metaphor's', and behaviourist theories in trying to understand such behavioural traits. Freud, as mentioned earlier, titles 'perversion' as a possible result of regression. The regressed offender has developed an age appropriate sexual and interpersonal orientation, yet under certain circumstances may regress to sexual involvement with children. The fixated offender has never developed psychosexually beyond a primary sexual interest in children. Weldon, developing a Kleinian perspective brings gender into patterns of offending behaviour. As a penis is a projecting organ, sexual gratification is inevitable in that the penis projects outwards in active search of its sexual goal, (this provides an explanation for non familial sexual abuse). In terms of the female, the womb is no passive organ, but rather has a strong quest to engulf sperm and therefore has an active need to draw things in through the medium of the vagina. Weldon then argues that as the baby / child is an extension of the mother, abuse will often occur as an introspection, in terms of an abusiveness of the self. this can be further argued by 'punishment of the self' evidenced by such things as self mutilation and bulemia. Elliot has stated that the severity of abuse shows no differentiation in relation to gender and male / female perpetrators. 'Oral sex, forced mutual masturbation, penetration and object sex were all predominant', regardless of gender. Upon discovery, denial is a key behavioural patter, common in the majority of offenders. Freud states that 'distortion of the past can often be subtle and unintentional'. However, Kennedy and Grubin in their study entitled 'Patterns of denial in sex offenders' state that one half of their sample of one hundred and sixty two men were unwilling to accept full responsibility of the offence. Projection and transference towards an external stimulus is often reported, such as placing the blame upon the victim, (the seductive child), the partner, depression, stress and alcohol. Perhaps patterns of denial are best summed up by Salter, who outlines six characteristics of offender denial within a psychological framework:-

a) Denial of the acts themselves (external conflict)
b) Denial of fantasy and planning (internal conflict)
c) Denial of responsibility (cause factor, external stimulus)
d) Denial of seriousness (distorted perception)
e) Denial of internal guilt (ego conflict)

f) Denial of the difficulty of changing abusive behaviour (behaviour modification)

'Psychosexual regression', 'behaviourism', in the form of 'conditioning', 'child aggression theories', 'socialisation', 'non-affliation', 'internalised conflict', 'conflicting mental apparatus states', and 'opportunity', are all fundamental issues in relation to explaining sexual offender behaviour, based on a psychological perspective. One can see that from the above, treatment will predominantly lie with a clinical, psychological framework.

Much of the treatment plans operating within England and the USA centre around 'behaviour, attitude, relationships, emotions, physical conditions, cognition and sexual interests'. These categories are often implemented within a therapeutic and controlling framework of behaviour modification looking at 'antecedents, behaviour and consequences'. Penile plethysmographs are sometimes used to determine the level of deviant arousal patterns in offenders. the sexual offender is subjected to a variety of visual and audio material, whilst the connections to the penis, and other parts of the anatomy, produces readings of arousal. This sexual offender is subjected to a variety of visual and audio material, whilst the connections to the penis, and other parts of the anatomy, produces readings of arousal. This psycho-physiological method helps to assess the arousal level and thus determine the behavioural approaches needed in relation to offender rehabilitation. Aversion therapy, developed originally from 'classical conditioning principles', includes stimuli such as video, audio and slide material, whereby the aversive stimuli will include electric shocks and unpleasant smells. This therapy portrays a classic example of 'negative punishment', and is used primarily within secure settings. covert sensitisation, helps to instil within the sexual offender the relationship between antecedent and consequence of an offence, by means of linking the former with negative thoughts of the latter, hence emphasising a bypass of the behaviour. A popular model of treatment is group therapy which can take many forms. Psychotherapy, whereby sexual offenders engage in group discussion about their offending, in order to 'enhance insight and self control'. Salter argues that groups should be mixed, e.g. paedophile, rapist and molester, whereas Wyre states that groups should be constructed to the main themes in individuals offending behaviour, such as sex education and attitudes towards women, reconditioning, whereby deviant arousal fantasies are replaced by non deviant fantasies through the notion of operant conditioning 'Cognitive distortions', provides another area of concern needing a psychological model of treatment. Cognitive distortions are a predominant characteristic within sexual offenders, e.g. 'If he does what I tell him, he must want it'. Group work where peers

challenge rationalisations about such distortions in relation to cognitive development is often successful in cognitive restructuring. Perhaps the most controversial form of modifying sexual offender behaviour is that of surgical castration, (not implemented in the UK). The fact that orchidectomy can solve problems by curtailing sex drive has been argued by Malcolm Alexander. However John Gunn has replied to this model of treatment by stating that 'guilt, problems of sexual identity and suicide could result from surgical castration, whereas the less severe chemical treatments can be reversible in these situations'. It can therefore be seen that such behavioural treatments as 'negative punishment, positive reinforcement and operant conditioning' outweighs the practice / notion of surgical castration, as evidence suggests that many offenders still commit offences after castration.

In conclusive terms, it can be seen that profiles of the offender, behavioural patterns and models of treatment are predominantly explained, analysed and adhered to within psychological framework. Psychological theory is at the forefront of working with sexual offenders. It can be noted that firstly, there needs to be an on going development of integrated models of sexual abuse, both explanatory and therapeutic, and secondly an attempt to relate sexual abuse to general psychological theories.

This essay has provided a brief analysis of sexual offenders behaviour and characteristics based around a psychological framework, as well as outlining a descriptive and analytical element focusing upon behaviourist and cognitive theory in relation to treatment. The essay acts as an overview, where interested parties will need to look further afield for a more variable and in-depth knowledge of the psychology of the sexual offender and related models of treatment.

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