Proceedings of the Second International Conference on Adolescent Health and Welfare

'Youth - Conserving Our Resource for the Future'

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'Youth - Conserving Our Resource for the Future'

October 1998

at The Royal College of Physicians, London.

Editor - Dr Diana Birch, Director Youth Support

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Day Two - Friday 23rd October 1998

Preface

This conference was the second international conference held by Youth Support and drew colleagues from all over the world. Youth Support is a charity dedicated to the furtherance of health and welfare for youth and children and their families throughout the world and to that end we have promoted Adolescent Health and the training of professionals in the field for the last thirteen years.

Our annual forum meetings and conferences have provided a focus for professional interchange and growth and it is with pride that we announce that following this last conference a consensus was reached that the Youth Support Forum should become the British Society for Adolescent Health and Welfare. We encourage colleagues to join this group which already has a core of distinguished and knowledgeable founder and honorary members.

We are very grateful to the number of speakers who attend our conferences and participate in our activities at their own expense and would remind colleagues that as a charity, we do not earn from conferences - in fact they have been highly subsidised and have run at a financial loss - without the generous contribution of time and energy from experts throughout the world we would not be able to continue and we are extremely grateful to all of them - and to all of you who have purchased these proceedings, thus contributing to the overall effort - Thank you.

The conference was a vibrant interchange of information and it is in keeping with this spirit that we have kept editorial change to the transcript to a minimum and allowed the presentations to flow in an easy colloquial manner. In this way we hope to engender a feeling of ‘being there’ and reliving the conference to those reading at home or in the office.

I hope that you will all enjoy reading the proceedings and that we will see you all at our next meeting.

Opening

Diana Birch. - Youth Support

Welcome all of you to the second International meeting that we have had here at the Royal College. I know a lot of you were here at our tenth anniversary meeting two years ago and it's really great to see a lot of faces back again especially the people who have come from far afield. I am not going to speak very long at the opening because I'd like to pass over to Gail fairly quickly so she'll have a little extra time and then we can also take some questions, but I wanted to tell you just a little bit about Youth Support and what we are doing and tell you a little bit about the conference and some of the changes in the programme as well. It's really exciting at the beginning of a meeting. It's the first time we've tried a two-day conference and made it truly international - we have people here from America, from the West Coast, from the East Coast, from Canada, from Japan, from Chile, South America, all over. And it's really, really great to think, that back in '86 Youth Support started as a tiny little committee of people who broke away from the Health Service because we thought that the statutory services particularly the Health Service didn't really cater for the needs of young people - we just had paediatricians and adult specialists and we didn't have anybody in adolescent medicine. Everyone thought that I was completely mad because I just wanted to see young people and awkward people, pregnant school girls and I was doing this stupid thing of running Youth Support but it's just wonderful to see how it's grown and see all your faces here. We've had marvellous support from our American colleagues, particularly. I am really pleased to see a lot of SAM (Society for Adolescent Medicine) members here. Youth Support was born just before I went to one of the meetings which was held in Australia and I am very pleased to see some of our Australian colleagues here who've come so far.

Youth Support has developed a lot over the years. As I said we started up as a small committee, gradually we managed to do a lot of work on teen pregnancy, on an outreach basis in schools and so on as we didn't have a centre, and we started doing a lot of work especially in Jamaica, and you'll hear a lot about Jamaica later on in the conference. And the work that I did with the teen

mothers came to a beautiful climax in ’96 when I did the fifteen year follow up of my patients with a fantastic reunion of al the young parents. We opened the Youth Support House at the end of 1989 which was very exciting so then we had a residential unit and we could do counselling and a whole load of different things which again you’ll hear more about later.

We then diversified into something that again people thought I was mad, which was a pet shop called Warm Fuzzies, because I felt that in order to attract young people in to talk to you, it is no good sitting in an office or a clinic or something like that and a lot of the abused kids we work with like to be with animals. So we have a mini-farm in our centre, and in the pet shop it’s a strange pet shop, somebody said to me once, one of the kinds, “Hey, you can come here and you don’t have to buy anything!” And they come in and they stay all day, and it’s a refuge. I remember a funny story, I was in one of the American meetings a couple of years back and there were some doctors there discussing how to get young people to come into their surgeries and one of them said, “Whey, I’ve a brilliant idea”, he’d have all of them come in for their hepatitis shots and I thought, my kids would run a mile, you know, so we prefer rabbits and goats and things like that to bring them in.

The Jamaican connection I mentioned, upstairs in the library we have an exhibition of carvings, you’ll think Why? I mean at the last meeting we had these squiggle pictures that Donald Winnicott did with his patients and then you could see the connection immediately, psychotherapy with kids and all the rest of it. But the reason we have Lancelot’s carvings are that I met Lancelot in ’86 when I was in Jamaica and I’ve kept contact with him ever since. And he started up a project for teaching young people in a very deprived area of Jamaica, a trade, which was carving, he is a master carver. He did so well in fact that he’s done a carving for the Queen and he came over to England this year because he was invited to come and have tea with Queen. So he’s had tea with the Queen and he’s come to Youth Support, so that’s good. I will show you a picture of some of the carvings that in fact I bought in ’86 and you’ll see them in the library. Also Lance had a donation from the Prince’s Trust, to build, a building is really perhaps too elegant a term, let’s say, rather a large sort of a shed-type thing that Prince Philip gave him some money for where he could do work with young people and he’s visiting doing some work in Bradford now as well and we’re hoping that we will continue the connection and

may be have a workshop in Penge (Youth Support Projects) doing some things of that nature. To show you some of the other things we do in Jamaica which we were helping deprived kinds in hospitals and so on and that's one of the abandoned kids that we worked with then. And also the continuing connection is actually being with the women's centres of Jamaica you'll see some displays about that and Pamela McNeil who runs the women's centres of Jamaica is going to do some of our presentations.

The other connection we've had is with Russia through the years and one thing I am terribly proud of is that we have Andrei Smirnov here in the audience, could you just stand up, Andrei. I just wanted to introduce him, could you give him a round of applause. Thank you. So I called Andrei my Russia bear, because what impresses me about Andrei, we've known each other for a number of years, he works in Sverdlovsk, which is now Yekaterinburg, which is on the Europe-Asia border on the edge of Siberia, and works with very deprived kids and we've done some stuff together on Russian runaways which are, I mean if you look at the deprivation of runaways and street kids in London or Los Angeles or anywhere like that you have not seen anything until you've seen the way they are in Russia. Some of you might remember we made a focus of this a few years ago in one of our meetings and I showed a video, but you know they are really pathetic kids and you'll hear more about that from Andrei, but also what impresses me about Andrei and his colleagues is that they do sterling work on an absolute pittance and you know I am very proud that we've been able to help them to come over again, so very welcome. And these are some of the kids in Moscow that we worked with as well, see holding up Youth Support T-shirts and we've had lots of trips back and forth.

So now this is some of the latest bits we're doing that you'll see more literature about, we've been doing some work to do with the Italian earthquake, a lot of people do not realise, because there was not a lot of publicity, but there was a series of earthquakes in my town in Italy last September, September 1997 and the people are still living in containers and tents and stuff and some of the towns were very badly damaged. All anybody over here hears about are churches, and especially the church in Assisi, you know, what a shame, but what about places where people live. And so we've been giving money to some of the poorer families which were very lucky a number of people donated, and also in 2000 we

are hoping to have a conference out there looking at traumatic stress in young people and children and also related to things like earthquakes. You'll see some information about that conference and it would be lovely if some of you could come, also there's a book 'Putting Down Strays' which is about the Italians in the War, which we are selling in aid of the Earthquake Fund. So I draw your attention to that.

Although I've Known Gail Slap for a long time and greatly admire her, she is a very difficult person to introduce because her CV is just so long, we could be here all day and she's just so impressive, she has been an ex-President of SAM, the Society of Adolescent Medicine, she served as, it seems to me, I might have this wrong not being American, but she seems to me to have been Professor in Goodness knows how many towns and Universities, and one of the reasons also why she is here is because she also has international renown and she's really tried I think to put international adolescent medicine on the map and I am very grateful to her for that. Gail at the moment is actually Professor of paediatrics and internal medicine and Director of the Division of Adolescent Medicine and Associate Chair in the Department of Paediatrics in the Children's Hospital in Cincinnati. Previous to that she held a similar post in Philadelphia. I don't think I'll really say anything more about Gail but all superlatives you know, you could apply as she started off with her first degree with magna cum laude, and even if you don't speak Latin it sounds very impressive, doesn't it. So I'd like to pass over to Gail and we hope to have a little bit of time for some questions at the end of her talk.

Adolescent Reproductive Health - Lessons Learned and New Directions

Gail Slap

Thank you Diana. It is truly thrilling to be here, there are so many familiar faces and friends and so many other people that I really look forward to meet. I think one of the most thrilling things for me is actually walking in this building. The Royal College of Physicians has always had this mystique, this is the seat of medicine and over the years that I've gone to various meetings at the American College of Physicians which is the professional organisation that represents internees in the United States I've always looked at this huge gorgeous mallet that the Royal College of Physicians presented to the American College of Physicians and I thought, the ACP, the American College, uses a kind of an ever-green tree as its symbol, I think there is a subtle statement there, a big difference between the sort of symbolic appearance between the Royal College compared to the American College, they both do wonderful work, but this really has a kind of history and special feeling around the world, so I feel honoured that we are meeting here today. I must say the other thing I've learned about London this time is I thought Bangkok and Mexico City were the places with bad traffic now I understand why your meetings don't start until 9.30 10 o'clock in the morning. I wasn't prepared. OK

picture

What I want to do today is talk about adolescent reproductive health and I'd like to do it in a variety of ways. We'll talk some about clinical service, but really what I'd like to do is consider with you where we've gone in terms of our research efforts in adolescent reproductive health and where I think we need to be heading as we move into the next century. Well, first I think it's fair to a ask a question why adolescent. Firstly, and I think you all know this, 20% of the world population is 10 to 19 years old, there are 1.5 billion teenagers between the ages of 10 and 24, 50% of the world's population is under 25 and this is climbing, 86% of youth now live in developing countries and further more if we look at youth around the world living in urban environments, a youth is three times as likely to live in a city in a developing country as in a city in a developed country. These youths face the highest risk, they face the least support. And even more than that group is the 70% of the world's urban migrants who are youths.

So why adolescent reproductive health. Well, whether you're married or you are unmarried, people are most likely to begin their sexual experiences during the adolescent years. 50% of African women and 30% of Latin America women are married in adolescence, and yet if we look at what's happening to the average age of marriage around the world it's actually increasing. So the time between puberty onset and growth considering even somewhat later the beginning of menstruation, menarche, and the time of marriage we are seeing an increased length of time. What that means is that we're likely to see increased sexual behaviour during unmarried years. Now in North America we know that over 75% of teenagers are sexually active. If we look at births we know that about 20% in the United States and over half of African first births are to adolescent mothers and around the world the number is 10%. Whether you think that's right or wrong and I think I've heard people argue both ways one thing's for sure, and that is morbidity and mortality faced by mothers and by their infants is greater during the adolescent years. Maternal mortality for adolescents is twice that of adults, the risk of low birth weight is about 1 and a half fold, the risk of death during the first year of life infancy is about twofold, the risk of neuro developmental delay is about threefold. And finally 1 in twenty teenagers around the world is affected by a sexually transmitted disease.

But adolescent reproductive health means more than the risks, it means more than the pregnancies, it means more than the

sexually transmitted disease. It also means looking at individuals - take some examples - three girls, all aged 12, best friends, birthdays within one month of each other, and helping them cope with the differences in their pubertal development, but also trying to understand what controls these difference in development. If you consider the first 12-year old, she is 10-0-4, she is 50th percentile for height and weight, note that she is not smiling. Why is she not smiling? She is wearing braces. Look at this teenager on the left. She is also 12 years old. What was the first thing she did when I asked to take her picture. She kicked off her shoes. Why did she kick off her shoes? She is worried about being too tall . She is barely 10-0-2. And this 12 year old, 10-0-2 notice what she is doing, when I asked to take the picture. She is standing on her toes because she is fearful of being too short. So they all have their own difficulties and differences to deal with and yet they are all entirely normal.

Now let's look at this 14 year old. This too is adolescent reproductive health. She has delayed puberty, markedly delayed puberty. She is in the hospital constantly for her sickle-cell disease. And let's look at this 16 year old father who's hospitalised after a gun-shot wound out on the street. This young man has 2 children. We cope not just with the violence of the inner city, not just with the medical complications of his gun-shot wound, but we cope with the difficulties that this young family faces.

Now what we do know about risk behaviours is that they increase dramatically during adolescence and yet I think there is a tendency to say all risks at all times. Data from the United States shows that the risks at age 11 to 12 are going to be different than the risks at age 18 to 19. Certainly in the prevalence if nothing else. What's going to increase most dramatically, as you would expect is sexual activity - alcohol is the earliest behaviour likely to start, it quickly increases and consider what's likely to happen is the sexual activity is increasing, the same time this experience with alcohol and other drugs is increasing. The chance that the sexual activity is going to happen in a risk way is very very high. Well the World Health Organisation responded to many of these issues in early 1990s with a call for action and we've seen several publications over the 90s from WHO and also from UNICEF, most recently the 1997 report which I am sure many of you have seen. What in the earliest work that went on in the 90s what the WHO asked that we do is to document the health status of adolescents, looking at

morbidity, mortality and the prevalence of problem behaviour around the world.

But the WHO asked us to do something else and that was to identify the positive indicators for adolescent health what I would consider the good adolescents, as well as the bad adolescents. I think we've done a good job and are working hard on this. I don't think we've done as much here. Yes, we've identified the negative indicators, we're getting much better in identifying which adolescents are at risk. But we don't really understand is what makes a teenager resilient. They ask that we explore the perceptions of teenagers regarding their health needs and problems and again I do think we've made headway here. Now our job is to truly explore the perceptions of teenagers rather than giving teenagers instruments that are developed by adults that force them to respond to what our preconceived notions of their perceptions are. And finally we were asked to evaluate the effect of interventions and programmes and again I think we are moving steadily in this direction.

When I thought about what are the critical research issues in adolescent reproductive health this is what me list would look like:

- what is the access around the world to reproductive health care;
- how do we modify risk behaviours for HIV and other sexually transmitted diseases;
- how should we screen for STDs and how shall we treat for STDs; not just in terms of what is the best treatment, but also what is the most realistic treatment, given the environment.
- Contraceptive counselling and compliance;
- pre-natal care, content, quality and utilisation;
- gender roles and responsibilities, which I don't think we've done enough with; and
- physical and sexual abuse, and I'd like to point out here I am talking not just about girls but also about boys.

Now, I won't have time to go through all of these, but what I'd like to do is walk with you through at least two of them. Let's take a look at what's happening to access, how teenagers present and who they present to at least in the United States to start. And then let's take a look at what's going on with STD screening. And finally what I'd like to do is go through a type of case example for HIV treatment.

First utilisation. Data from the United States comes from a very large data centre, it's called the National Hospital Ambulatory Medical Care Survey. Now at the time that we did this analysis I think this was the best data centre we had to look at utilisation patterns in any age group. I think now in the United States we have something new that I think is going to really improve our ability to look at utilisation. It's called the Medical Expenditure and Provider Survey, but for now let me share with you what this survey showed. The three components of this survey: one is on emergency department utilisation, one is on physician offices and one is on in-patient hospital stays. The data I am going to be showing you is on the physician offices. What we did in this study was took the adolescent years and rather than looking on block, sort of 11 to 21 year old approach, we decided to ask the question, does utilisation across adolescence change, and does that utilisation change in a way that makes our current guidelines, the gaps, break future guidelines for adolescent preventive services makes sense, or either some dis-synchronies here. What we found is when we looked at visits compared to census population proportion what you can see that across adolescence there is under-representation in visits compared to the percent of population. Now I am hesitant to say there is under-utilisation because for example it would make logical sense that the geriatric population would use more services than the adolescent population. The trouble I have with that, is when we look at emergency services what we see that adolescents are over-utilising emergency services. And they are over-utilising because of crises be they injury, STDs, pregnancy.

Now let's look closer what happens to visit numbers by age and sex. What you see is that during childhood and into the early adolescence years girls and boys are seeking physician offices about equally. We begin to see some change in the mid-adolescent years and look at what happens by late adolescence 18 to 21, girls are over twice as likely to seek care in offices as are boys.

Now let's keep going. Well you might say how does all this relate to non-insurance. And I think we begin to see something very telling. When we look at the non-insurance rate, What you see is that males are far more likely by late adolescence 18 to 21 to be uninsured as females, well why is this, And here we begin to get

some indicator of what's going on . Look at what happens to public insurance at age 18 to 21 for girls, look at what happens with boys, remains absolutely stable . So what's going on here? Why are the girls suddenly receiving so much public health insurance while the boys are remaining quite low and flat. And the answer is adolescent reproductive health problems as you might expect.

Looking at the percent visits to various specialist by age. What you can see at age 11 to 14 is that about 40% of the office care is to paediatricians and that about 25% is to family practitioners. A very small number are to obstetricians /gynaecologists. Now let's look at what happens at 18 to 21. Adolescents are as likely to see an obstetrician /gynaecologist as they are to see a family practitioner. And this is not 25% of female visits, this is 25% of all visits. What's happening is that males by and large in the late adolescent years simply are not seeking care at the rate that females are and females are seeking care primarily for reproductive health issues.

Now let's take a look at what the leading diagnoses are. By 18 to 21 nearly a third are coming in for prenatal reasons. At 11 to 14 adolescents come in for routine care, pre-school, pre-camp kinds of check-ups. How many 18 to 21 year olds do you think are coming in for, check my ears and listen to my heart, no. What they are coming in for is pre-natal care.

Let's move on now to talk about sexually transmitted diseases. In 1997 the Institute of Medicine in the United States issued an important report than was called "The Hidden Epidemic". And what the Institute said in this report was that public awareness about sexually transmitted diseases was dangerously low. And the theory was that it's low for three reasons: one is obvious, and this is the stigma regarding sexually transmitted diseases which inhibits both discussion and education. A second reason though is many infections are asymptomatic and undetected. And the third reason is that the sequelae of the infections are often delayed. If you can consider for example cervical cancer and human papiloma virus or of you consider infertility following pelvic inflammatory disease. Secondly the impact on women is not widely recognised. A large survey which was done about five years ago in women ages 11 to 60 showed marked underestimation of the effect of STDs on female anatomy. Thirdly pathogens are still being identified. Consider since 1980 we have identified 8 new pathogens for sexually transmitted diseases. Next, clinical

spectrums are still being described. Consider here, the newly reported relationship between bacterial vaginosis and pre-term delivery. Consider the many new clinical manifestations of AIDs that previously were unrecognised.

And finally prevention in the United States is unfocused and it's controversial. And that's despite good evidence that various interventions work. Let's take a look at the school-based interventions. Education about sexually transmitted diseases is under-funded, it's restrictive, it's inconsistent and it's delayed. This was a report from the Centres for Disease Control in 1996. Programmes that teach contraception have not been shown to hasten sexual initiation, there have been many reports on this, one of the best summaries came again from the Institute of Medicine in 1995 and yet despite this we continue to see teaching programmes in schools that are really not talking about contraception what they are talking about is abstinence. It's not that its' wrong to talk about abstinence but we must do more than just talk about abstinence. School condom availability programmes have been showing to decrease sexually transmitted diseases. But are few and still relatively new, in the United States it's estimated that only 2 per cent of schools distribute condoms. And finally students in schools with condom availability do not have intercourse earlier or more often and again this is not new work, this is going back 4 years, and yet we really have not seen a change.

We've seen other successful interventions,. But once again the implementation has been markedly delayed. So whether we look at individual counselling or couples counselling or programmes for high risk groups or peer leader education, or mass media campaigns they have been shown to work, and yet have they been implemented broadly, for the most part - no. One of the things that these studies have done is look not just at the ability of interventions to improve knowledge but also the ability of the intervention to change behaviour. I think our next step is to look, yes, at knowledge, yes, at behaviour, but also to look at health outcome.

When we think about STD surveillance strategy most surveillance strategies, no matter what country you look at, use passive reporting rather than active case finding. What that means, is that no matter how bad the numbers sound they probably still an

under-estimation. Secondly the surveillance data are difficult to interpret when we consider that 8 new pathogens have appeared in the last 18 years, that we have new syndromes, and we have new tests, such as LCR. Periodic behavioural health surveys are very important, they've been underdeveloped and they've under utilised and they've often been blocked in many countries, including at times in the United States.

Provider performance measures. And I think this is very important. Increasingly certainly in the United States we have seen measures of the doctors doing what they should be doing, what are called performance strategies or screening strategies typically these have not included STD screening, they've included things like our mammogrammes being done at the appropriate rate in some cases our PAP smears being done at the appropriate rate. Several of larger managed care organisations are now beginning to include chlamydia screening as a performance measure and I think it is a very important step in improving care.

Well, if we think about what the current focus for adolescent risk research has been certainly over the 80s and much of the 90s we've tended to look at selected problem behaviours, at youths in difficult circumstances, we've looked at the deficits, the problems, the risks of individual adolescents and we've looked at family and peer characteristics. What are the limitations to this kind of approach? I think the biggest problem is rights of the youth, it imposes a deficit model. What that means it will not help us identify the predictors of success. Why is it that in adolescent who's impoverished, who's on the streets, who has minimal support may still do well. And there are adolescents who despite very adverse circumstances do do well.

I think the second thing it does it de-emphasises the study of neighbourhood influence in youth development, yes, we've looked at the individual, yes, we've looked at the family and the immediate peers. But we really have not used the kind of sophisticated and often qualitative research methodologies that are needed to look at neighbourhood. And I am not talking here just about the neighbourhood where the adolescent lives, think about the adolescent's day: they may wake up in one neighbourhood, go to school in another neighbourhood, play basketball in a third neighbourhood, go to movies in a fourth neighbourhood, they are

very very mobile, and all of those neighbourhoods can have influence and impact on the adolescent's development.

And finally I think this approach encourages fragmented services that really are aimed at the crisis, at treating rather than preventing the sequelae of problem behaviours.

Now what I'd like to do is take you through a case example of why I think this approach is a problem. Consider here two 18 year old men, both have HIV. Both are good candidates for triple chemo therapy. Both live in urban slums. Both are uneducated, unemployed and poor. Both rely on local hospital clinics for their health care. Both have families that want them to take medicine yet neither has done so. Why? Two situations sound very similar.

One man lives in Punei?, India. The annual cost of the three drugs is US $10,000 which equals the combined annual salaries of 30 workers. The drugs are neither available nor they are affordable. The medical doctor has little to offer and the man decides to see a local healer.

Now consider the second man. He lives in Philadelphia, United States. The annual cost of the three drugs is the same and fully paid by the Government. The medical doctor has the medication and urges the man to take them. The man refuses and decides to see a local healer. The diseases the same, the outcome is the same, the individual characteristics seems the same, the reasons behind the outcome are different. But are the reasons really different? I would challenge they may not be so different as they initially appear. How does the neighbourhood influence in Punei? Really compare to that in Philadelphia? Do these two men perhaps share sentiments of uncertainty or distrust or disbelief in health care system that are more similar than they are different? Are the reasons for not using the medication therefore are more similar than they really are different? So within example like that what I would suggest is it's time to shift our prospective, it's time to explore the effect of environment, the economic opportunity and the subsocial network on youth behaviour, it's time to move beyond easily measured demographic and economic factors to the more complex study of social interactions, both the density of the interaction and the quality of the interaction. What this means is that we need new methodologies, we need to be working with social science and scientists, we need to combine quantitative and

qualitative methods. And finally it’s long overtime to translate our research into services that promote positive outcomes for all youths rather than services that try to curtail negative outcomes for some youths.

The new direction then in reproductive behavioural health research that I would see are to define what are the societal realities and expectations regarding reproductive behaviour and health care, to identify the neighbourhood norms and expectations for sexual behaviour, to begin to remove neighbourhood barriers to help the behaviour and to try to define programme effectiveness as more than improve knowledge, more than better behaviour

Plenary P1 Adolescent Sexuality

Chaired by Chris Wilkinson - King's College Hospital. London
and Pierre-Paul Tellier, Montreal

STIs - The Issues for Young People

Diane Noble and Gillian VanHegan

Gillian VanHegan

I am Gillian VanHegan, I am the medical director of London Brook and the spokesperson for Brook UK. As Chris was saying, we across the UK, Brook Advisory Centres, setting up specific advisory centres for young people, those who are aged under 25. We offer quite a range of services. Diane now specifically works for London Brook and these are the range of services that we offer around contraception, unwanted pregnancies, counselling, and basic STI testing. Now I am going to set the scene for you about sexually transmitted infection services that we offer and then Diane is going to tell you about how we're going to develop these services in the future. As I say, at the moment we have very basic services that we can offer to the young people, because of a lack of resources, mainly financial resources. We can only offer testing at the present time to young women we're referring for termination of pregnancy, or young women for whom we are inserting intra-uterine devices. We don't have the funding to offer chlamydia screening to all the under-twenty five's which would be absolutely ideal. And for those of you in the audience who are not medical I am going to dwell for a little while on the actual STIs.

We heard this morning about the prevalence of STIs world-wide. Well, in the UK we know that about 90% of the STIs are in the under 25s. And depending upon which study you look at, chlamydia is very prevalent, 4 times more common than gonorrhoea. The Department of Health study showed that 25% incidents of chlamydia are in young women who were referred for abortion, that was under 20s who were referred for abortion, that was 25% incidents. And the study we did in our Brook Centre in St. Thomas's hospital showed similar incidents. There have been many other inner city studies and the prevalence rate in those has been about 10 to 15%. Now, why are we so concerned about

chlamydia as an infection in young people? Chlamydia is a very hidden insidious infection, in fact in about 70% of young women who have chlamydia they have absolutely no symptoms at all. The young men are more likely to be aware of this infection because it sits in the urethra, they'll have pains when they pee, they will have possible a discharge from the penis. The young women are blissfully unaware that they are carrying chlamydia. And it's very concerning because of what we call sequelae, because of the follow on effects of the infection. That is that PID can result from chlamydia infection, in fact about one in ten carriers it's thought progresses into pelvic inflammatory diseases.

After one attack of PID there is about a15% incidence of infertility in a young woman. And if she has 2 or 3 attacks of PID she has an over 90% chance of being infertile. A terrible thing for a young person. As well as infertility we know there is an increase in ectopic pregnancies in young women who'd had PID because of the damage of fallopian tubes any developing ovum will have fertilised and can embed in the fallopian tube and therefore an ectopic pregnancy will develop and this can be a life-threatening situation for a young person when it ruptures and they move rapidly into shock. Despite all this that we know about chlamydia we feel that young people are really very unaware of it.

In London Brook over the last few months we've been doing an audit asking young people, what do they know about chlamydia? And in the young people we asked 50% of them said yes, we've heard the word "chlamydia". I think many of those probably were saying they had because they didn't want to seem stupid or because they thought that was what we wanted to hear, because out of that 50% who'd heard the word chlamydia only 50% of them actually knew that it was a sexually transmitted infection and out of those only one in ten know that it could lead to PID and infertility. So there's a great lack of awareness around chlamydia and we need to inform young people about its prevalence.

Not only we are concerned about chlamydia in young people but also of course gonorrhoea. We have five of our Brook centre in London in the South East of London, in the Lambeth, Southwark and Lewisham area where gonorrhoea is 6 to 7 times higher than the national incidence levels of gonorrhoea, and in young women aged under 25, 67% of the test were in this age group, and there is

also a high prevalence in the ethnic minorities in South East London.

It's not only chlamydia and gonorrhoea, but there is also a rise in herpes, warts, pubic lice and many other sexually transmitted infections, HIV, hepatitis.

As I said, what we can do at London Brook at the moment is only very basic testing. Now, if young people need further testing we refer them to our Genito-Urinary Medicine Departments which are at the moment mainly in hospital settings although there are some individual ones in the communities but mainly in hospitals. So we decided in the six months' audit last year to look at the numbers of young people whom we've referred who actually turned up at the GUM clinic for investigation. With each client we were sending we discussed the relevance of the STI to them, why we were sending them, we gave them a letter and at the bottom of the letter there was a tear-off slip which said, we are trying to track our clients can you please return this slip if they turn up in your clinic. We discussed with the young person a specific clinic that they could go to near to where they worked, or college or where they lived and those who weren't sure which GUM clinic they wanted to go to we gave them the cross-London list of GUM clinics. You know, for the next six months we correlated the information by the tear-off slips that came back to us, and the doctors who had time at the GUM clinics actually writing back and telling us our clients had turned up there, if the client came back to one of our centres for repeat pill prescription or whatever we said to them, "Did you actually go the GUM clinic to have your STI testing?"

Out of 332 clients that we referred we only have evidence that 57 out of these young women actually turned up at the clinic. This is only 17% of the total number that we referred, allowing for the loss of the paper work between the GUM clinic and us and us the GUM clinic, that would still be about a quarter of the young people that we referred who turned up at the hospital clinic for testing. So this says that we do need to be able to offer far wider services actually at out Brook advisory centre, when the young person accesses our service they are not happy to be referred to still another service.

I'll finish off by telling you what we can do for the young people at the moment. And that's around education. hopefully preventing STIs. We do at the clinics have many leaflets, posters that we give

to the young people, we discuss STIs with them at every possible consultation that we really can and define the risk for them.

We hope to make as much liaison as possible between the Brook Advisory Centre and GUM clinic at the hospitals. We try to take school groups in to the GUM clinics so that the young people can feel comfortable about where they actually going. And we do share staff, some of us work at the GU clinics and work in Brook as well and we can give a very positive note to the young people about the kind of service that they will get when they access the GU service. We also do a lot of combined training so that our staff at Brook meet the staff from the GU clinic and we are doing a big meeting next February when we are going to be sharing skills between Brook and the STD Department at St. Thomas's, so to finish off as I said we are at a very basic level as to what can offer to the young people in the centres at the moment but we have great hopes for the future and Diane is going to tell you about some of those.

Diane Noble

Thanks Gillian. I am going to talk about three things. First of all following on from what Gillian said I am going to talk about why at London Brook we want to set up sexual health centres in the capital. I am going to talk about what we mean by sexual health centre. And finally the issues that we faced and continue to face in developing this service.

London Brook is an organisation which now probably spends about just as much time talking about STI as we do about contraception. And I think those of us working in the health field now have such a high awareness about STIs it is really important to keep reminding ourselves the very low level of awareness generally around population and more specifically amongst young people. I've got a little story to tell you now. I actually first came to London twenty years ago and that was to go to University, and our college doctor had a mission, and his mission was to put every female student on the pill. It didn't matter what you went to see him about, you could have a cold, you could have a sprained ankle, you went in there you came back with your packet of pills. So everybody was enjoying themselves and nobody was worrying about getting pregnant and then a shock horror, the word went

around that a very popular male student had an STD. Now, I had a house actually sharing with seven other women and we sort of pooled our knowledge and that pooling led to what we had kind of heard about syphilis because it did come up in history classics, but generally people died of it, it was sort of Henry the VIII, it was this thing called VD and that was it, that was what we knew. And we kind of figured that people went to hospital and we sure as hell were not going to ask anybody at the college. I wonder how things have changed. Well, clearly the awareness of HIV and AIDS since mid-eighties has had an impact. But research still highlights the very narrow view of sexual health young people hold. And that narrow view is really summed up by perhaps avoidance of the risk of pregnancy and to some extent avoidance of the risk of HIV and AIDS, but the very low awareness of common STDs and the need to protect from these.

Although some young people might now have a knowledge of HIV and AIDS the extent to which they see themselves at risk turning to motivation to protect themselves from that risk, for the majority of young people the risk of HIV they perceive at low. Condom use continues to be erratic, particularly young women who a method of contraception such as the pill. A recent study from the health education authority revealed that only 32% of 16 to 24 year olds had heard of chlamydia. The issue of knowledge of the sexual risk is further compounded by the difficulties young people experience translating the knowledge they do possess into their personal behaviour. They too often lack the skills to manage relationships, to negotiate around sexual activity.

Well, to some up the world STI rates we know are high, attendance at GU services we know is low, awareness of common STIs we know is low, perception of risks is low, the transition of knowledge to behaviour is difficult and young people continue to have this narrow view of sexual health. And there is something else I think I need to add to that. National Brook has recently published a survey that they did of 700 Brook clients about teenage magazines. And the question they actually asked was what young people wanted more information about. At the top of the list of those 700 young people was: sexually transmitted infections. So one thing that has changed is that young people are aware I think that perhaps there is something that they need to know about.

London Brook strategic plan is to have a number of sexual health centres situated in different geographical areas of London, the North, the South East and West. And later these centres will be different targeted local interventions. The first of these sexual health centres is due to open in Brixton in January 1999. The second, planning permission willing, will be in Camden and will open in April 1999. Let's have a quick look at a sexual health centre. Well, the sexual health centre will be a walk-in service open at regular times on at least six, hopefully seven days a week. There is a range of services that we be offered and testing and treatment of sexually transmitted infections is the key and this is a comprehensive STI screening and treatment service.

The new centre is Brixton is being refurbished to accommodate a wider sexual health service. As you go into the main entrance, there is an education and information room which has a range of sources and which will be a base for education of out-reach staff, so young people will be able to come in and access information without necessarily going through into the more clinical part of the service. All the consultation rooms are multifunctional for counselling or clinical service, and adjoining each consultation room is a separate examination room appropriate for contraceptive or STI work. There is also a primary analysis room for use in STI screening. And that model for the Brixton centre is really providing the blue-print for the future for other centres. A vital part of our strategy is to link local interventions, some of those are existing for us in Brook, we currently have things like, a centre at the sixth form college in Islington, we have peer education projects, we have a project called sexability which working with the young disabled people, and we have a range of satellite clinic sessions. The way that we are hoping to work in terns of targeting interventions is to be able to work very locally, geographically, working with young people in housing estates, particularly around the key centres in some towns like Brixton, and targeting specific groups of young people with emphasis on socially excluded young people, those outside the education system and the health system. Well, I hope you all agree that it's sounding pretty good up until now, let's look at some of the issues we face and continue to face in implementing this plan.

One of the things that we have achieved is that we've had funding agreed by Lambeth Partnership and Health Authority for comprehensive chlamydia screening and treatment programme at

the new Brixton centre and this is a first step, but it's a very crucial step in the provision of that wider STI service. We are hopeful that it is part of the health actions on initiative in Lambeth, Southwark and Lewisham, further funding is going to be available for a health adviser to be seconded from St.Thomas GUM service to Brixton Brook that would support contact tracing for chlamydia positive clients and build links with GUM services locally. We're also hoping that funding will be sufficient to allow the GUM staff at St.Thomas's to do an out-reach session at the Brook clinic.

The term sexual health is becoming more common now with GUM and family-planning, GPs are using it. London Brook health centres are based on a very simple idea: if young people don't go to the existing service, so let's take the service where they do go, to a familiar and trusted environment. What I really wanted to end by saying is that London Brook is a special service for young people and we believe in a unique position to offer a positive experience of sexual health in its broader sense, a real decrease in the prevalence of STIs among young people is linked to a change in young people themselves from that narrow view of sexual health to a broader view of sexual health, and crucial to this is normalising of STIs, removing the stigma, moving both the preventative work and the treatment of STIs into more settings and bringing it into the main stream.

C.W. Thank you for a very good presentation and in the interests of time we won't have any questions for this speaker, our next speaker is Yuko Matsuhashi, Doctor Matsuhashi is Professor at Hiroshima University of education in Japan, she was trained in adolescent medicine in the USA and addresses international issues in sexuality. Today's presentation is entitled "Sexual Exploitation of Youth in Japan".

Sexual Exploitation of Youth in Japan

Yuko Matsuhashi

Thank you very much. Good morning guests. Minors under the age of 18 should be protected from commercial sexual exploitation by the child welfare law, anti-prostitution law and ordinances for the health of young people. But the punishment for adults who exploited minors has not been clearly defined in Japan. I received 17 leaflets advertising adult video tapes that were thrown into my mail box at home between May and July in 1998. The performers of the first group of video tapes are of 14 to 16 years of age. The second group of video tapes type cast a sort of child in Lolita, they are twelve and thirteen.

About 82% of high school boys and in about 51% high school girls surveyed said they had ever watched adult video tapes. Japanese high school girls, now mini-skirts and these white socks in fashion among them. Most of private high schools for girls have their own uniforms. These uniforms are sold at the price from £95 to £250 at the shop for fetishists (known as maniacs). In 1993 almost 800 ordinary school girls were asked the question, will you sell your belongings at the shop for maniacs? 300 hundred girls, that is 38% of them responded, about 64% of girls answered yes they would sell their junior school uniforms, nearly 63% answered yes they would sell their high school uniforms, about 30% replied they would sell their bras and panties, 13% of girls answered to be a performer of adult video tapes. They can get about £4 per one panty. If they sell 10 panties they will get £40 easily. At last in '94 girls realised a high school girl is a sought after commodity and uniforms are the symbol of it. Until then girls have hated their uniforms forced to wear by schools and teachers.

When the police exposed date-club offices in Tokyo in autumn of '94 total of 300 girls under the age of 18 were caught. About 90% of them were high school students. If a man calls up at date club office they give him the location of the office. When he arrives at a date club office he needs to pay £25 for entrance fee, £12.5 for arrangement, £12.5 the award for the girl's service. So he has to pay total £50. Then he peeps into the room where girls are watching TV or reading comic magazines through a small window. Then he picks up a favourite girl among girls and goes out to town with her. After that it depends on negotiation. But only a few high

school girls worked at date club offices. Most of girls hesitated to go there.

Propagation of personal communication devices changed the scene. Only 6% of Japanese girls compared to 11% of American high school girls have portable phones. But about 43% of Japanese girls compared to 90% of American girls have beepers. We call beepers pocket communicators. 30% of Japanese girls compared to 10% of American girls use them more than 5 times a day. (summer ’96).

Now I’d like to explain the system of telephone club and two shot. I will explain two shot first. A man buys a card which cost £15 for 30 minutes by vending machines in town. Then he dials a number of a trader that is written on the card. Then he can talk to a woman after waiting for a few minutes. Both men and women do not need to go anywhere here. They just need to dial. Call from a woman is free. They can communicate each other by phone. Next is telephone card. A man needs to pay about £15 for entrance fee and rent on their room and phone. Then he is waiting for a call from a woman whose call is free. They can communicate each other by phone. Telephone clubs started in 1985. Hand-bills or leaflets advertising telephone communication are everywhere in town in Japan. This slide shows pocket tissues on which the phone numbers of telephone clubs are written. Once I got 7 pocket tissues when I was walking along a wide road between a big station and a department store. They need to get not only high school girls but also adult women, married women. High school girls and junior high school girls are doing telephone communication such as telephone club Two Shot or message dial. They just chat or talk about sex with strangers. If they want to see each other they can make a promise. After that it depends on their negotiation. They go shopping to buy goods for a girl, go the movie or go to the hotel to take a picture or a video-tape of a naked girl and so on. Of course the purpose of most of men is to have sex with girls. These telephone communications is business affecting public morals. They seem to be new style prostitution starting from mid-eighties. And I heard that similar businesses spread out to Korea and Taiwan.

The mass media in Japan do not use direct terms to discuss these matters - they avoid the use of the word rape, they say violence, they never ever use the word rape. About 27% of high school girls

compared to 17% of junior high school girls had ever tried telephone clubs in 1995. The current data shows that the number of junior high school girls who experienced calling of telephone clubs has increased from 17% to 31% in 1996. The number of high school girls who experienced it has increased from 27% to 44% in 1996. The reason why they call up telephone clubs is as follows - 70% of them answered that they were curious about telephone communications. Nearly 60% of them answered that they were bored so they did it. 42% of 14-year old girls responded that they wanted to tease somebody. Several girls form a group and one of them calls up and makes a promise to meet. They hide themselves behind something and peep the man who shows up. For them it looks like playing a game.

How about their concepts of morals? 53% of girls think that talking about sex with a stranger is a problem but it is OK if she wants to do it. About 23% think it is OK. How do you regard having sex with strangers in exchange for money and goods? 52% of them might not engage in sex for money. 37% answered it is a problem but it is OK if she wants. About 11% answered it is OK. Experience by age of prostitution in girls. More than 2% of junior high and high school girls had ever done prostitution.

Why they have sex. Half of them answered that they had sex because they wanted money or they did it because their peer had done it. If they hear one friend had age relationship they think, I can do it because she could do it. If she has done it I will do it. This is their way of thinking. Doing similar behaviour to peers is their value standard.

The socio-economic status of families of these girls belong to higher middle or middle classes or sometimes high class. They do not belong to poor families. Their parents discipline is relatively strict. So they are good girls at home. They play good daughters role at home hiding their secret jobs behind. But even if parents notice their daughters secret job they would scold once of course but they would not follow their behaviour. Mothers would behave as if they were afraid of daughters. Parents would not interfere in daughters behaviour. Girls have realised that reverse side of men of their fathers age in Japanese society. At school they play normal students role. Of course they do study ordinarily.

Here I need to explain how girls use beepers. If they want to do prostitution they leave the message on message dial. The response from men comes by beeper. Girls set beepers on vibration mode so nobody knows in the classroom if the response comes during the lesson. What are occupations of men who want to have sex with high school girls? Incredibly they are teachers, staff of PDA, policemen, presidents of companies and physicians whose social positions are high.

The number of big teams of clubs under the age of 18 in 1995 is 3 times more than the number of 1992. Young girls were often involved in serious trouble in 1992 the number one motivation was curiosity, but in 1996 the number one motivation is money: 46.8%. Some girls have sex with 200 men in 6 months and earned £ 25,000 and deposited £12500. One girl said, man's penis is like a tampon, I feel nothing. I think other things during the sex. Young girls have also become obsessed with possession of designer clothes and other brand name goods.

The interest of the mass media and also the support of one male sociologist have added to the problem. This slide shows the consciousness of sex before marriage in junior high school boys and girls. The answer that it should be avoided is less than 10% in both and boys and girls. About 17% of girls replied it was OK even if there is no love between them. Almost half of boys and girls in high schools answered that it is OK even if there is no love between them. Until 1993 the number of students who had experienced sexual intercourse was higher in boys than in girls. But since 1996 more high school girls have experienced sexual intercourse than boys. I think it is because of age relationships. If girls hesitate to have sex they willing to send their photo pictures both in clothes and bikini swim-suits putting their names down to sell things for men. I investigated my own students of Hiroshima University. The experience of calling up telephone club was 9%. And 9% of them knew girls who are doing under age relationship. About 81% of them thought that under age relationship should be avoided. But 6% answered, I am curious.

Why they have come to sell their belongings, pictures of even their own bodies easily? The reasons are as following: girls know well that prostitution is wrong and a crime, but 30% of Japanese men buy sex with cash. They may think that they would be similar to other men. Two: fathers are always busy at work and out of home,

girls need fathers. Why fathers are always out of home? I think that couples will not be getting well with each other. About 30% of Japanese fathers compared to 10% of American fathers and 17% of Koreans think that divorce should not be allowed if there are children. The percentage of couples who do not have sex after delivery is gradually increasing. Where are those husbands going? And where are those couples going? Finally some of them would divorce after their marriage of 20 years and over when all their children would have grown up. Divorce rate among people who have been married for 20 years and over is 16% in Japan.

Who do they talk to about worries. Besides Japan and Korea mother is the number one person. In 70s mother was the number one person in Japan also. Since 80s number person is friends. Mothers are playing good mothers role. They think that for daughters good mothers are like friends. But girls need real mothers, not friends. They want to be scolded or appraised by parents from the bottom of their heart.

The TV programme about the girl who had HIV through under age relationship and would die soon was on the air this summer. Many young women took blood tests for HIV after finishing the programme. Now dying women are framing the plan of the law which protect minors under 18. Thank you.

Teenage Abortion

Lars Holmberg.

A study of the management of young men in the decision-making process at Outpatient Clinics for Adolescents in Sweden (Outpatient Clinic for Adolescents, Borlänge, Child Health Unit, Falun Hospital, Falun, Sweden)

The purpose of this study was to obtain knowledge about the opportunities available to Swedish teenage boys and young men for obtaining advice and support during the process involved in making decisions on abortion. The study was carried out at Swedish Outpatient Clinics for Adolescents. We also wanted to obtain knowledge about the staffs' views of male attitudes and feelings regarding abortion. This knowledge is intended for use in developing models for advice and support in this difficult situation. A questionnaire focused on current management routines and staff experiences of questions and problems taken up by the male partner concerning abortion. Questionnaire answers indicated that the potential father, as well as the mother, requires active care and information together with the partner. There was also a need for individual support and information for male partners requiring engagement of health care professionals who are familiar with the problems involved.

INTRODUCTION - Unwanted teenage pregnancies are not uncommon in Sweden today. The number of induced abortions among teenage girls in 1996 was 4,366, a rate of 17.8 per 1,000 girls. The incidence varies geographically and has been influenced by several factors among which are the cost of contraceptives, concerns about side effects of the pill, a tradition of early pregnancies and the level of unemployment.

To be or to have been a potential father, potential father refers to the current pregnancy, is of course experienced differently by each individual. The teens and early adulthood are sensitive periods in life when an experience such as termination of a pregnancy can profoundly influence relationships and the mental health of the individuals involved. Many males experience a situation which has been described as a life-crisis, an integral aspect of the male human condition.

In order to support potential fathers in this difficult situation, we need more knowledge of how they react and their thoughts and emotions accompanying the decision of whether or not to terminate the pregnancy. Currently we know very little about this aspect of the situation. Although there are a number of studies of young men´s attitudes to the termination of pregnancy, only a few address the problems of those with an experience of personal involvement in a pregnancy.

The ultimate decision on whether or not to terminate the pregnancy rests with the girl. But what attitudes are held, which questions and problems are to be faced by the young potential fathers when choosing between termination of pregnancy and becoming a father?
The aim of the study was to obtain knowledge on the opportunities teenage boys and young men have for obtaining advice and support during the process involved in making decision on termination of pregnancy and the level of advice and support available to them. The aim of the study was also to obtain knowledge on the staffs´ views on attitudes and feelings of boys and young men. This knowledge is intended for use as a first step towards developing models for supporting young men in the decision-making process after an abortion or when the pregnancy is continued.

MATERIALS AND METHODS - The majority of pregnancies are confirmed at the Outpatient Clinics for Adolescents in Sweden. Management differs between the clinics but as a rule the pregnant girl has access to medical and psychological care when deciding about the termination of her pregnancy. The potential father is often invited to meet a member of the staff together with the girl, depending on her attitude to the matter.

After an abortion the girl is usually followed up in one way or another by the Outpatient Clinic for Adolescents. Follow-up rarely occurs for the male partner.

In the spring of 1995 an investigation was carried out in Swedish Outpatient Clinics for Adolescents regarding the routines and the management of the situation following a positive pregnancy test. The investigation focused on the experiences and impressions of the professionals working in these clinics. A questionnaire was

sent to all 150 clinics. The questionnaire contained 15 questions covering the following topics:
- Which professions are represented in the staff?
- Number of pregnancy tests?
- Estimation regarding age structure of the pregnant girls and their partners at the clinic?
- Does the partner usually accompany the girl when visiting the clinic and which professional contact, if any, is available for him?
- Is the male partner routinely offered individual support?
- Examples of questions and problems concerning abortion by the male partner alone and together?
- Common reasons for abortion?
- Possibilities for the partner to influence the decision on whether or not to terminate the pregnancy?
- Examples of worries and common reactions from the boyfriend?

The questionnaire was addressed to the head of the clinic with a request that the questions should be answered by the staff together.

RESULTS - The questionnaire was answered by 121 clinics, yielding a reply frequency of 81%. All questions were not answered by all clinics. The staff composition varied between the answering clinics, the only category represented at all 121 clinics was the midwife. The others were social worker, gynaecologist, general practitioner, nursing aid, psychologist, paediatrician, registered nurse, venereologist, child and adolescent psychiatrist.

Of nearly 15,000 pregnancy tests divided among 113 clinics answering that question approximately 20% were positive. 72% of the girls ranged in the age from 15-20 years, only 3% were younger than 15 years and 25% were older than 20 years. 55% of the partners were younger than 20 years of age. In roughly 25% of the cases the partner accompanied the girl at the visit when the pregnancy test was positive or at the next visit. In most cases both boy and girl together were offered a visit to a midwife and/or a social worker.

19, that means 16%, of the 121 clinics offered individual support routinely to the partner. In those cases a visit to a social worker was the most frequent routine, the next most frequent alternative was a visit to a midwife.

According to the impression gained by the staff of the clinics the three most common questions or problems mentioned by both the girl and the boy together were: concerns about bodily complications, particularly sterility (mentioned by 49% of the clinics); practical questions on the performance of the abortion and other questions concerning the procedure (mentioned by 47% of the clinics); secrecy, information to parents, worrying about responses by parents and similar problems (mentioned by 44% of the clinics).

Examples of common questions or problems mentioned by the boyfriend were concerns about the female partner's bodily complications, the practical performance of the abortion, and also a feeling of powerlessness and difficulties in influencing the decision. Reflections and worries concerning their own maturity and age were common.

The answers from the clinic staff regarding the three most common reasons for deciding on abortion were too young, unwanted child and social or financial problems.

Differences in the type of services offered to the male partners was reflected in the answers in only one area. In clinics offering individual support to the male partner, 47% mentioned problems in the relationship compared to 22% in those not offering this type of service to the male partner.

The decision on whether or not to terminate the pregnancy was stated by 84% of the clinics as one of the three main sources of concern for the boyfriend. 53% of the clinics reported male partner concerns about the surgical operation and possible bodily complications such as sterility. As many as 47% mentioned anxiety for emotional or sexual consequences as the main concern for the partner.

On the question "common reactions from the boyfriend" when the girl decided on abortion 90% of the clinics stated relief as a common response, 30% mentioned grief or depression as frequently occurring whilst 22% stated disappointment or irritation. When the girl chose to continue the pregnancy 60% of the clinics reported that pleasure, pride, expectation or happiness were common responses from the boyfriend whilst 47% of them mentioned aggression and 42% disappointment.

DISCUSSION - The questionnaire was answered by 81% of the clinics but unfortunately some questions were left unanswered. Fewer answers were given to open questions and those requiring experience of individual support to the partner. A majority of the questions were answered by estimates.

In our study the focus was on boys and young men. The staffs' views of their attitudes and feelings were based on experiences from about 25% of the male partners. The main concern of the potential father was considered to be the decision on whether or not to terminate the pregnancy. The majority of the clinics stated that the partner frequently or rather frequently was allowed to influence or participate in the decision. At the same time there were experiences of difficulty in influencing the decision as well as feelings of powerlessness and of being excluded. Questions concerning one's own maturity, age and role as father, were given as important considerations in the process of decision-making by the male partner. The age of the couple, the unplanned child and common problems in young people, i.e. social and financial considerations as well as uncertainty, ambivalence or difficulties in the relationship, were given as the most usual reasons for deciding on termination of the pregnancy.

It appears that a similar situation exists in Sweden as that revealed in some American investigations: a willingness for serious participation by the male partner in the decision on abortion with a need for emotional support, complicated by the right of the girl to determine whether or not to terminate the pregnancy, indicating the possibility of a conflict of interests. The experience of abortion may challenge the partner at a critical time in identity formation and in moral development. Their feelings, if not appropriately dealt with, may create problems for their girlfriends and professionals in obtaining a smooth resolution and outcome of the pregnancy.

It is thought-provoking that only an estimated 25% of the boys accompanied the girl when the pregnancy was confirmed or at subsequent visits, since questions about the practical performance of the abortion and possible bodily complications as well as questions about secrecy and information to others appeared to be essential, for both the girl and the boy. Almost half of the clinics also reported that consequences of abortion were of either an

emotional or sexual nature and required discussion with potential fathers, preferably alone.

The results differed, with regard to problems in the relationship as the reason for deciding termination, between clinics with experience in seeing the boyfriend alone, 47%, and the remaining clinics, 22%. A possible explanation is that it was easier to have the discussion when the male partner was interviewed alone. The opportunity to express feelings can strengthen resources and facilitate an appropriate solution to the crisis, thereby diminishing problems in the future.

The reason for sorrow and disappointment in the male partner, which was apparent in both those involved in continued pregnancy as well as termination, can be explained by the experience of being excluded, powerless or on disagreement with the decision. The reason why a majority of the clinics reported positive reactions when a pregnancy was continued is unknown. More secure relationships or potential fathers of a higher age group are perhaps more common in these cases.

CONCLUSIONS - The result of the investigation indicated that the potential fathers benefit from active participation and support including information together with the partner. Consideration should also be given to those questions and problems which require individual support from personnel who have the knowledge and resources to help them in this difficult situation. It is therefore necessary to obtain more information directly from the male partners through qualitative studies and we intend to strive for an improvement in information to and quality of care for this group in Sweden.

It is true that only 16% of the clinics routinely offered individual support to the male partner but a good deal of the remaining clinics noted that they were already either planning this or that our questionnaire had raised the idea of providing a similar service. In the future we plan to repeat the investigation in order to find out how far these plans have been implemented.
The answers to our questionnaire have given us knowledge on how the potential fathers' attitudes, questions and problems during decision-making on whether or not to request abortion were interpreted by the staff at Outpatient Clinics for Adolescents in Sweden. We also obtained an insight into how their, hitherto often

neglected, needs are met. This knowledge will now be supplemented by a qualitative study through interviews of current cases as a basis for working out methods for developing this service in the future.

Chairman: Our next speaker is Doctor Jorge Pelaez Mendosa and I apologise if I didn't pronounce that right. Doctor Mendoza is an Auxiliary Professor of Obstetrics and Gynaecology at Havana University School of Medicine and he is the President of Juvenile Section of the Society of Obstetrics and Gynaecology in Cuba.

Sexual Practices in Adolescence – Sexual Initiation

Jorge Pelaez

Thank you. First I would like to thank the organisers of this conference, specifically Dr. Diana Birch for the kind invitation. I am very happy and honoured to be addressing this important meeting. I also want to apologise to the audience because my English is really bad. But I promise I am going to do my best.

We listened previously to speaker talking about some problems that are very common during adolescence, abortion, sexual exploitation and STD. Now I am going to talk about the first step in sexual behaviours during adolescence, it is sexual initiation. Risky behaviour in adolescence is very common. We recognise under this a precocious first intercourse, poor recognition of the risks with regard to relations, health concerns, in inappropriate circumstances and places, frequent change of couples, ignorance about sexuality, birth control is not considered, Lack of essential knowledge and use of contraception and insufficient knowledge about STDs and their prevention. Today adolescents are affected by disproportionately high prevalence of unplanned pregnancies, sex transmitted diseases including AIDS and other STDs that affected their reproductive health. Risky sexual behaviour is considered responsible for almost all of these problems.

We are going to talk now about sexual initiation and we define that as the first coitus. An intimate experience of communication of the signs of affection existing between two human beings which could take part voluntarily. And precocious sexual initiation we define that sexual relationship that begins before the adolescent's arrival to consolidation stage between age 17 to 19 years (Bloch and Erickson classification) To remind you this classification covers four stages. First stage is between 12 and 13 years, second stage between 14 and 15 years - motivation manifestation, third stage around 16 to 17 and the fourth stage is over 18 years. We consider that any relationship that begins before this stage is precocious.

Masters and Johnson said in 1989 that commitment in a couple does not imply only preoccupation about sexual pleasure but includes direct reciprocal responsibility on birth control as a result

of such union, in other words pregnancy. That is not common in a couple of adolescents that are below 18 years. That is another reason why we recognise that the relationship that begin before 18 years is precocious.

This is the consequence, the popular consequence of precocious sexual initiation: frustrating experience, favouring sexual dysfunction, continuous change is couples resulting in risky sexual behaviour, increased rate of STD, genital infection and their consequences - cervical changes neoplastic and PID, higher risk of abortion, unplanned pregnancy and their consequence and higher risk of PID and in the medium and long-term consequence, we are talking about infertility and ectopic pregnancy.

The main objective of our study is to know the frequency of adolescents attending secondary school that have initiated intercourse, to determine the course that led them to have a precocious intercourse and to study the adolescent environment, establish risks and protective factors for precocious intercourse and to know the characteristic and motivation for the first intercourse.

As you can see we develop a history that include a junior high, technical and high school institutions from Havana city where they were randomly selected. A self-responding questionnaire was supplied to all the students who went to classes on the day established by the study. A total number of 2713 filled the questionnaire, 73 were excluded because of incompleteness or mistakes totalling a sample of 2640 students. This is 1425 females and 1215 males. Informed consent was obtained from each individual and institution.

Here are some of the results. The majority of the students included in this study were in the second stage of Bloch and Erickson, between 14 and 15 years. There is significant difference between the no-initiation and initiation and it represents that the males have a higher proportion of initiation during adolescence, they also start earlier than women. The higher group is 14 years in males and the higher in female is between 15 and 16 years.

Partner in the first intercourse - There is not big difference between male and female, it was the boy or girlfriend the majority of the partner of the partners in the first intercourse. The only

difference was in the when the partner was a friend more common in females and if the partner was a relative there was no difference between female and male.

In males the paramount motivation behind first intercourse was group pressure and family pressure. In women we had the peer and the partner pressure. And the difference was significant.

Where happened the first intercourse? As you can see the majority in both sexes were always in park. I had a lot of problems in finding a correct word because we found in the dictionary alleys I don't know if it is correct, it is small street, dark street, you know something like this, and parks. But you can see that there is a lot of places, all of them are not good to have a sexual relationship. You can see motel/hotel is very small, beaches, camping, party, even a school.

And here the enjoyment by gender concerning the first intercourse. When we asked them, How did you feel in your first intercourse? And we found also a big difference between male and female. Very pleasant - male always. Female – almost nothing. Pleasant – the same, too much male, few female. Fair stresses – more female, indifference – more female, unpleasant, almost every female.

The use of contraception in the first intercourse was also a thing that we want to know. And we found that only 14% of the students use contraception in their first intercourse. Why they didn't use contraception? First – unplanned relationship, that's very common during adolescence. They were surprised by the relations, they don't plan it, they didn't know that they are going to have the first intercourse. Ignorance about contraception, ignorance about the risks of unprotected relations. But you can find some other reasons, but for example, here is very important, I call out-drop effects. So of the first intercourse in the adolescence were all these high risk sexual behaviour.

Sexuality information errors. Is it important to prevent and to delay the sexual initiation? – I think so. You see that when there is a very good level of sexual knowledge the percentage who don't initiate is bigger. When the knowledge level is very bad or bad the majority have been initiated. The sexual information level is protection factor against the proportion sexual initiation.

Here is the influence of the peer group in the sexual initiation. We have 2 groups of peers. We divide the adolescents into the peer groups where the majority are initiated, had sexual intercourse and a peer group in which the prevalence is not initiated. When the peer group is initiated the majority of the students included in this study will start the sexual relations. When they are not initiated there is a big difference and the majority have not initiated. And when they ignore peer opinion also the majority have not initiated. And we can conclude in this case when they adolescents ignore if the peer group have or not sexual relations they are free of pressure, of group pressure to start the sexual relation because it is clear that it is not a topic for conversation. Here is the incidence of abortion in the peer group. When the peer group had a high incidence of abortion almost all the students had been initiated. When there is not intention of abortion this thing changed. And when they ignore even big the difference.

What about the family? We recognise a very importance to the characteristics in the sexual practice during adolescence. And as you see when the relationship define very good or good you see that the big percentage of the sample have not initiated. When they said that the relations in the family is very bad or bad almost the majority of adolescents have been initiated even when they say that is regular. The closeness with the parent is also a very important topic. When the adolescent lives with both parents the majority has not been initiated the sexual relations. Even when they live with the grandparents or others the difference is very high and almost always has been initiated the sexual relations.

Finally I would like to show you the life projects and the importance of this in have a preventing protection factor for sexual initiation. In this study we find that 39% of the sample have a clear and defined life project, 30% - absent and 32% is confused, they are sure about the future. When we connected the life project and the sexual initiation we found that when they have a clear and defined life project they majority of the students have been initiated the sexual relations. That is one of most important protection factors. When there is absent almost all had been initiated, even when they said that they had a confused life project.

We arrived to these conclusions that there is high percentage of adolescents that initiate precociously their sexual relationship

more frequently males. The majority of adolescents start their first intercourse voluntarily, also through a high degree of pressure from their counterpart and group. The patterns to a group in which the majority have begun sexual relations as well as to belong to a dysfunctional family behaved as a risk factor of precocious sexual initiation. A big majority of adolescents had their first intercourse in inappropriate places and circumstances, did not use contraceptive methods. A high percentage of female referred to a non-pleasant experience during their first intercourse and living with both parents as well as a clear definition of their life plan behaved as a protective factor of the precocious sexual initiation. As recommendation we can say that an intensive work should be developed aimed to elimination, modification of control of reproductive risk factors of relations with special attention to the precocious sexual initiation. The following aspects to be considered: gender perspective, education in sexual health, project for development of youth, psychological and social pressure.

Chairman: We move on now to presentation by John Rees, Claire Lewis and Nathan Curry called APAUSE which is a school-based sex education intervention programme. They are from the Department of Child Health Post-Graduate Medical School in Exeter University.

Co-chairman: Well, they are getting fed up I think, it's marvellous that we have young people participating, it's always important when we are having a youth conference to have those with which we are working with present and passing on their opinion and their knowledge. Thank you.

APAUSE

Claire Lewis and Nathan Curry

Nathan: …. I really really like you.

Claire: No.

N: I really like you and I think that's what we both want now.

C: How do you think I feel, you putting all this pressure on me.

N: Oh, everybody in school is doing it, I mean everyone's done it,

C: No means No, don't you understand?

N: Oh, don't be like that, it's not fair on me, I mean, come on, I really love you.

C: Sorry, I am really sorry, but I can't be doing this right now, we'll talk about it tomorrow, when…

Claire: OK. Hello, my name's Claire, and this is Nathan. We're both are pupils at Exeter College and we're both 17 years old. What we've just shown you is a role-play in the APAUSE programme to show young teenagers that they have the right to say "No" if they want to.

Nathan: APAUSE stands for Added Power and Understanding in Sex Education. It is a project looking at methods of communicating the medical problems of teenage sexuality to 13 and 14-year olds. Part of the course is taught by people like us – peer educators.

C: We ourselves are students and can remember what it's like being 13 and 14. We've been more recently that these pupil's teachers. And so our word has almost more credibility. We are not trying to give them any thoughts of knowledge, we are simply there saying that you can have power, you are allowed to be confident in these situations.

N: We ask them into the classroom and saying, Hey, not all 16-year olds are having sex, or it's all right not be to having sex at your age. It gives them a bit more credibility, they know we've been there a few years ago, we know what they are going through.

C: I remember when I was 13 or 14 I thought anyone over the age of 16 or under the age of 25 was cool simply because of their age. And so when you've got a year 9 pupil who is at an influential stage talking about a sensitive subject like sex with someone they can relate to gives them more confidence.

N: So, how does it work? Well, firstly we as peer educators go through an intensive 2-day course. We firstly learn about contraception, STDs, that sort of thing, so that we know what we are talking about in the classroom. We then learn about how to handle difficult situations. We can't really say, go and stand there in the corner, so we learn how to deal with the class. We also go to teach the course as part of the team of four. We teach four sessions once a week. First one's called risk appreciation, second one's called pressure in relationships, third one's the power to be me and finally we do a round-up session where we go through what we've learned in the three other ones.

C: The sessions are structured using scripts which we learn during training sessions and also given to take away and take a look at before we approach. But we are allowed to ad lib. The scripts are written by John Rees and his fellow workers, I suppose, and they are very adult in their wording, so obviously we change them depending on what the class's stereotypes are. And to stem mayhem we also establish 2 ground rules in the first session. We don't have the authority of teachers, like Nathan has said and it's important to establish a form of respect to which both the peers and pupils must apply. The three rules are: no personal comments. These apply both to the peers and the pupils. We are not allowed to tell them any information about ourselves and in return we do not expect them to talk about themselves to their friends. Secondly, no put downs. You are not allowed to turn to someone and say, that's stupid for not knowing the answer. And lastly, listen to each other. They've got to listen to us and in return we've got to listen to them.

N: Session 3 "The power to be me" is a particularly successful and enjoyable session. In this session we use role plays to help young people say "NO" in difficult situations. being able to resist pressure is useful in all walks of life. But in this session we look specifically at sexual situations.

C: OK. In these role plays we get each member of the class to come up to the front of the classroom and resist a pressure situation put forward by one of the peers. We use methods we discussed beforehand in the classroom with them and saying “No” to a 17 – 18 year old gives these pupils confidence.

N: The role play we showed at the beginning was an example of what we use in a class and hopefully what we want to do by the end of the session we do in the classroom every member of that class can do exactly what Claire did to me or the other way around. We have three simple methods, although it might look complicated, they are three simple methods. These methods are quite simple, they look quite complicated there, it is quite easy, OK. First of all, you say ”No” and keep repeating it, you give no excuses and look them in the eyes. You turn the pressure back on to the other person. Firstly, this is in two parts, you firstly say how you feel, I feel really uncomfortable, I feel really awkward. And then you ask them a question, so that they are back on their defensive, something like, Why do you keep on pressurising me when I’ve already said “No”?

C: OK. We’ve done enough talking, we’d now like you to participate in trying out these exercises. One of us is going to act as a stage manager, which is me for now and Nathan is going to pick on one willing female. (audience member chosen)

N: First of all you are just going to say “no”.

C: Look him in the eye and say “No”, simple as that.

N: Three times.

N: So, you know, we’ve been going out for quite a while now, you know, I really like you and I think it’s about time we start having sex.

Answer: No.

N: Come on, I really, really like you, I mean, this is it, this love, I am telling you. Look, everyone’s at school doing it, I mean, all mates go all over me, it’s really good, oh please.

Answer: No.

C: Thank you, well done.

Rees: Now, we need a male volunteer. All you want to say is “not quite” and say how you feel, so you say “I feel really uncomfortable, I feel really awkward”. OK?

C: You know, it’s getting pretty boring in here, do you want to slip out to the back and have a bit of fun. Oh, come on, you know, you’ll enjoy it.

Answer: I feel really uncomfortable.

C: Please, I’ve been watching you all day and…

Answer: That’s made me feel really uncomfortable.

C: OK, finally we are going to pick another woman because there are more of you and I just want you to do what we did before: to say “No” three times and then finally I mean you could walk away, we are not trying to end relationships here, we just want you to get out of an awkward situation.

N: I really like you, you are really attractive.

Answer: No.

N: Come on, all my mates at school say that it’s really nice.

Answer: No.

N: Oh, come on, please, please.

Answer: You make me feel really uncomfortable.

N: Oh, how do you think it’s making me feel, I mean, I am in love with you, you know, I mean I really need this now,

C: Thank you very much.

N: So that part works. And we do that to every member of the class, every single young person has to come up and either say “No” or as we did at the beginning go through all the methods. And

so every single person has a chance to turn someone down who is older and at college. And that gives so much confidence. Does it actually work? It's got a lot of fun for us as well as for them and the main thing is we found is that after APAUSE they actually discuss sex with other people, they go away and they actually talk about sex, a pretty taboo subject for a lot of 13 and 14 year olds, notable parents in the yellow there and other school friends at the bottom. I mean, think about it, when you are 13 and 14 they don't really go, hey, guess what, I learned to say "No" today, but they are, they are going away and doing that. So now we pass you over to John, the project manager and he will give you a lot more facts and figures. Thank you very much.

Effective School-based Sex Education

John Rees - APAUSE

How lovely and reassuring to know that there are three young people presenting this today. I think we need to emphasise that this is not an abstinence campaign, as we've heard from earlier speakers there is no evidence at all that campaigns of just saying "No" is simply enough, but I think we learnt very effectively from Nathan and from Claire and from our previous speaker a lot of young people are getting themselves into situations where they are not able to stay in control for all sorts of reasons and we need to empower those youngsters to be able to manage their relationships.

The model that we are working on added power and understanding in Sex Education, and the important part here is that it's very much a multidisciplinary relationship between education and health. We've heard from two of our peer educators but we're also working with school nurses and teachers, the original research that some of you may have seen in the British Medical Journal in 1995 was a research team of a GP and a senior teacher, a model which was going to be very very expensive to reproduce, so we've now watered that down slightly to have visiting teachers such as myself working with health professionals, somebody who comes in with a lot more credibility about what it's like in the clinic or on the ward.. Working in this collaborative fashion with young people. Central and pivotal to that triangle are the teenagers themselves, we need to change the style, the approach, of traditional sex education.

The assertiveness work which you saw from Nathan and Claire we've evaluated with a large questionnaire to more than 5000 young people in different schools. We have a number of different schools, some in Exeter, in Devon, in the south-west of England, some in different parts of the country. The students knew very few ways of being assertive. Having had the peer counselling and doing that sort of stuff they were able to show far more assertiveness skills. We said that this is not a knowledge based programme, although young people's knowledge is not particularly good, simply giving them information doesn't necessarily empower them to change their behaviour to manage their relationships. As a teacher with twelve, fifteen years' experience I could try and teach kids to try and spell gonorrhoea but it isn't necessarily going to stop them catching it.

We've asked young students aged 13 and 14 the vast majority of whom are not sexually experienced - why do you think young teenagers might have sex, what are some of the reasons young people might have sex? They replied - because of pressure, because they think their friends are, because they want to look good in front of their mates is an enormously powerful influence on why young people say they think that people become sexually active. Very few of them, perhaps as few as one in six, are suggesting because they're in love, or because it's the next stage of their relationships. They're curious, they want the experience, and we do also have to recognise the role that drugs and alcohol play in this, and of course childhood prostitution is not unknown even in this country. Having said that the money thing tends to be - 'I've taken you to MacDonald's three times, come on how about it?'. Worth a try perhaps, I don't know!

Traditional approaches to sex education are not working. Many of you will of read about a researcher from Sheffield University who interviewed a young man of 16, and said tell me, you've had 11 years of education in Britain now, what do you know about sex? And sex education? And he said 'I know how to do it with rabbits, because the teacher showed us a film about rabbits', looked terribly embarrassed and said 'of course, when you're married, people are very much the same'. I think that we owe more to our young people than that young man was reporting. Again traditional approaches have tended to focus on the needs of girls and young women, and I think we need to show a shift in that. We know that

for a lot of young people, sex can have some pretty devastating and negative consequences. Many of you will be very much on the sharp end of sexually transmitted infection and disease, of the special care baby unit, and we've already heard from other speakers about the vast numbers of problems this rather grey and dismal slide can lead for young people. That's not to say that we are anti-sex or anti-relationships. We would expect young people to have multiple partners. But I think what we do need to do is to work with them, and I emphasise the word *with* them, so that they can manage those relationships to their satisfaction.

With quite a large number of students, 4000 young people a couple of years ago, we've divided them into three academic groups, the largest number is this group who are taking an average number of GCSEs, that's a 16 year old exam. We've got an academic group who are more able, and a group who are taking less GCSEs. Our evidence is slightly contradicts some of the stuff from the NATSEL survey, but in every group of every academic ability, girls are having slightly more sex than boys. Anecdotally with Britain that would sit with my parental experience that our young women of 15 -16 go out with guys of 17, 18, 19. Who do our young men of 15, 16 go out with? Girls who are a couple of years younger. I suspect that there may be cultural differences - I don't know, that would be fascinating to discuss. The trend then, seems to be, with more academic ability to have slightly less sex. If we sit that against knowledge, we can see that if we could just get people to have more knowledge, we could assume, if we could just get more knowledge, they would have less sex at 16. However the knowledge of the students is almost exactly the same, in fact in a couple of cases, the students who have had sex are slightly more - I'm not sure about that - but maybe in this sort of case, the students who have had sex have actually had to get a little bit more information. I think the message to take away is that we can't just equate knowledge with them changing their behaviour or managing their relationships.

Just giving them facts doesn't enable young people to change their behaviour or manage their relationships. We need to work from a different premise. And the collaborative goals theory, the social learning from Bandura's social inoculation theories and so forth, that some of you will be familiar with, say that of course we do have to have some knowledge. If we're expecting people to make informed decisions, we would expect them to know what

they're talking about, to dispel some of the myths about it - can you get pregnant the first time? Can you get pregnant if you do it standing up? Sex in the bath? No jokes about tap dancing. We need to give them knowledge. But just having that knowledge probably is not enough. We need to change the social soup that they swim in, the thinking that they have, the common understandings. And there's no point in you me or anybody else lecturing young people and saying 'of course you realise good communication is an essential part of a relationship'. We need to take them through a series of workshops with teachers, with health professionals, with peers, so that they arrive at some of these conclusions and understandings themselves. And of course if we're serious, I think, about getting them to manage those relationships, we need them to practise. Practical sex sessions in the classroom may be attractive to 16 year olds, maybe some difficulties for the rest of us to answer, but if we're serious about them discussing, negotiating contraceptive use, if we're serious about them resisting unwelcome pressure, the theory says we need to get them to practise that.

So the APAUSE programme, set up in 1991-1992, was to promote the positive emotional aspects of relationships. And from that I hope that there's a series of objectives which many health professionals, educators, and I hope young people themselves would wish to sign up to. The main intervention in year 7-11, 12 year olds, through to 16 year olds, is part of a rolling programme, a spiral curriculum which we revisit, and I think we've heard from some other people this morning, we need to start that much much younger in school. Having said that, I think there's a very different sort of relationship if we can talk to youngsters, to 4 and 5 year olds about assertiveness techniques - things that go in our bodies, things that go on our bodies, stranger-danger, whatever, we start that process at a young age. But I would suggest to you that young people's understanding of the reproductive system will be quite different at age 8, 9, 10, that it is at 14, 15, 16, because of the social change, the emotional and psychological development and so forth.

So the APAUSE programme, the results of which I'll speak to you about in just a moment, are three sessions in year 9, when the students are aged 13, 14, this is adult led, teacher, nurse, three sessions the following year, but the main filler of that sandwich four peer led sessions that Nathan and Claire referred to. The

good news is, although this is not a knowledge based programme, that before the young people have the peers input and for this example we trained our adult staff, our teacher nurse teams, to try and deliver some of the stuff that you saw Claire and Nathan doing we changed it slightly. It was ethically difficult for me to sit there with a 13, 14 year old girl and say come upstairs and see my luminous boxer shorts or whatever line was appropriate. We would ask them for other different pressured situations and the school nurse and I would model them. My colleagues would model that. The good news is that as a teacher of 12 or 15 years' experience I can communicate knowledge slightly better than Nathan and Claire. Having said that for both males and females their knowledge was good the changes in knowledge.

But if we take a social understanding, a cultural soup question, like most teenagers have had sex by the time they are 16. If you are 14 and you think that everyone at 16 is doing it, there's a lot more pressure on you to do something about that. Most 16 year olds in Britain are not having sex. If I tell them, or nurses, and with no disrespect to any of many colleagues who are sitting here, we can change behaviour, or sorry we can change that social understanding a little bit. But the peers as you can see are overwhelmingly more significant, they are better able to do that than we are. That is not to argue for either peers or adults. I think it's a question of saying there's an eclectic mix here, well we can work together, we can work collaboratively with and for our young people.

We've asked the young people, having had the APAUSE programme, set against quite a large number of control, comparison schools, 'what do you think about your sex education?', fairly soft piece of evaluation, what do you think about your sex education? And having had this style of work that as I say we're trying to deliver, young people are saying it's OK, far more having had APAUSE, both boys and girls. Interestingly, the boys' school sex education is more important, it's better for them. Girls are getting knowledge from elsewhere and perhaps they know some stuff already. But having had APAUSE, youngsters are saying it's OK. And those of you who work with young people know that OK is a fairly strong recommendation. With no disrespect to my two colleagues here. They learnt a lot, so schools results are actually showing statistical significance.

Whether or not they should use outsiders, youngsters overwhelmingly are saying we've heard from a couple of other speakers and presenters this morning, who are saying we need to get outsiders, not just my normal biology teacher, we need to get people from the GU clinic, we need to get a practise nurse, we need to get people with credibility to work with youngsters in their own setting preferably. And having had APAUSE, it isn't a question of the grass is always greener, but having had outsiders the students still value them. If we ask them knowledge questions, we can see statistically significant changes, I mean again already young women knowing a lot about contraception, and their general knowledge was pretty good. This is not a knowledge-based programme, but again the knowledge of sexually transmitted diseases, if we were doing GCSE STD in a 16-year-old exam in Britain, large numbers of our young people would be failing. We've already heard that.

Let's have a look at beliefs. If we think that everybody's doing it, if we think that sex is going to be really good, if we think that it's all right to pressure people, if we think that girls get a bad reputation and huge gender differences between stereotypically what we think about girls who've had a number of partners and boys who've had a number of partners, still a lot of gender difference a lot of social difference there. And as you can see, here is an example which is by no means unique, I think perhaps we've got some evaluation that other programmes haven't always had the resources to pick up, but by working in this collaborative style sex education in school can make a difference. The question I think we asked inappropriately is just to say, 'is it difficult to talk about sex, or to negotiate' - this is a synthesis of a number of different questions - 'is it difficult to negotiate contraceptive use?' And we were really frustrated that we hadn't made a difference. Having said that I think it's probably a bad question. We know that it's difficult to negotiate contraceptive use, we know that these things are not easy to talk about. Maybe we need to shift the question to ask 'is it simply too difficult to talk about?'.

The results from the APAUSE programme were published in the British Medical Journal and I think were certainly within Britain, unique, possibly within Europe unique, and that youngsters who had this style of work were more likely to have correct knowledge - well they ought to because it's a very expensive programme. Having said that we are now making it more cost-effective as we

train in-house teachers and personally as a teacher myself I can see that pervading into the curriculum is going to be very very important. Those of you who are based in Britain will know, working in schools, about the curriculum review in the year 2000, where I think there are strong indications that at last the government is coming to recognise and education is coming to support the notion that we don't need just English and Maths and Science, we need personal social education as well. More power to that.

What I want as a parent, as an educator, as a member of society, is for our young people to enjoy happy, rewarding, successful, fulfilling relationships. Those of you who are over 25 will remember that earth-moving is still a possibility within an intimate relationship. It may move a little more slowly or gently, who knows, but I would love to see this for many of us for many of our young people. I think if we work together, with them, we can achieve that.

Plenary P2 Health and Physical Challenge

Chaired by Gerben Sinnema Utrecht Netherlands
and Simon Clarke Westmead Hospital New South Wales, Australia

Primary Care and the Adolescent

Ann McPherson

We have heard that in some countries young people may be denied access to services because of financial problems. In Britain, there are financial problems and there are people who feel excluded from services, but they do have access in a way that many other countries don't have and that's something that we need to work on. We know that 70% of young people like other people will go to see their GP within any one year and on average teenagers do consult 2 or 3 times a year, so we do see them and although coming for specific reasons, this could be seen as opportunities for all sorts for other things. We don't use them as opportunities for giving them health information or health promotion or whatever else we might want to do it's also important that when they do come their experience is positive and it can be used in a way that at least tells them what is available when they might need something else so that they don't think, "I am not going back there because I've been put off."

There was a study done in primary care asking what they would like to know about, these are the things that came out top. Now, contraception came out top, both boys and girls, but more for girls than for boys. How do I know what's best for me, where do I go, at what age can I take the pill. These are the sorts of questions that I am sure in general practice we are not starting to address.

Period problem. Why is the period so painful, why aren't they regular, what can I do about heavy bleeding. And I think when we actually talk to young people about these problems we don't address them in the sorts of way or the sorts of questions which they are actually asking us.

Weight. How can I lose weight, what's the ideal weight for my height. We know that 70% of young girls will be dieting at some

time or other and I think 25% or 30% of boys will be wanting to put on weight. So whole area about weight and giving information.

Exercise. What's the best form of exercise, how can I find out about a healthy diet. We've recently done a study, I look after a lot of students in Oxford asking them what they wanted information on and interestingly food and diet one of the things they wanted much more information about and of course they are older teenagers. One of the other things we asked them was whether they thought they ate a healthy diet and they said, yes, until they got to University. So we also need to make access when they actually leave home to more healthy diet, better.

Sex. Where can I go to get good information about sex, I don't think they necessarily want it from GPs, they want information about contraception from GPs, not about sex. There is a lot of misinformation about STIs with the young people and where to get that information. I mean I think one of the things in many English schools in the UK is that it's so patchy what sort of health, sex education they get and it does seem that it is time that we actually sorted that out and made sure that in any school there is actually good and effective sex education, it's rather like not advertising cigarettes, it seems to me it should be one of those things that happens and we shouldn't still be discussing it.

Confidentiality. There's always comes up very high. Can I trust my doctor to keep what I tell him/her confidential, is there anything they will tell my mum about and we have to be honest about that and do you discuss patients with your colleagues and of course most of us do, so I mean that whole thing of what confidentiality means is important.

Sexuality transmitted diseases. How can I protect myself, these were the questions. Is vaginal discharge normal. I mean that last one is incredibly common and yet I think it's very rarely addressed as to what's normal and what is not. Just how heavy your period is, whether it is what's normal or it is not. The teenage magazines do quite a lot of it but actually I think it's an area that people and mothers find very difficult to talk to their children about.

Acne. Is there a cure for it, does eating chocolates cause spots, do any of the cremes work. I was agony aunt in one of those teenage

magazines for a bit and these were the sorts of questions that came up again and again and again.

Stress and depression. Why do I feel so stressed up, does anyone care about me, why does love hurt so much.

Cancer. There is quite a lot of anxiety about cancer, probably because it is so high profile but of course if one's looking at deaths in young people after traffic accidents and suicide cancer is one of the things that does cause death, but I think they are worried about cancer in a different way. If I look at older teenagers, University students, they will be worried about breast cancer and cervical cancer when they are sitting there smoking cigarettes. And that whole view of what is risky and what is not, there is a lot of misinformation.

So the next thing we did was to ask them what they liked about visiting the local health centre. These were things that the younger teeagers felt were important. Friendliness, and I think that meant that it was somehow a surprise that they got all this. And what was that they didn't like. They didn't like it being too morbid, sad and quiet, too quiet and stuffy, too short a time with a doctor. We know that actually that's true, that they are seen for a slightly shorter time than adults and that maybe because they are coming more with minor illnesses, but it maybe because we don't know how to talk to them. You see a teenager and you think, "Good, that's a good way to catch up when you are running late in the surgery", so I think there are all sorts of things to look at there. And too long waiting to get in, of course a lot of these things that other people, other than young people will also complain about. The very quiet waiting rooms, in our own practice we tried to use all different sorts of music, but you can never please everyone and you will always get complaints whatever you are using. So I don't know how we get over that one.

Other things that you think your local general practice should be doing. Confidentiality, they felt was something we should be talking about and I just give a little look of a poster that was actually sent out to all general practice: here to listen, not to tell. We talk about confidentiality, if you ask people what confidentiality means at that age they often don't know what we really are talking about. So we need to explain it. And there is a very good little leaflet which was produced by the Brook which actually entitled

“Private and Confidential” and when we did some research looking at which leaflets young people felt were the best this one came out top of the list partly because it was to do with the way it was presented, but mainly to do with the information it gave. And it actually gave them information that they didn’t have before about what confidentiality meant. These are available form the Brook Advisory.

These are the things that they wanted: more advice on contraception, not to be treated like children, doctors specifically for 10 to 20 year olds. I think if we looking in general practice there are quite a lot of problems how you provide clinics, in some areas it seems to work very well and in other areas clinics have been set up and they really have not worked at all.

Listening without a patronising attitude, asking about the male or female doctor, I mean the patronising attitude, doctors tend to do whether they are talking to young people or not young people. But I think young people find it much more difficult to deal with.

To know what’s available, and I think it’s another thing which I think we’ve been very bad at is actually telling them, for example, that they can change doctors when they want to. And they very often don’t want to see the doctor who they’ve been seeing all their lives with their parents. And I think we should be much less protective and worried about what other health professionals feel or our colleagues feel and actually I think it should be advertised that they can change doctors and go to their own doctor. However nice you are as their GP it may be that they just need someone whom they hadn’t known with their parents and say at 4 or 5. And good written information on contraception, exercise and diet.

So how do we make a practice more young people friendly? Find out what young people want and also find out what you are doing. If you start to look at what you are doing it’s amazing how you think you are doing one thing and you find you are doing another. When I am doing training for GP trainees I give them an audit questionnaire which is in this pack about promoting adolescent health in your own practice and it has in black do you have a leaflet about emergency contraception, do you have a leaflet about confidentiality, and I get them to go about their practices to see what they actually doing. And it’s amazing that just by doing that it makes them realise that they are doing very little of these things

within the practice and one can start actually change what is going on. So there is nothing like looking at what you are doing to see that you are not doing to see that you are not doing what you think you are.

Making sure that team actually knows what confidentiality means, doing some training, see what the staff are actually doing, some of you may have heard me saying this before, but one of the things I do, it was ringing my own practice pretending to be a 15-year old asking for an urgent appointment and it's amazing to see the sorts of things that you think are being done well and some of the times they are being done quite well but partly not as well as you want them to do. So worth at least doing a bit of discreet investigation or getting some 15-year olds or 13-year olds to ring up to see how they are dealt with. I think the Brook did that, they actually tested their own services and even within the Brook specially targeted at young people they found that there were some problems still. So training very important, have a meeting, start to talk about what you are doing for young people. Many receptionists are actually women who have had teenagers themselves, and are actually interested once you give them their heads to provide ideas as to how best to deal with young people when they actually come and register or come to see you or phone up.

Emergency contraception. Most practices still don't have any information about emergency contraception and that you can get it whatever age you are.

Adolescents. One of the things when we asked them is they do want to be able to phone on a no name basis. NHS directives coming in that allow some teenagers to phone up to get information, but I think we need to make it easier at every level.

Notices and magazines. See what they are reading. How many of you have read one of these magazines? That leaves half of you who haven't. If you are dealing with young people, this is where they get most of their information form. Now, you don't need to be shocked by it but the Sugar is one of the less lurid ones, but certainly if you are dealing with young people you do need to read what they are on about. And some of it is incredibly explicit. But if this is where they are getting their information from, if we are miles behind than where they are getting most of their information from we are not talking their language.

And having good written information about practice facilities, we produce a little booklet like this with a rough guide about the illnesses, a little rough medical guide about how, to help them to deal with their own illnesses and the things that are local within that area. And that's patchy, we have to as GPs actually provide information about the practice, but most of it would be the sort of information which is not relevant to young people.

Clinics. I'll be interested in people's experience of clinics who say are very variable, we've tried one specifically for young people and we found that it really hasn't worked in our particular area and in some areas it's been very successful.

Once again leaflet which are specifically targeting young people, the Family Planning Association does excellent ones but if you go around practices and I go quite a lot, if you look at what leaflets are available, very few of them are targeted at young people.

And then lastly helping parents I mean one of the things I think we've neglected to realise that it's parents who are giving most information to young people. There was someone this morning who was saying we mustn't blame parents when goes wrong, which we are tending to do, but in terms of health care if all our research shows that apart from magazines where do they get all their information from and help is from their parents and I think we need to be looking at ways in which we can give more information to parents to help them. And we see most of those parents, especially the mothers, most of them will be having regular cervical smears or problems with menopause, so we are seeing them and we can actually, it's an opportunity.

This questionnaire was completed by Chris Donovan with 347 students 12 to 18 and 62% didn't know how to register with a GP and I think that just shows that we need to be giving them much better information about how to use the health services. We somehow assume they know and yet I think there is only way that teaches them. Once of the things we should be telling parents is encourage them to get their own young people to actually ring up and make their own appointments. And I think these figures show how with a little bit of better information one could actually change the access that young people have to primary care whatever other resources we are giving them and whatever other things we are

setting up, at least let's use the stuff that's there already. And that is just something that was produced over 20 years ago within this country which we should be looking at within the services that we offer and it seems that we made some progress but there is an awful lot of way to go. OK. Thanks.

Question re. Emergency contraception.

Answer. There was a paper in BMJ which showed that the kids not only knew about emergency contraception and they knew when the accident had occurred they knew when they needed emergency contraception but they couldn't get it.

Question I tried to get my 15-year old daughter to go to GP on her own and she won't because they do not allow her to reister with her own doctor. How young can a teenager get registered with the GP?

Answer. I don't think there is any law. I think part of it is what GPs will accept and there is quite a lot to do with how we tell them, how encourage them that it is perfectly all right to take on young people from other practices. There is an enormous sort of problem about people feeling very protective about their patients. Now it seems to me most of us are overworked and there are far too many patients to go round so one shouldn't feel that just because someone wants to register with someone else it maybe because we are not doing things right and we need to look at that but certainly with young people we need to be encouraging them to take responsibility and not be possessive of them.

“Does School Health Have A Future?”

Leon Polnay.

I am Leon Polnay, I am professor of community paediatrics in Nottingham, for the last 20 years I’ve been a community paediatrician working within a city area. I picked the titled “Does School Health Have the Future” because certainly in quite a number of districts in the UK school nurses and school doctors are threatened species and I just want to perhaps start with a few cartoons, illustrations perhaps why school health finds itself in such a vulnerable position.

The first one relates to how we rate and appreciate scientific aspects of medicine and practice and I think because school health is very much on the low side of things it does not get the publicity, it does not get the investment that it ought to. So I think that’s the first point.

Second point, we’ve got a lot of change in the NHS at the moment changing direction, we don’t know where we are going, why we are going and the direction seems to change. And in it people seem to think about what we are going to do with the big players, but some times because school health is quite a small service it gets missed out. And you know we end up on our nomadic journey. Another set of migrants here falling charismatically into the future. It’s symptomatic that we talk about NHS reforms when the implication is that there is something wrong, or evil, or bad about what we are doing now. There certainly is a need for school health to change but there is also a lot of people taking us in one particular direction and then having second thoughts about whether it’s the right thing to do. So, we’ve got problems in terms of policies and directions for the future.

Where we are going? This is a rather more optimistic picture of the main highway which we are on between birth and adult life and the aim is to deliver individuals up this end who are healthy, well-educated and competent and in order to do that there are some very important intersections on the main highway: there is this one with education and I think it’s important to remember that teachers and paediatricians are both people who spend all their time with children and should be working together. And another set of intersections which we could call social services with other

important services for young people. One more point I should make we are very much in a position of lack of development and research to back up school health which is one of the reasons why it is vulnerable, I think we do need to develop a research component to that programme and I think it's quite a revealing statistics when one looks at how research and development money that comes to individual districts is distributed. So in my district our community trust gets £ 67,000 to support research and development. Some community trusts get none. Our teaching hospital down the road has over 2 million. So we don't really start as equal partners in this.

Well, where have we come from. School health itself started after this report was published, amazing document, the 1904 Committee report of Interdepartmental Committee on Physical Deterioration and I think there are still important lessons in this report for all of us. The report was commissioned because of the large number of recruits for fighting the Boar war who were unfit for service. And they wanted to know why that was the case. And what did they come up with. First of all was that health in adult life was linked to health in childhood, therefore we should promote the health for children and amongst the recommendations were recommendations related to juvenile smoking, alcohol, exercise, diet, open spaces, clean air, they recommended that growth was a very good way of monitoring the health of children and they also thought that regular medical inspection, I hate the word itself, was a good means of actually discovering at an early stage children who had remediable medical problems. So I think it was a very good start to school health.

Because I come from Nottingham I couldn't resist putting up a picture of Robin Hood and I suppose he had a particularly effective form of advocacy in terms of redistributing some of the inequalities of health and wealth in the local community. Unfortunately I don't think I can take this sort of apparatus when I am arguing this our health authority on how they distribute wealth and NHS resources but I've got a lot of sympathy with his particular approach.

In terms of community child health and school health I think we've got good news and bad news. Good news I think relates to skills and training over the 20 last years there are now training programmes for school doctors and for school nurses, we've developed national policies, eventually we've agreed about what

they are, we've got a growing body of knowledge, growing influences and very important alliances with other bodies within and outside health that work with children and young people. But there is bad news. And at the top there are cuts. I first showed this slide at the meeting of European Union for school and university health and I think the title of my talk was "Cuts and Freezes Spread Diseases". Didn't translate very well into Finnish unfortunately, but I think the issue is that is you suddenly cut a bed in a coronary care unit you see an immediate effect. If you cut little pieces off every year from your school health service that it isn't that same dramatic effect and not too many people screaming.

Those are image problems of school health and I think I made myself popular with some colleagues and I am popular with others in terms of suggesting that people should sharpen up and smarten up their own image. There is still some lack of influence. We certainly have poor information systems to govern our arguments and I am certainly impressed that people in 1904 in many ways had better information than we have. So for example this week on Tuesday we had an evening meeting and I listened to one of our local obstetricians talking about teenage pregnancy. The most recent data that was available was 1996. Whereas the report for 1908 was published in March 1909 and they did that every single year and they had no computers. So timely information. We lack the infrastructure, I think, very often and our clinics perhaps are poor shop windows for the types of service we would like to offer. And I think very important I don't think we are marketing the service in appropriate way to parents, to young people and health commissioners.

Other areas. I think what people call the new pathology, there is certainly lots of problems within school that require medical input. Bullying, I mean that actually has a mortality, you only have to look at your newspapers to see that. Coping with stress - incredibly a large problem. With targets for teachers, lead tables, pressures of examinations, stresses of will? Problem, where do they go? ADHD, substance misuse, self-harm, low self-esteem, surviving family breakdown, you know, these are common events, and where do the young people go to assess health for that. And to this I would add school exclusions, we need to be involved with those who are not in school but are of school age. And children and young people with Chronic Fatigue syndrome. So there is new

agenda, you know it's not flat feet, you know, and all the other things that people associate with school health.

I've got another set of cartoons which I call inappropriate school health. One of my favourite one of two little nits on the child's head and one saying to the other, "Pretend to be dandruff, here comes school nurse." But we've got some serious medical problems that we need to address.

A report by the National Association for the Education of Sick Children looked at the educational experience of a 100 children, young people with chronic illness, and I think it should be compulsory reading. It worries me that, you know, as a child in school forty to fifty years ago with asthma, these were my experiences, and I don't think they've changed that much, keeping up with work when children are away from school, hours of coping other children's work rather than the teacher taking you through it. Real education, actually realising that children are entitled to that. And sometimes out of sight - out of mind, if the child is at home or in hospital. But there is a very real need to provide good education for children with chronic disorders, and we might be talking about 6% of the total population.

Children with disabilities. We have more of these children, not less, so it does not provide an excuse for reducing school health services. Children with learning difficulties, specific learning difficulties, but I think the important point here is that these children are now in main stream schools, their teachers need support, their teachers need advice and they also need independent school as well, and those are often more disadvantaged particularly in getting health advise.

Health promotion. We had a whole series of ideas to promote health. We had Health of a Nation, we had Our Healthier Nation we now have Health Improvement Plans, we now have Health Action Zones. I am not sure how effective they are. Certainly in the Trent Survey these don't seem to decrease, they actually increased. And we actually not making an impact on many of the major health promotion issues and my feeling is not that we are doing things wrongly, but we are not doing enough of it, we are not reaching the critical level of activity to have an effect. You know, here is an example, where I think a lot of schools have been mobilised to look at the common problem of back pain. Huge

problem in adult life in terms of working days and costs and we are actually seeing that over half of teenagers we were looking at have experienced back pain in the last month. And that was one in five, that was a big problem and we found that the children who had back pain tended to carry their bags on one shoulder rather than on their back, they carried heavier bags, they tended to be taller. And there are very simple things that could be done to relieve it, like carrying less weights, carrying them properly and having seats which are the right size for the young person. And schools are very interested in this and young people seem to be very interested in this. And October the 5th was the National back pain week and there was great interest in schools in bringing about change, so back pain is an example.

Children in need in schools, children who are looked after by the local authority, children who are caring for disabled parent or sibling, very often these young people are invisible, people do not realise what they actually doing . Children who are poor and very important children who just need a friend. And OK, that's not a drug, but for a lot of children a school nurse is a friend they can go to talk to in confidence, she's there, she is available and it is a very important life line for them. And I think people underestimate the importance of this. And very important to require long-term support and continuity in terms of people who work with them in school.

General paediatrics also impacts upon school and school health and all of these problems may have major implications for school, headache might interfere with work, skin rashes night interfere with relationships, cause enormous worries, great concern about growth, which we've heard about, asthma might interfere with games, confidence worries about going away on school trips. And again the background of all of this there is also concerns about teachers being responsible for medication. And one extreme view is we're hear to educate and not medicate and other teachers are extremely keen to do everything they can to help the child with any paediatric problem but they require the support on a on-going basis.

There is a public health role and I've already mentioned that I think we had better information at the turn of the century. We ought to provide a picture not just of individual children but of each school and a profile of health problems within that school. We ought to be able to provide this population overview. Here in 1908 and it's time

to show you the data that they grouped the growth data of children so they were actually able to show that children in schools from poor areas were smaller and lighter and children off in schools from better-off areas. And this is an inequality in health and they wished to address that. One way of addressing that is school dinners and I am delighted that we've discovered nutritional standards for school dinners and the aim was by the time the next year's report was published that that inequality was diminished. So information is needed for a whole variety of reasons.

Evidence-based medicine sometimes is difficult to supply for school health because the most interesting and relevant outcomes are distant in time, complex and it might be quite difficult to link them to the intervention. There are other people making claims for resources, elderly, acute and there is a horrible thing about saving money. What are the selling points? I think school health does reach for young people that other services don't and it's got access potentially to all young people, nearly all go to school. It's cost-effective, it's a locally sensitive service, that takes account of local population and its needs. It's a specialist service, it's got a long-term perspective, it's got a good track record of working and teamwork with others and it will also overview the whole population. The threats to it are still ignorance about what school health does and its gradual erosion and aspects related to lack of money for training, recruitment it needs investment. I finish with a slide which I pinched after the conference in 1992 to mark 100 years of school nursing. It's an excellent title, the message which I want people to take away and that is that the health of a nation begins at school and therefore we need good school health services. Thank you.

Chairman - Thank you very much. That was somewhat exhausting, I feel tired just listening but it really did emphasise the enormity of the role that you have, I think Ann talked about the role with prevention of cancer and it's very interesting that more and more we hear about the need to get the fast foods down that the fat that those kids are taking in is way in excess of what they need and we area doing to see a lot more cancer in younger people possibly because of their high fat intake. And that's sort of thing that come up in schools.

Adolescents with chronic conditions.

Joan-Carles Suris.

Good morning, I am Joan-Carles Suris and I work in Barcelona, Spain, directing an adolescent unit in a private hospital. OK. My grandmother is 95 years old and she has two great favourites. First one is royal family, although she says that since Princess Grace died things are not what they used to be. Her other great favourite is Barcelona soccer team and she says that players don't play like they used to play and she says probably because football players today earn too much money and we agree on that. But the fact is that one of the things that she very often says that during these 95 years things have changed a lot and this world goes and goes faster every day. She often tells me that when she was born there were practically no cars in the streets and now we fly to the moon. When she was young to go to America was an adventure and now it is 6-hour flight. And she says that it's difficult for her to understand things nowadays. The century we are living in is a century of great changes and especially in the second part of the century things are going so fast that sometimes it's difficult to follow. And this is true for the medical science too.

In the last 30 to 40 years medicine has achieved so much that many of the diseases that were usually fatal in children are now being treated so well, not only with new treatments and also with a better use of already existing ones. Now these children survive into adulthood. In fact you know that for the majority of children with chronic conditions that is 84% of them will survive at least to age twenty. I use cystic fibrosis as an example, in '69 there was medium survival age was 14 years and some 20 years later it has doubled and was 28 years. Now we are over 30 I think. In fact the impact of the chronic condition both on the adolescent and his or her family depend on several variables. They need to be taken into account. They are the degree and type of incapacitation, the degree of feasibility, the prognosis, the course, the type and amount of treatment required, the severity and the symptomatology. But from an uncategorical point of view all the adolescent, no matter what chronic condition they have, we have to know that they have common problems, so that's what we'll be doing today, just talking about problems they have, no matter what kind of disease they have.

We know and this is not news that adolescents with chronic conditions are more likely to see their physician but again using CF as an example the number of visits in a study was 4.5 per year and almost over a third of CF patients were hospitalised at least once in the year with the minimum stay of 12 days. I think that the interesting part of it, this and other studies I found that many of adolescents with chronic conditions miss more days of school than can be attributed to the severity of the disease or the treatment. This fact implies that they have less contact with their peers, increased isolation and poorer academic results. In fact adolescents with chronic conditions are more likely to repeat grades to be drop-outs.

Parents pay a key role in the development of adolescents who have chronic diseases but mothers and fathers do not deal equally with the child's condition. In fact we know that mothers are more likely to be distressed or depressed especially because they tend to focus on the daily needs while father tend to focus on more long-term requirements and problems. In the same situation mothers are more likely to drop their jobs to stay with the kids than fathers, that something that we know, and in fact often fathers have a tendency to find refuge in their work to avoid some situations at home. However it is not clear if divorce rates are higher in this population. One of the things we all do as parents no matter the situation of our children, we tend to be over-protective and that's especially true for the adolescents with chronic conditions.

In the study done by Robert Blum in Minnesota they found in a group of adolescents with cerebral palsy that parental over-protection was significantly related to lower happiness, lower self-esteem, lower perceived popularity, higher self-consciousness and higher anxiety. And in fact we know that adolescents with chronic conditions are less likely to have a positive body image. Three studies, all done in the same year 1994, done in British Columbia with Roger Tonkin, found that 36% of girls with chronic conditions had a positive body image against 50% of the controls. A study done in Minnesota by Bob Blum - 48 against 60, and a study done in the city of Barcelona by our group is 49 against 61. And we know that an abnormal body image may lead to lower self-esteem again, segregation from peers, increased absence from school and other activities, increased anxiety over sexual functions and sexual relations and depression and /or anger. So there have been

many studies exploring the emotional well-being of adolescents with chronic conditions but they have always been controversial. Some studies show that there are no differences with their healthy counter-parts, other studies found an increased rate of emotional distress among them, and still others found that females have problems more often than males but that males are more severely affected.

Using a sample in Barcelona, these are surveys we did among school-kids aged 14 to 19 over 3000 subjects, girls with chronic conditions are significantly more likely to have emotional problems, to feel in a bad mood, to feel sad, to feel that nothing amuse them and to have suicidal thoughts. But they are also significantly more likely to have depressive symptomatology, so just frequent crying, sleeping problems or lack of appetite. Almost one fourth of them feel that they need professional help, and these are also significant, but you ask them if they have seen a mental health professional, there are no differences between two groups, and this is the only one that is not significantly different. We did the same study with males, and we found no differences between males, I don't know if that is that males at least in Spain just don't cry.

So the process of puberty is rarely affected by the disease but the disease itself or the treatment can delay its beginning. And this in a time when the main objective is to be normal. The later maturation can be interpreted as having a damaged body. As puberty progresses differences can become accentuated and feeling different from peers may lead again to social isolation. Again using CF we found that puberty in girls with CF the peak height velocity was around a year later than controls and the maximum peak height velocity was around 2 cm lower and the menarche was around 2 years later. And in fact we looked at age in menarche for different conditions and if we take a standard in a Western society it's between 12 and 13 years, well for CF girls it was between 14 and 15, for girls with diabetes it was between 13 and 14, with sickle cell it was between 14.5 and 15.5 and for chronic kidney disease it was almost 16 years.

I need to talk a bit about sexuality let me tell you very shortly a story. When I was training in Minnesota with Bob Blum I was finishing my MPH and I needed a theme for my project, so I went to Bob and I said, "Bob, what could I write about?" And he said two

probably most famous of his words which are, “I have a wonderful opportunity for you”. Well those of you who know him, if he ever tells you “I have a wonderful opportunity for you” it means it usually a great idea and it’s usually a hell of work, so when he said that after two years with him I said, “Well, let me think about it”. Two days later I went to him and said, “It really a wonderful opportunity because I found that I could do the review of all the published literature in less than 2 hours and they all fit in one slide, so it was wonderful. So it was by late ’91 -early ’92, all we know were the four studies, the first one done in London in ’77 studying adolescents with spinal biphida, only one girl was sexually active, it was a very low rate, a few years later they did another study with several diseases, 26% of adolescents were sexually active, and most of them using contraception, there was a study done in ’86, and it was done in New York city with several diseased girls, several chronic conditions, they found that in fact girls with chronic conditions were more likely to be sexually active than the controls. And finally the study done by Barbara Kramer in Ohio I think, they found that for spino-biphida it was 28%, for cystic fibrosis it was 43% and for controls were 60%.

The results of the study we did in Minnesota found that for boys the cases under control for visible and non-visible conditions were practically the same: 46 against 45, 43 against 39, and for girls it was also very similar: 42 - 38, 37 and 33. So no big difference here. There is a study done by Marie Chauker in France and was published in ’96 and they found that differences indicate that males with chronic conditions were more likely to be sexually active: 52 against 42% and girls were also more likely to be sexually active: 37 against 28. In continuing looking at that we wanted to know if other risk behaviours such as using drugs was also more often, happened more often or less often in adolescents with chronic conditions, these are again data from our survey, and we found for those having ever tried tobacco there were for females no differences; 72 against 74, for those being regular smokers again no differences: 1/3 in each case, for ever trying alcohol around 80% in both groups and for ever trying cannabis it’s 15 and 12% and no differences between groups. For males the same thing, the only one for cannabis it’s 14 against 25, the difference was not significant, but the number was point .6 probably because the numbers were small.

One other thing we've been talking a lot lately is resilience and individual family and community factors together with the characteristics of the condition can predispose to risk and on the other hand factors associated with resilience are having a confidence, having mastery, having high self-esteem, having a significant other, being able to discuss stress with others, having a non-parental adult to turn knowing where to go for support, having normal adolescent experiences developing leisure activities and interests. And we also often say that when kids with chronic conditions get to adolescence one other thing they do is not being compliant with treatment and in a time when the goal is to achieve independence being compliant means accepting that he or she is dependent on the disease, on treatment, on the health professionals, on the family or whatever. And not being compliant is just the way of showing that they are independent. So I think it is very important when you plan a treatment for an adolescent with chronic conditions to have him or her involved in the planning.

Many of the aspects of adolescents that I have been discussing here are related to each other and it's difficult to view one without the other. According again to Bob Blum the factor associated with optimum functioning of chronically ill adolescents are family and peer support and knowledge of one's physical condition, involvement with health care course, having a network of friends with and without disabilities and parental support without over-protectiveness. Just to end with, a health care professional's goal must be to encourage these youths to develop their full potential and help them through their adolescent years, because we must remember that even though they have a chronic condition, they are still adolescents. Thank you very much.

Chair person. Thank you very much for a lovely presentation. In response to question from the audience –

Answer: Adolescents with chronic conditions are less likely to receive any kind of guidance on sexuality or drugs than normal peers. The other thing is that in my country most of these kids are seen in specialised hospitals. If they go the primary care physician it is to get a prescription and that's all nobody takes care of their needs. Specialists are good at treating the disease but that's it. Primary care physicians usually say ask your specialist, so they don't know where to go, parents too, not only the kids, they don't know what to do with the kids.

Informal And Formal Use Of Health Care Resources by Adolescents And Young Adults

Jeanine Pommier

I am Jeanine Pommier, I work at the School of Public Health in Nancy, at the faculty of Medicine that's located in the north-east of France. The research I am going to present today is "Informal and Formal Use Of Health Care Resources by Adolescents and Young Adults". You'll see that this presentation in a very methodological presentation and I will try to tell you first how we came to work on this subject. At the School of Public Health we've been working on adolescent health for many years and at one point we thought about health services and many studies have shown with what frequency adolescents consult for example we know compared with other age groups adolescents are the ones that consult the less. However we know that they do have health problems. We also know even if they do not consult much that approximately 70% of adolescents have seen a health professional in the last year. We also know that as a mean they consult between 3 and 5 or 6 times a year. We know that girls consult more frequently than boys. We know that between 15 and 20 of them have to the hospital in the last 12 months and I could go on. But in general we know with what frequency they consult.

We also know where they consult. We know that most of them prefer going to the general practitioner, it depends on the age group, I think in the first presentation they showed very well, this morning I meant, Gail and in Gail's presentation, she showed us that if we compare the different age groups, professionals they consult are different but in general they consult general practitioners, they like to go to a non-family doctor, we also know that they consult when they go to the hospital, they go to specialists, but it also depends on the age group.

We also know for what type of problems they consult. And we also have an idea why they do not consult. But as you can see all the things that we know are related to the institutional health services. And we ask ourselves these adolescents have health problems and they don't always go to the institutions. So what happens when they have problems and they don't go to consult to the health professionals. And that's what we call here for "informal health services". And what we meant for informal health services

was the help they get from parents, the help they get from friends, the help they get from the neighbourhood, in fact other persons and other services that are surrounding the adolescents but are not strictly related to the institutionalised health services. So that's the reason why we wanted to explore all this part the use of health services.

But we also wanted not to enter this problem from our point of view, we wanted to have a little bit of the adolescents point of view and we wanted to work with them to try and construct a tool that will allow us to investigate all this domain. So how did we proceed? Here the results that I am going to show you later are just a little part of the research project, I'd like to tell you what the whole research project is all about, so you can understand.

We wanted to study this more from a qualitative point of view and from the adolescents point of view because we have many data from the institutions, but we wanted to talk about the adolescents and to have the real experience. The easiest thing we could so was to construct the tool ourselves, we as professionals in our team we have sociologists, we have psychologists, we have some therapists, we have doctors and that's what we did. We constructed a tool to try to study these things I was telling you about, but we also said, well that's not the right things, so also worked with 3 groups of adolescents who have worked separately, and they have also constructed a tool to try and find data about the use of formal and informal services. And so from all these 4 tools that we constructed, one with the professionals and three with the adolescents, we are going to do a final data collecting tool and this tool is going to be used by adolescents themselves to find the data among the peers. So that's in general.

Now I am going to present you a small pre-test that we did from the tool that was constructed for the professionals because unfortunately I only had the results of other tools 3 days ago, the tools that were constructed for the adolescents, but I can tell you some of the things that came out. So the main objective of this small research was to pre-test our data-collecting tool and the objective was to determine under what conditions young people seek formal and informal health care, what type of health care they use, and what factors influence the choice of health care. And the second one was to compare the results of socially and economically disadvantaged young adults with university students.

We did a qualitative study with semi-structured interviews, we studied more or less 25 adolescents, one of them being socially precarious young people, we have 8 girls and 7 boys going from 18 to 25 years old and they were involved in the training course for professional rehabilitation. The second group we studied were the group of 14 university students going from 18 to 22 years of age and these students were interviewed during the compulsory medical visit during the first academic year. We tried to talk to these students before they were seen by the nurse or by the doctor so that we could avoid the influence somehow that they might get after talking to them. And the AFORIS group, the AFORIS is the Association that works with the precarious adolescents. The AFORIS group were seen at where they usually work day to day. And it was really important, we went to see these youngsters first of all to see if they were willing to accept to be interviewed and we also were very careful to tell them that is afterwards they needed to go and see somebody or talk to somebody there was a counsellor who could help them out.

It was fortunate that we did that, because I'll tell you later what little things that happened during these interviews. We wanted to see everyday behaviour and the impact on their health status, we wanted to see what the health problems were and how they used the health resources as a whole formal and informal; the things they do if somebody close to them is not doing well. Sometimes they have promised to talk about themselves but you tell them, tell us what you will tell your best friend to do they can talk more easily. We also wanted to see what the relationship with doctors was. They quite easily accepted to talk to us, however the average boys and girls that are the precarious adolescents had more difficulties in answering the questions, many times we had to reformulate these questions, ask in this manner and in another because we wanted to really stay with as more open-ended questions as possible so they had some troubles in these questions. And also we saw that talking about health in general, even if the said health was not a worry but was quite a sensitive subject.

When we did these interviews I was expecting a baby and I never thought it would have such an impact but as soon as they saw my big belly, because it was quite big, one of the girls said, no, I don't want to talk to you. Later on she talked to one of my colleagues

this girl had a baby who died just when he was born, they see health services and they knew that we were doctors, somehow they think about these previous experiences and sometimes they are not very willing to talk because they are just very sensitive things and around maternity it was a real problem because from these 15 adolescents we had 4 of them that had problems around this area and to see me pregnant was just impossible for them to deal with. So that was something that really shocked us.

We only had 25 adolescents, so we cannot generalise, here I am going to show you some trends, but as I tell you, it was just a pre-test and with only 25 interviews I think we still cannot really draw definite conclusions, but at least it gives us an approach and that's what we were seeking. For example, when they were asked what they would do if they had a health problem. University girls in general answered they wait to see if the problem goes away, that's the first thing they do. And almost simultaneously they talk to mothers, that's very important because you'll see that university boys also wait but when they talk to their parents they talk to parents, that's mum and dad, but girls always said, we prefer to talk to mothers. That was a big difference. And sometimes both university boys and girls talk to friends or boyfriends and girlfriends, but almost all of them systematically talk to their parents and it's interesting to know that these adolescents do not live with their parents anymore because they are living in Nancy, they are going to the university and most of them have their family who live elsewhere. But they call their parents and they go and see them when they have a health problem. For the girls they usually wait for a family decision to decide what to do. And they also talk very much about family solution. While boys also waited a bit for a family decision, but they never mentioned a family solution.

And for the AFORIS group, that is more deprived adolescents, the girls said that they usually waited and postponed when they first had a health problem but they also self-medicate, and they do not talk to family and very very few of them talk to friends. They only consult when they think it was a serious problem, so we also had to explore what seriousness was for them, it was high fever for example, almost all of them mentioned high fever as a symptom of seriousness, cough and aches. And it was also interesting to see sometimes when they consulted they consulted directly to the hospital, thing that we have not seen with university students. And

for the boys, I couldn't find some tendencies for these boys, because on the extreme we had boys that said that they systematically consult, but I think that was almost a pathologic case, on the other side we had boys that totally rejected the use of formal health services except the hospital in extreme cases. We also had some boys that said they use the internal force and self-suggestion to try and fight against the problem and there was also self-medication and then eventually use of the hospital services.

A big difference between the university and the AFORIS group were the use of the hospitals, they go more easily directly to the hospitals than to general health services and we see that in the AFORIS group also there was more self-medication than in the other group and also that they hardly ever speak to family and friends, and that is very interesting because when we asked them what were the things you'd like to do this AFORIS group always mentioned that they like to be with friends, they like to be surrounded, they like to go out with the friends, however when they have problems, they not very often speak to them. I have to say that the differences are also related to the type of problem because some adolescents could tell us in general their behaviour but some of them told us it very much depends on the health problem.

When we asked some what they did if someone had a health problem in general most of them answered that they'd like to talk to this person and listen to this person. It's important to cheer them up, to find out what the problem is and eventually tell hem to go to a doctor. But in all four group the first thing that comes out is that it's important to talk and another interesting thing that came out also was in the AFORIS girl, there were two of them that had said that when somebody had a problem they always told them to go to a doctor and they were quite pushy about it and they went with them to the doctor. It was interesting to see also in the interviews what the real behaviour was, they said that they were really afraid to go to the doctor and when they could wait and postpone they did it as much as possible.

Here was the positive point and the negative point for using informal health resources. For example, they said that they use informal health resources that is social support because they can help them decide what to do. They have somebody to talk to, they give them support, they give them medication, they have the

experience, they are always there and they are older than them. And the reasons why they wouldn't go to these informal health services that is family, friends, surroundings is that sometimes they don't see the problem, that they don't care, they mentioned the lack of confidentiality, and that they wouldn't understand.

They very much talked about the relationship to doctors. And we could see that of the positive comments in relation to formal health services were oriented to the family doctors, they very much appreciated the family doctor. Seven of them preferred the family doctors when they go to see somebody in the health services they like to go the family doctor, somebody they have known for a long time. Why? Because they already know them, they can talk to them, they trust them, they take time, they try to listen, they are serious and they ask questions.

Some of the reasons why they don't consult. They don't feel at ease with doctors, because sometimes they don't explain things, they are too cold and distant, they give injections, they don't consider people as human beings, they don't allow consultations with somebody else, that's interesting to see because some of them wanted to go with their friends, and they do not trust male doctors. There was a girl who said that. Still, why they don't consult in relation to services, because sometimes opening hours are not compatible with their hours, they need to make appointments and cannot be received right away, they stay in waiting rooms for too long, visits are too short, they don't have time, they have immediate needs which are very important for them. There is also financial matter and the complexity of administrative papers.

Other reasons why they don't consult. Because they are scared to find out what they have or that it might be a serious problem. Sometimes they think there is no solution for their problem, some of them said it was related to cultural, educational background, and they gave some examples there, if the previous treatment didn't work and they didn't like to consult formal services usually for emotional, psychological problems, stress and tiredness. They said their doctors were not trained for that and that they wouldn't understand that type of problem.

So what did we learn from this pre-test. So about the tool: that the methodology was appropriate for this type of question, that

AFORIS group found it more difficult in answering the questions, and we also found that there were some things we could correct in our tool, for example, that we have to sometimes go and explore other resources that sometimes don't come to mind spontaneously. Maybe it's important to explore a bit more about the type of support they look for and received in the informal sectors. When they go to talk to parents and they go to talk to friends what are they expecting to receive from these parents and these friends, I think there we need to work some more to explore that area. We also need to work on how health was dealt with in the family, in the surroundings when they were children. And this came out spontaneously from them, that some of them said that acted today because they saw some things when they were young and I think maybe it is interesting to see what the representations they have of use of health resources when they were small.

We should explore a bit more about the sex of the practitioner, there are some studies that exist already in that field but maybe we should ask a bit more about those questions. It was interesting to explore more about the perception of the seriousness of the problem because apparently that's also a key point. Another thing that we can work on is when there is a decision to consult maybe we should go and see more closely for example for the university students we saw that the family really helped them in the decision but in this decision to consult we have to know more who decides when and how this decision is taken because I think all these points can be really useful for health services, not only for health services but for health promotion in general because if we don't know what they expect from health services, how they leave health services we cannot give them an answer that is appropriate to them and also maybe in terms of health promotion if we see that family peers and surroundings how they are used, maybe we can work and give more support to family and peers so they can deal with the problems of adolescents around them. Just 2 days ago I saw the tool that was constructed by the adolescents, and it was interesting to see, they were quite similar, I was surprised to see many many similarities, but their questions, they talked very much about how help was dealt with in the family and when they were little, that was one thing that was quite present in the adolescents' questionnaire.

Transition From Paediatric To Adult Care.

Marcelle de Sousa.

I am a nurse working with Russell Viner to set up an adolescent unit at the Middlesex in London which will have the first dedicated adolescent health service, so we are many years behind North America and Australia but we finally arrived with the help of an Australian.

Robert Blum in 1993 talking for SAM I guess said that transition is a purposeful planned movement of adolescents and young adults with chronic physical and medical conditions from child centred to adult oriented care system. This paper is about how you don't do that. I did this work while working in a large paediatric renal unit here in London. It was a regional unit and it was only one of three at the time in the UK. And because of that we had a large population. We used to transfer approximately 20 teenagers a year into adult system without any preparation whatsoever. And when I said there was no adolescent facility I meant there was no member of staff who bothered to acknowledge the needs of these adolescents. What were the reasons for transfer. Usually it was the end of secondary education and it meant that this teenager, this young person might be moving to university or college away from the unit. And so a letter would be hastily dictated by the consultant, it will be a phone call to the next clinic and the next visit will be to the adult unit.

The second reason is actually more entertaining, it was what one of our paediatricians called when they reached adult status. This basically meant if they asked for advice about contraception, if they arrived at the clinic with a partner, if they arrived at the clinic pregnant, this is a paediatric clinic, or as one girl did so beautifully arrived with a picture of herself on page 3 of a popular tabloid in this country with very little clothes on and then one saw they weren't right in the paediatric clinic. So what happened, the play leader or activities co-ordinators as they like to be called when dealing with teenagers or they heard a group of teenagers discussing how unhappy they were about going to adult unit, the two of us began accosting, it is the only word I can think of, teenagers while attached to dialysis machine so they couldn't escape from us, accosting them in the corridors of clinics where they are sort of going out to have a quick cigarette to ask them what they felt about being transferred to adult units. And they all

said that they wanted preparation. And so we set about having a meeting, and we invited these people along, don't forget these are all part of a multi-disciplinary team, but we had to invite them to come and talk to the teenagers.

The nurses from the various areas were invited. One of the nephrologists came along, the psychologists gave us her backing, the play leader, the pharmacists and a social worker. And from these meetings, I believe the term is not politically correct these days, we brainstormed with these teenagers, and we held several meetings. We had about 10 meetings and out of those 10 meeting we came out with a list of suggestions for preparation. One of the things they wanted was a year's notice, they wanted to be told that next year they would be going to an adult unit. They wanted to be able to visit the adult unit before they actually became a patient. They wanted sessions with the pharmacist, now this is very interesting because it reflects two of the earlier speakers, none of these teenagers knew how to register with the GP, they didn't know how to take their prescription to a chemists, they didn't know which chemist would provide which drug, because their parents have always done it for them.

They wanted sessions with a social worker, the social maze in this country is absolutely appalling, the forms and the bureaucracy, leave alone an adult trying to fill them a teenager moving away from home and from us would not know how to deal with it. They wanted time to discuss the future, and the reason they say children member of staff, it wasn't just with a psychologist or the social worker, they wanted actually to talk to the doctor or the nurse they formed a relationship with. And the next one is interesting, they wanted us to tell their parents about the next suggestions, about attending clinic on their own. They couldn't tell their parents that they wanted us to tell them, that this was part of their preparations going to the adult unit. They wanted a map of the adult unit, here in the UK many of the adult renal units are part of large district hospitals and it's quite a nightmare trying to find your way around it. So it was a very practical and good thing to do. And they wanted contact with a nurse prior to their transfer. They wanted a copy of their discharge summary, this upset all our paediatric consultants. Because they were many things that they would put into it, they knew their adult colleagues and so they'd said, this little sod never takes his tablets and they couldn't put that. And we had a lot of fun editing these discharge summaries

that went with the teenager to their unit. They wanted ability to keep in touch with what they called the parent unit. They wanted to be able to phone the nurses or doctors just for a little while, I think as a point of reassurance.

Doctor Suris pointed out that many of these adolescents are not confident, they are unable to face doctors or any other person of the team on their own and they wanted to be able to know how to ask questions, what sort of questions to ask. As part of this preparation, and I never know whether it's a good thing or a bad thing, we brought back some teenagers who'd already transferred to adult units without preparation, and they really upset everyone. And these were the sort of things that they came out with: the nurses didn't know me, I was just another patient, not a real person with feelings. Because often in the paediatric clinic they all knew the nurses and doctors by names and they knew the patient. But in a large adult clinic they didn't know them. It was silent in the adult unit, they were old and asleep, will this be me in the future, this was frightening. And this came from a young man who transferred while on chemo-dialysis to an adult unit. And that is the sort of picture that they went to. Coming from a paediatric unit where the teenagers were often dialysed together in the afternoon after school with lots of music, lots of activity going on this really was not a very pleasant prospect.

Why bother going to the clinic where a doctor doesn't look, listen to talk to you? I don't know my results from visit to visit. Some teenagers who were told what their creatinine results were in the paediatric clinic each time, which is the way of checking on compliance, they went to the adult clinic and no one ever bothered to tell them. They'd no idea what was going on. And that was just a picture to show you of an adult ward the teenagers went from a nice paediatric ward to things like that.

We didn't leave parents out of it. We decided we had to talk to parent as well as to what they felt about transferring to an adult unit. And this is what one mother said, " I will never get over the loss, I can't tell you how isolated we all feel". And that was because they felt they weren't made welcome in the adult unit where they were transferred to. And because of that we actually had a parents' evening as part of our preparation, where we sat and spoke to parent. We brought in adult physicians, adult nurses to come and talk to them and make them feel that they would be

welcome in adult units, they just had to take a back seat role, that was all.

To summarise. All these views went out into practice. We prepared a programme. The pharmacist, the social worker, the psychologist all gave their time and we really made an effort to prepare an ex-batch of teenagers that went away from us. We had very successful parent evenings. The Parents actually were quite relived to be away from their teenagers which is quite surprising, they had a chance to voice their fears, but to also say, I am really glad, I am tired of looking after them, I am tired of ordering their drugs, I am tired of being a watchdog going and collecting their drugs, I am tired of washing their clothes and cooking for them, can't you teach them that as well. So, I have now left that unit, I never had time to evaluate it and go back to the teenagers who we prepared to ask them whether it was a good thing or a bad thing, but perhaps someone will continue the work and we'll find out at another conference. Thanks.

Chairman. Here is the summary of transition in ten minutes. Very good. Well done. Questions.

Question - re. Parents

Answer - One of the things that happened and it just really irritated me is you'd have a teenager and a parent in a clinic and you'd ask the teenager the question and a parent would answer they never gave them a chance and it was interesting I thought that the teenagers didn't want to tell their parents themselves, don't come to clinic, let me go on my own, but wanted us to do as I call the dirty work, but we were very happy to do it.

Question - Cut off point re age?

Answer: No, that's also interesting, no, it is very much the end of secondary education, but when we told our teenagers that by the time they done their O-levels or A-levels and they've got their results which is usually in the summer they would then be moving on. We had a girl who was 22 and still was sitting for 1 A-level in English, because she really didn't want to go. But that is the cut-off point, really, end of secondary education.

Workshop Presentations

‘Psychological Issues in Teenage pregnancy’

Diana ML Birch

A. Teenage sexual belief systems.

That old black magic ... The challenge of developing sexual feelings and urges strikes at the core of our beliefs about the world, who we are and the meaning of our lives. How can we understand this challenge and the sexual belief systems of young people? Any assessment is inevitably influenced by our own beliefs and we must take care to retain objectivity, listening to our young patients rather than imposing our own interpretations on their situations.

Where do these belief systems stem from? Parental, cultural and religious beliefs and myths form a basis upon which the more contemporary ‘up market’ beliefs are built - for instance the current peer group stance or the ‘dish of the day' in terms of the media 'hero'. The immediate message can be as evanescent as the foibles of the pop charts - as professionals, we need to keep abreast of what the latest ‘no 1’ is teaching our youth. These belief systems, however bizarre and contrary to our own personal beliefs are at least tangible. We can understand where they stem from and we can to some extent modify them with appropriate input in the style of cognitive therapy, sex education etc.

In psychotherapeutic terms we can say that they are messages from the internalised Parental ego state (Transactional analysis), in simple terms the parental 'do this' 'don't do that' voices we carry around in our heads like a nagging conscience. Freudians would call this the superego. The intensity of these messages can be modified by educating or activating the Adult ego state (ego), the 'thinking' part of our inner selves which deals with factual knowledge. For instance group beliefs such as "You can't get pregnant the first time" or "It's OK if you do it standing up" can be confronted with factual knowledge such as '1 in 20 pregnant schoolgirls got pregnant as a result of the first time they had sex' and 'sperm can swim up hill'!

But at a deeper level, we have beliefs that are out of reach of direct social pressures. At this deeper level are what I would describe as 'magical beliefs'. Intrinsic ideas with a high emotional

content, a feeling of instinct and intuition and which may have no perceivable basis in current reality. These 'magical beliefs' acquired at an early stage of development may be ascribed to the Child ego state (TA) or perhaps the Id (Freud). They are very firmly adhered to largely out of awareness and profoundly affect the individual's sexual and reproductive practices. Failure to understand such beliefs can entirely sabotage a treatment or contraceptive programme. 'Magical beliefs' centre on fundamental concepts such as feelings about self, body and control and on the nature of life itself.

The adolescent during psychological development is much preoccupied with the question "Who am I?" confusion inevitably arises when "Who am I?" becomes "Who are we?". Establishing a personal identity can be an almost impossible task for a pregnant adolescent who suddenly finds that her identity is changing beyond her control, she is no longer a 'little girl', she is a fertile woman. The role of mother is thrust upon her before she has established her own identity, hence the belief that she cannot get pregnant and the frequent denial of pregnancy.

"I knew about sex and how girls could get pregnant, but I never thought it would happen to me." Many girls deny they can become pregnant. They believe that they are too young. Belief in the impossibility of pregnancy can become almost a 'magical protection' like a lucky charm used against the evil eye 'well it won't happen to me'. These teenagers are still at the stage of concrete reasoning and cannot identify with the experiences of others. They believe fervently in the invincibility of youth. This explains why health education methods based on 'shock tactics' do not work with this age group.

"My grandad smoked and he got cancer. I've been smoking since I was thirteen but I'm OK".

"You hear about things happening to other people but you never think it will happen to you. When my friend got pregnant, I sort of thought she must have been a bit stupid but then I realised that I hadn't come on (with a period) and I realised that I had been doing the same as her."

Operating at this basic level and being unable to identify with the experiences of others means that young people (or adults who

have not 'matured' psychologically) at this stage cannot learn from others mistakes, and perhaps can only learn from their own.

Teenage sexuality is profoundly affected by beliefs about control. A feature of adolescent development is an internalising of the 'locus of control' ie an assumption of responsibility for one's actions and one's body. Many do not reach this stage, remain with an external locus of control and believe that they have no control over their bodies or actions. They are not in control of when they have sex and they are unable to control whether they get pregnant. They are not responsible. Pregnancy is something which 'happens' to them. It is a matter of fate. Many girls said that they hoped they would not get pregnant but never considered doing anything to prevent it. Such girls are accustomed to having little control over their circumstances. They live in poor housing, have little money, do badly at school and are unable to change their environment. When an unplanned pregnancy occurs this represents the ultimate loss of control, even their bodies are acting independently of their wishes.

In fact, within this belief system there appears to be an element of belief in the 'autonomous womb'. It is as if the teenager believes that the body consists of three areas; the non sexual body over which one can exert some control in, for instance running, walking; the sexual erotic areas which are under less control but can be fun to use such as the penis, breasts and vagina; and the third area over which there is no control, the womb. The belief in the autonomous womb explains why teenagers do not believe that sex will result in pregnancy. It also explains some of the denial.

"Well, I knew someone was pregnant, but I didn't know it was me."

Missed periods, feeling ill and tired, putting on weight and feeling the baby move all add evidence to bring home to a girl the realisation that she is pregnant. Despite this one fifth of schoolgirls do not face up to the situation until a third person, their mothers or sisters tell them that they are pregnant. Girls seem to be spurred into taking action by missing further periods, and lull themselves into a false sense of security in the middle of the month. It is as if each expected, but missed period reminds them that they could be pregnant and should be doing something about it, whereas as this danger time passes they can deny it again with another 'magical belief' - “Well, perhaps I was only a little bit pregnant."

Lack of control is at the basis of the teenagers notoriously poor use of contraception. Only 7% of London pregnant schoolgirls have ever used contraception. Young girls deny to themselves that they are having sex and convince themselves that if they do end up in bed with a boy, this is a 'once off' and not a regular happening. This denial is a protective mechanism. They are conditioned into believing that girls who have sex or want sex are 'sluts' so they must convince themselves that they are 'not like that'. The belief is that unplanned sex is an accident. Nobody can be blamed for the occasional slip, for 'getting carried away', 'swept off her feet' ... the cliches are endless. However premeditated sex is inexcusable. "I never thought I'd be doing anything like that. I went to a party and I suppose I got a bit carried away, you know how it is."

B. The Self Esteem Study

In order to explore the relationship between ideas of self and sexuality, a research model compared a control group (secondary school age girls) a group of pregnant schoolgirls (aged 13-15) and a group of schoolgirl mothers with children at least 2yrs old. The groups were investigated by - A self esteem measure, A 'deprivation score' looking at life experiences; A 'sexual' scale estimating degree of sexual experience or sexual trauma.

Girls who were more deprived, had lower self esteem but those who were pregnant were less affected by these adverse factors. Similarly those with adverse sexual experiences were generally more deprived and had lower self esteem measures. Again the pregnant girls were less affected. It would seem that pregnancy partially protects the individual from threats to self worth but the effect is temporary. By the time the child is two the harsh realities of life take their toll once more. The temporary nature of this boost to self esteem may account for repeat pregnancy, in an attempt to re-establish identity with the counter culture and redefine alternative dimensions of value. Why does it seem that pregnancy is such a potent source of self value? " ... Seen from the young girl's viewpoint, pregnancy may not be so undesirable. Certainly it brings heartache and hardship, the extent of which should not be underestimated, but for underpriviledged girls with little education and non existent job prospects, motherhood is a fulfilment. With the birth of her baby a 'failed' school drop out, an unemployable misfit, becomes an acceptable member of society with a valued

role - that of a mother. She is successful and out of her loveless world she has created her own baby who will love her."

In pregnancy, a girl identifies with the ideal mother which she never had and can never be. We need to help her to identify instead with the ideal woman who has no need to be pregnant in order to achieve self value. Pregnancy can be used by some deprived girls as a source of self worth and as a false solution to their problems. That being so, an alternative solution must be offered. They must be given a different way of valuing themselves in order to ensure that, when they become pregnant, this is because they desire parenthood with all its responsibilities, hardships and joys and not merely as the only perceived escape from a catalogue of problems.

C. Repetitive Patterns -

Why do girls 'repeat' their pregnancy experiences? Girls with multiple relationships can progress from one relationship to another and repeat the experience without seeming to 'learn' from the previous situation. A high level of emotional flexibility and a kind of resilience can protect them from some of the knocks while 'enabling' further continuance of this inherently damaging pattern. The same could be said of repeating the experience of pregnancy and childbirth. If bringing up a child is hard and girls are just coping with a baby - or two, or three - why have another? Why repeat the experience? - particularly if it is not an entirely 'wanted' event. It is interesting to look at this repetition in terms of failure to 'work through' a painful experience. The girl enters into - 'falls into' - the next scenario while she is still reeling from the first. She has no time in which to 'lick her wounds', take in the experience, learn from it and so modify her future reactions. In general a traumatic event is followed by a reaction which gradually dampens with the passage of time and settles in resolution. That initial impact could be a conception, a pregnancy, childbirth, or a partner leaving.

Let us consider the stages of 'recovery' from such a 'trauma'. The initial strong reaction - the 'outcry' - is followed by a period of denial when we don't really want to deal with the situation and we would rather it 'went away'. As the denial period progresses, the 'victim' is confronted by reminders which nudge reality back into the scene ... intrusive thoughts and memories of what has really happened stop us from continuing in the denial process. Constant

reminders and confrontation of denial allow a period of 'working through' to be entered into when we can come to terms with what has happened and this results in completion and acceptance of our situation. It is only by working through all these stages and arriving at understanding, accepting and fully realising our situation that we can stop it happening again.

So how is the process applicable to repetition of pregnancy? At each stage we could see how a girl could either 'work through' to the next stage or be blocked in the process. The 'blocks' can be derived from her social circumstances, by the presence of other types of emotional assaults or other traumas in her life or by the too rapid arrival of another man on the scene or another pregnancy. Basically she may not get time to deal with one stage and move on to the next before another 'trauma' raises it's head. Any of such influences will arrest the recovery process and in fact send her 'back to square one'. Each time she is sent back to 'Go' she will find it that much harder to stay on the path and will experience repeated re-experiences of the same harmful route - she is as if trapped in a mad game of 'Monopoly' never able to throw the right dice to get her 'out of jail'.

D. Pregnancy as a Maturation Experience.

Leading on from our discussion of self worth and the manner in which young women with unfulfilling life experiences, with abusive childhoods and with poor future prospects can 'use' their pregnancies as a source of self worth .. it is worthwhile considering what else a pregnancy could contribute to the emotional changes and developments going on for that young woman in adolescence.

The pregnant girl can identify with the foetus and concretise her experience of the 'inner child' in her developing baby; this allows her another chance to be 'loved this time' by the 'ideal' mother. It also results in a confusion between container and contained and thus confusion of the boundaries between the mother's 'self' and the baby's 'self' - preparing the ground for an overly symbiotic attachment and problems in separation and individuation. Many of the theories and factors put forward above could be said to be negative and perhaps interfering with 'normal' maturation and development but are there aspects of childbearing for the young women that could be described as positive and beneficial?

If in pregnancy a young woman is identifying with - and almost becoming - the ‘inner baby’ - will the development of this inner baby allow for the re-experiencing of the same stages of development by the young mother? Just as she can be loved and wanted again as a ‘new baby’ - looking at the experience from a rather psychoanalytical point of view - can she have another chance at ‘getting it right’ for other emotional or ‘psychic’ aspects of her development? “ ... It is striking that despite advances in contraception and the easy availability of termination of pregnancy, a considerable number of teenage girls still become pregnant and some become mothers. For many the normal developmental crises of puberty and adolescence, followed by that of first pregnancy and motherhood, facilitated further psychic growth ....”

Certainly there are situations where pregnancy does seem to afford an opportunity for ‘psychic growth’ , for maturation and personal development. There are also unfortunately times where the ‘traumatic nature’ of the pregnancy and birth experience afford the opposite - where the experience can seem to “... revive primitive anxieties and conflicts ... which cause them to regress” (Pines 1988) and where the “... birth of a real baby may prove disastrous”. That is ‘real’ baby as opposed to ‘fantasy’ baby or ‘ideal’ baby.

So what makes the difference? What turns the potentially positive experience of pregnancy and childbirth into a negative and vice versa? The key to the question lies in the girl’s ‘object relations’ - in other words how she sees her self and the world around her - how she experienced her world and thus herself as a child.

To very much oversimplify for the sake of this current discussion - Just as the young mother experiences some of her world as ‘good’ and some as ‘bad’ - she has in childhood internalised a view of her mother as the ‘good mother’ or the ‘bad mother’ and thus also a ‘good internal object’ and ‘bad internal object’. If we develop the premise that the foetus is the ‘child within’ with which the mother identifies - then that inner child can be also be seen as ‘bad’ or ‘good’ depending on the expectant woman’s previous life experience. The baby is an embodiment of the girl’s ‘object relations’ and the conception can thus be the stage upon which the early drama which defined the nature of the ‘internal objects’ can be replayed .. and hopefully altered for the better.

If, as is hopefully most usual, the child represents the idealised mother - the child is the ‘good object’ ... but if the child represents the hated mother - the child becomes the ‘bad object’. In other words if the ‘action replay’ that we are allowed in identification with this developing ‘new baby’ evokes feelings of the existence of a perfect ‘idealised mother’ - then this experience will be positive and lead to growth and positive maturation and change.

If however the ‘action replay’ evokes the revival of memories of the neglectful and rejecting mother of say an abused girl - then the baby will be perceived as an unloving rejecting being who becomes unwanted, unlovable and rejected - the experience leads to regression and is more likely to lead to a need for further repetition ... another try .. another hope that it might be different .. might be better.

The way the pregnancy / birth experience is perceived will very much depend on how the mother herself is cared for during the pregnancy. If the young mother is being ‘held’ and cared for and nurtured during the pregnancy , the outcome is likely to be positive - if not - if the mother is not ‘held’ and cared for herself - perhaps boyfriend has left and she has no support - the outcome is likely to be negative. A vulnerable or fragile personality could break down completely under the ‘assault’ of a pregnancy experience.

Hence the experience might be summarised thus :-

+ ve - Brings identification with unspoilt self / child ... care for neglected child -> Love and caring for baby.

- ve - Brings identification with the ‘unlovable’ child -> projection of negative hostile feelings. - > Rage and jealousy of baby.

Throughout this discussion - we must maintain the concept in our minds that the vision of ‘self’ as experienced by the mother is completely wound up and inextricably linked with the vision of ‘the object’. In other words the ‘object’ which is the mother and at the same time is the child is also the ‘self’.

“The special task that has to be solved by pregnancy and becoming a mother lies within the sphere of distribution and shifts

between the cathexis of self representation and object representation".

Those mothers who are not 'held' during their pregnancies and who thus re-experience their childhood rejection through rejection of their pregnancies - may to some extent find that a therapy experience can put right some of those wrongs - In therapy for these girls - they need to find their 'ideal mothers' in the professional setting - in the transference - otherwise they will attempt to 'do it again' in a slightly different situation, with a different partner , with a different baby - in the hope that this will 'make them good'. Hence the 'repeaters'. Perfect mothers are hard to find!

Improving Health Professionals Communication Skills With Adolescents

Daniel Hardoff

A role play project with teenage actors

Prepared by - Daniel Hardoff MD, and Shifra Schonmann PhD. Division of adolescent medicine, Bnai Zion Medical Centre, the faculty of medicine, Technion, and the laboratory for research in theatre/drama education, the faculty of education, Haifa University.

Trustful doctor-patient relationships are essential for efficient health care. Physicians frequently feel uneasy when confronting adolescents who seek advice in their clinics. This may result from the difficulties of adolescents to clearly express their health concerns, as well as from their reluctance to share their feelings with adults. The establishment of communication skills with patients is required at all levels of training in medicine, and various methods have been developed to improve these skills, including the use of actors as role models. Only few reports describe this method with regard to adolescent patients, but none of them used actors who are adolescents themselves.

In this workshop we describe a two years project that has been developed in collaboration with WIZO secondary school for arts at Haifa, in which eight 17 years old pupils of the theatre department were trained by a theatre specialist and an adolescent medicine physician to role play 20 different medical situations in front of groups of paediatricians and family practitioners. Various issues regarding chronic illness, sexuality and eating disorders were included in these role play situations. Emphasis was given to the fact that frequently adolescents do not bring up their main concern in the presenting complaint. The physicians were asked to adhere to a physical as well as psychosocial system review in order to reach sensitive issues within the unique world of adolescents. Participants will have an opportunity to experience this training method with several of the adolescent actors, and to discuss its value in obtaining communication skills with adolescent patients.

The title of this session is on improving health professionals communication skills with adolescents. And we are going to do that or to demonstrate it using role-play techniques with teenage actors. We have here three already at the end of their teenage years actors with whom I work for two years and I will present them when we start doing the role-play. I have just a brief introduction that I would like to read to you, so it will be short enough and then we'll proceed with the workshop itself.

While medicine has improved in various technological dimensions doctor /patient relationships remain at the core of medicine. Obtaining an appropriate history is still the basis for evaluation of any patient. The more skilled health professional will arrive sooner at the correct diagnosis with minimum further additional tests, Creating a trustful and confidential atmosphere between the doctor and the patient will enhance compliance for therapy and reduce unnecessary tensions. These statements are true for patient of all ages and for doctors of every speciality in medicine. Adolescents are placed at the unique developmental stage where officially they are considered as minors but gradually become capable to make their own decisions and take responsibility. In their striving for independence adolescents frequently refrain from listening and following adults' advice. Health professional who work with adolescents usually feel as adolescent's advocates however they are frequently faced with rejection and even hostility. Therefore their ability to be trusted and authoritative and at the same time to succeed in obtaining maximum information from a teenage patient requires special communication skills.

While experience is a major factor in this respect technical guidelines and history taking are helpful. One method is a system review both medical and psyco-social which enable the doctor to address issues which have not been presented in the chief complaint and in the past medical history. Teenagers came to present their complaints, frequently hiding the main problems and the review of system may reveal that. There are several methods that have been developed to train professionals in history-taking and in communicating with patients and role-play is a common technique to exercise doctor /patient relationship. The use of actors for role-play has been proved to be effective.

Our project in unique since the actors who train us doctors for communication skills are themselves teenagers. Thus a more

authentic clinical experience is created enabling the trainees, the doctor, to receive feedback from the adolescent actors about their feeling during the interaction. In this presentation we will focus on the methodology and not on the training itself aiming to create in this audience a brief image of what is happening during the training session. We hope this presentation will serve as a stimulus to use this educational tool in your settings.

I will not elaborate on the technique itself at the beginning, what we would like to do is to present you how it is done, but will do it briefly. Every case that we develop takes about an hour discussion. They are set up in a group of physicians, nurses, other practitioners, social workers it does not matter, they sit in the hall and a case is presented by the adolescent actor, where a volunteer is sitting in front of the audience is taking the history and after some time we stop the scene to get some response from the physician, we are doing the exercise, the actor himself or herself and audience and then we continue. We will not do full exercise of each case, just demonstrate the method.

There are three actors here and I would like to ask the physicians in this audience to volunteer here not to test their ability in history taking, but to demonstrate how it works, we will not elaborate on each case we'll just go from one case to another because we are now very short in time and as I said usually when we do this session it is one and a half hours and we present two cases only. So, we will start now and we will stop many times and I will ask Michelle Shapiro who is an actress this time she will be a 14-year old girl who comes to the doctor. Would you like to be a doctor, school doctor, it's OK. She comes to school maybe.

Doctor: How are you doing, Michelle?

School-girl: OK. I just feel sick, I've been feeling sick a lot lately, I didn't really want to come here, my mum made me.

Doctor: Can you tell me a bit more about how you feel sick?

Girl: I feel nauseous, I feel like throwing up sometimes, and tired and stuff.

D: And did you have this other times before or do you think it is a bit unusual for you to feel like that?

G: Oh, I don’t remember, but I don’t think I ever felt this way.

D: And what are your ideas about it, feeling like this?

G: I don’t know, that’s why I came to you.

D: Right, good. But you didn’t want to come to me.

G: Well, I guess I did, I mean it’s not fun to feel this way all the time, so ...

D: That’s right. And how long have you been going on for now?

G: Oh, two or three weeks now.

D: And I’ve got a few ideas about it and shall I tell you what the possible things are that can make you feel like that?

G: I don’t care, do I really want?

D: The first thing that comes to mind that it could be symptoms of early pregnancy, does that shock you completely?

G: Well, I did not plan on getting pregnant right now or anything, I mean it’s not like what I want to do with my life right now.

D: Are you going to school?

G: Yeah.

D: How it’s been at school?

G: OK.

D: have you got a boyfriend or something?

G: My boyfriend does not go to school, he is much older.

D: Oh, right. How old is he?

G: Twenty.

D: Twenty, yeah, and have you been together for a while?

G: What does that have to do with it?

D: Well, we can leave that if you want. Have you had any close relationship with him?

G: Well, we are going out, what do you mean close, I mean...

D: Have you made love together?

G: You mean sex?

D: Sex.

G: Of course.

D: Yes, and about contraception?

G: Well, we are careful.

D; What does that mean, how are you careful?

G: Well, we are just careful, I mean, we make sure that you know that nothing happens and stuff...

D: Aha, how can you do that?

G: We just don't, I mean...

D: Do you choose a certain time when you have sex or you don't have sex?

G: Ah, no. I just do whenever I feel like it.

D: Right, does your boyfriend withdraw maybe before you come?

G: Oh, well you put it that way, yeah, I guess.

D: Right. So that's the only way you are careful at the moment. You think you could become pregnant by being careful like this or is it not possible?

G: No.

D: You don't think you could get pregnant. Well,

Hardoff. We'll cut here, OK, applause to the doctor. Of course thing might do on and what we are doing in a session with a group of physicians, this case, I mean you came right to the point.

D: What would you say, was it actually good or

Hardoff: We do not say whether it was good or not good. But this is the time to stop and get the audience response of they thought about what you were doing, but before usually what we do and we are not doing now is that we cut the thing we ask first the doctor who's doing it to tell the audience how he or she felt but this is an awkward situation, this is not a clinical situation, it is in front of an audience and you had first to express how you felt, then we ask the adolescents how she felt and then we ask the audience to comment whether they thought it was an appropriate or inappropriate way to get some suggestions. Then we'll ask someone else to continue, but you were very good, you came straight to the point, we have exercised this many times with general practitioners in the community where they see many other people and from time to time they see a teenager and when a teenage girl comes to them saying that she is feeling sick, they think of all kinds of things like viral diseases, gastro-intestinal problems and you name it and they forget that they have to do a system review and to go over the system, sometimes they get sucked into how they vomit and how what the colour of the vomit was. OK, is it green, do you ever have eat, you know they go and do what doctors should do, right and then they forget sometimes that they have to go over the system to ask about gastro-intestinal, urinal and so on and also ask about the period. If they ask about the period then we will reach the diagnosis maybe a little later than you did because you just went straight to the point quickly in fact immediately. Of course, you might get something else.

Doctor: I just came from a workshop about teenage pregnancy, so...

Hardoff: But we have experience a difference response from different doctors in different groups because not all of them oriented to think this way and what we wanted to demonstrate right

now is not to see how quickly you got to the diagnosis but to show you how it works in this situation. We will move on because we could dwell on it quite a while, because then we could discuss contraception, termination of pregnancy, whether she wants to carry the baby and I mean there is a lot more to discuss and this is at least an hour of exercise with a group of doctors, but for the purpose of this demonstration I will leave it here and we'll go to the next case and we'll se how it goes, OK?

There is no reason to be under stress because I am not examining the people, I just want to show, to demonstrate the method, OK? This young gentlemen, his name is Gull and I'll give you just a brief past medical history so that things will go straight to the point. Gull is an asthmatic and from early childhood. And he used to be OK for many years by taking some preventive therapy with inhalation and from time to time he had asthmatic use venti-inhalation and he was quite all right for many years and just recently he suffers more from asthma, he's been twice in hospital, he had urgent therapy and he's now coming back to you as his practitioner, his doctor because he is now back from the hospital and want to consult with you or maybe he does not want really but he was brought to you. OK so this is the situation. Now we'll let it go.

Doctor: Hi, Gull, how are you, I haven't seen you for some time, what happened, I heard that you have been to a hospital, what happened there?

Boy: I just had more asthma that's all, I just had one attack, nothing serious.

D: You were in the ward for couple of days? Were you in the ward?

B: Ah, yeah, never mind, it wasn't like two days, more like one day.

D: How did it go, was it a very bad experience or did you have a good time?

B: No just, you know, I pass along, it's not something serious, I think.

D: But you think maybe you so ill just like that and then went to hospital because you are very good when I saw you in the past.

B: I don’t know, it’s kind of this period, I don’t know. Nothing serious, I don’t know what causes it, I don’t think there is any special reason.

D: OK. Because you’ve been taking your medication regularly in the past, has anything happened that you’ve been not using them regularly?

B: Yes, last couple of months I’ve reducing things because I want to try and get along without. I think it will do me good, I think it’s a bit hard at the moment but I think I can take it.

D: OK, are you now at the college, what are you doing now, can you tell me what is happening to your life in general?

B: I am just in school, that’s all.

D: How is it, are doing well or having some...

B: yeah, sure.

D: That’s good. You have a lot of friends?

B: Well...

D: Do you go out and have fun? You seem it’s important to have a good time and when you meet your friends, do they know that you are taking medication for asthma?

B: Some of them know, I don’t go showing that, that’s stupid, you know...

D: yes, that’s right, so have you had opportunity to meet anyone else who has asthma like you?

B: I’ve met a few downtown, in the community, yeah, I know some people.

D: And it’s not nice to be taking medication when you are going out, so it can be difficult.

B: well, I think I am going to be good without it, soon I'll leave it, I think it'll be fine.

D: How are your mum and dad feel about it, your life and taking medication, do they nag you?

B: Yes, of course.

D: That's the pain, isn't it.

B: yeah, they wanted me to come here.

D: I can understand you grow up and you want to distance yourself, you want to be independent, because a lot of youngsters feel like you when you talk to people, maybe a lot feel like that, you are absolutely right. Having been to hospital and come out do you feel you need to do something else about the medication?

B: I don't think so, it wasn't so bad, I can get over it and I am sure it's soon will not bother me again.

The workshop continued with further discussion …

Special seminar

Youth & the Media

Victor Strasburger

Chaired by Diana Birch and Laura Clarke

DB - Youth and the media is something that's a bit close to my heart. Many of you will know that my daughter was at stage school and is an actress and so I've been very interested in youth and the media from very different angles, and I'm very pleased to see some people from Italia Conti stage school here, so we have some young people who are actually involved in the media as well, and I hope that you'll ask questions and interact and I'm also really pleased because we have a speaker, Victor Strasburger, who is from New Mexico where he works with adolescents. He has published so many things on youth and the media, that I won't go through them all because there's just pages and pages of really excellent work and he's looked at the media from all sorts of different levels. You will be getting a handout as well of some of his work, but some of the titles are 'Sex Drugs Rock'n'Roll' and so on, but the one I like as well, is the one about 'Why Should you tell your kids to say no in the nineties when you said yes in the sixties'. And I think that that kind of title gives you a little bit of an idea of how Victor approaches his subject, so I won't take up anymore of his time and I'll just pass over to him.

Victor Strasburger

Well thank you, it's a pleasure to be here, I did part of my paediatric training at St Mary's in Paddington Green Children's Hospital, so this is a second home for me. I hope in the next forty or fifty minutes to give you some fresh insights about the effects of media on kids. This is the television set very much like the one that I grew up with in the fifties and sixties, big cabinet, small screen, now we know that 91% of the world's children have access to television. We know that a sizeable number of them even have televisions in their own bedroom. In the United States of course, with the recent Lewinski / Clinton business, children now as young as seven or eight are asking 'what is oral sex?' – I did an interview for the national public radio a couple of weeks ago and tried to explain to parents what to do when your kids ask about this. My own seven year old asked about it. We know that people begin

watching television at a very young age. Babies as young as six months will attend to the television set and we know that they are exposed to a great number of potential dangers.

When we talk about television we are probably talking about a medium which exerts its greatest influence during childhood, but whose impact isn't really seen until adolescence. So, between the ages of 1 and 2 and 8, probably the impact of violence in the media is most crucial between the ages of 8 and 13, sex and drugs in the media, but then play it out progressively during adolescence. If I asked adolescents, and I noticed in the study from Cuba when they asked about sources of sexual information they did not include media, that's not uncommon, but if I asked the teenagers sitting here do the media influence you they would probably say 'oh no no no, we're beyond that, we're smarter than the media' but if I asked them do the media influence their 5 and 7 year old brothers and sisters – 'oh yes, it's awful, isn't it awful?' And so when I talk to teenagers I use that approach. And in fact I would suggest listening to the APAUSE studies that in fact the easiest way to train teenagers to say no would be to take a group of teenagers and tell them you're training them to train younger teenagers to say no, and that would make them very comfortable.

Now these are American data but they are in fact worldwide data as well. There's a study which I'll show you in a few minutes that is international in scope which in fact found the exact same thing, that children and adolescents are spending roughly three hours a day in front of the television set. It is, worldwide, the most important leisure time activity of children anywhere. They spend more time watching TV than they do in school, than they do playing with friends, than they do in sports, than they do in anything else but sleeping. Now American television as I'm sure you've heard and seen, and I know in London they're big fans of American television, I come over here to see Ally McBeal, here's the breakdown of American television, every year the average child sees a high degree of sex, drugs and violence, every year.

Now you may think that American television is simply America's problem. It is not. Media are our second leading export, we are the largest producer of media in the world, it is likely that what you see on American televisions last year or saw last year you will see on British TV this year, on European TV next year, unfortunately. This is a study which found that more than half of 12 to 17 year olds

have in fact a TV set in their own room, a third of grade school children, even a quarter of pre-school children. This is my summary slide for American TV, I'm not a big fan of American television, it is not all bad, but it is largely, certainly potentially harmful to children and adolescents, and I'll tell you why in a minute. Having said all that, TV is not to blame for the world's ills, whether it's violence, or teen smoking, or teen sexual activity. There are many many other factors, and if I were to list them, television and other media would come perhaps fourth or fifth. I will show you data that tell me as a researcher that media contribute perhaps as much as thirty percent to violence in the world, to smoking among teenagers, to sexual activity among teenagers. Thirty percent, by no means the majority, but a sizeable chunk that if we could make that thirty percent go away or make it healthier, we'd have healthier teenagers.

We know that children imitate what they see on television. And yet that is not the direct effect that we are most concerned about. There are in fact direct imitations - many of you know there were several killings, just in the last few weeks, in France, teenagers and young adults who were said to be imitating 'Natural Born Killers'. This occurred in Oslo, Norway, a woman gets up on the front of a ship and imitates the scene in Titanic and falls off. That kind of direct imitation is in fact rare, and it is not what we worry about. It makes headlines, when it happens, but it is not the effect that we're most concerned about. Rather what we are most concerned about is the subtle, cumulative insidious effect of media on young people, what one group of researchers calls the stalactite effect, the constant drip drip drip of electronic limewater on people's brains, so that if I went across to the front row and asked teenagers for example to identify certain key words in commercials or key programmes, they would know it, and yet they would not admit that there's any relationship between intimately knowing those characters and those key pitch phrases from commercials and their own behaviour. That's how well ingrained the media are in our lives.

If you ask a group of two or three year olds 'how do the characters, how does television work?', they'll tell you the characters come in through the plug. They are tiny little characters and they crawl in through the electrical cord. Television to young people is real. To children it is absolutely real, to teenagers it is a display of what's hot, what's new, what's fashionable, what's hip, what's chic, what's

cool, it is absolutely real. And so the biggest fallacy in Hollywood and other places that produce media is that children and teenagers understand that this is harmless, this is entertainment, everybody knows that this is not real, it is not reality, because the studies show over and over that young people think that television is real. This is the way real people behave in real situations. One of the speakers this morning alluded to Bandura and the social modelling theory, and it is absolutely crucial in understanding the impact of television. The social modelling theory says that children learn to behave by imitating attractive adult role models. There are no more attractive adult role models than what you see in the media, on television, on the movie screen. Some of the role models are people we might not necessarily like for our children or teenagers, but they are there just the same.

It's funny for me to be addressing a group of health professionals because in fact you are the most resistant along with teenagers to accepting that media has an impact. My own field, which is paediatrics and adolescent medicine, has been very slow to accept the data that have been published for years and years. Part of it is because this data is not published in the medical literature, it's published in the communications literature, in the psychology literature, part of it is that you all don't watch much television, you certainly don't watch what teenagers and children watch. Part of it is that you grew up when television was gentler and kinder than what it is now. It may be a whole host of things, part of it may be that you subscribe to the Hollywood thinking which is that it's harmless, it's just fantasy. But it's clear to me that physicians, nurses, other medical personnel are the most resistant to accepting that media have an impact on youth. Teachers accept it unquestionably; parents accept it a little more readily than health professionals. TV can be pro-social, it can teach people to respect their elders, it can teach them numbers and younger children numbers and letters, it can teach them racial tolerance, there are a number of positive aspects of media, but unfortunately most of media relates to negative aspects.

The media have become a worldwide marketplace, and many people now feel that television in particular exists, particularly in London it would be ITV and Channel 4, Channel 5, in the United States all the commercial channels basically exist to sell a certain demographic group to a certain group of advertisers. Public television varies around the world, the BBC is one example of

public television which is quite good, although they just lost the cricket contract to Channel 4, shame on them. But TV commercial television now exists to sell products. The programming is almost irrelevant. TV has been accused of being one cause of anorexia nervosa and other eating disorders among adolescents; there are a handful of studies which examine this. Certainly the image of women has changed in the last forty years, has gotten progressively thinner and thinner, Marilyn Monroe is a size 14, you would never see someone like that as a role model or a movie star today. A size 14 is quite large if you look at the total body fat of models today it is 25% lower than what it was even 10 or 20 years ago.

Now lets talk about violence because it's really been the most well-researched aspect of the impact of media. There are over a thousand studies which now link violence on the screen, particularly television violence, but also movie violence, video game violence to aggressive behaviour in young people. Some of that work was done here, some in Australia, some around the world, most of it in the United States. People make the argument, well of course media are violent, the media have always been violent, this is Kenneth Branagh in Henry V, Shakespeare is incredibly violent, I mean Titus Andronicus, they eat each other in pies, what could be more violent. The fact is that children are not watching Shakespeare three hours a day around the world. They are watching violent TV and movies. In the research, you have to answer the question, does viewing violent programming, whether it's television or movies, lead to aggressive behaviour because of certain violent attitudes, or is it simply that people who are more aggressive choose to watch shows that are more violent in nature. This is what I refer to in my articles as the chicken and egg dilemma.

This was the first of several so-called naturalistic studies to look at this question. This was a community in western Canada, which had no television, compared with a community that had just one channel, Canadian Broadcasting, and another nearby community that had multiple channels. A group of researchers from the University of British Columbia went and examined kids two years before and after television was introduced into this community and lo and behold, two years after television was introduced, the amount of physically aggressive behaviours on the playground increased dramatically. This was also repeated in Western

Australia, so these are really international studies. Here's a study from upstate New York in the United States, answering that chicken and egg question. A significant relationship and our value of 0.31 in the Social Sciences researches about a 0.85 in the medical literature – significant relationship between watching violence in the third grade (so these are 8 year olds), and aggressive behaviour eleven years later. No relationship between choosing to watch more violence and being aggressive. What does this tell us? It tells us that children learn their attitudes about violence at a very young age. In this case, age 8. And once they learn their attitudes they are very difficult to unlearn. This is a meta-analysis, some of you may be familiar with this it's a statistical technique that uses studies as individual data points. So this is a meta-analysis of about 125 studies of the impact of violence on aggressive behaviour, and there have been several meta-analyses published in the literature, most recently in the early 1990s and again, you see here an effect, an estimated effect size of about 0.25-0.3 and the impact is on both girls and boys. Quite significant, 30%. If you could make society 30% less violent wouldn't you choose to do that. Here is one way we could.

Now a psychiatrist named Brandon Senegal did a very interesting study, he said, if you learn you attitudes about violence at a very young age, but you don't play them out until you're adolescence or young adulthood, then we should see a lag between the introduction of television into a society and an increase in the homicide rate, for example. Very crude means of measuring violence in society but probably an effective one. So he looked at television ownership in the United States and lo and behold, fifteen years after television was introduced, in about 1950, fifteen years later the homicide rate sharply rose to three times what it was pre-television. In fact it increased dramatically exactly where television had been introduced first, which was the cities rather than the rural areas. He could almost do it block by block within the cities. It's fascinating research. Just to confirm that he looked at South African whites, obviously could not look at blacks, but looked at the homicide rates among South African whites where there was no television until 1973, and fifteen years later, the exact same effect. The homicide rate has doubled, nearly tripled in South African since the introduction of television.

Now if I went to Hollywood, as I will in two weeks, to talk to writers and producers, and I showed them this, they would simply say, 'we

mirror society. Yes society has gotten more violent and we've gotten more violent because we choose to show society as it really is'. Well these data allow that interpretation, these are not cause and effect data, but they are certainly provocative data and make you really think about the impact of media in society, in any society. Most recently in the United States just completed the National Television and Violence Study, which found alarming amounts of violence on American programming, here's what's most significant. Most of the violence goes unpunished. Most of the victims are not shown in pain, so I'm sure all of you who treat adolescents have had the experience of dealing with a teenager who's been shot, who says 'I didn't know it would hurt', because watching it on television, or in the movie theatre, it doesn't hurt'.

If you want to reinforce aggressive behaviour and attitudes, the easiest way to do that is to show violence as being justifiable. That's exactly what American media do, and to a great extent, American media are your media, wherever you live. Here's another chilling, I think, finding: in our country children's shows are actually more violent than regular programming. I don't think you'd find that to be true in most of your countries.

Now, I want to concentrate on a very interesting international study because it will tell you that this is not just America's problem, this is a study from Unesco that was just published earlier this year. It was a national, international study and in fact it did not include the United States, it did include 23 different countries, 5000 students around the world, roughly 300,000 bits of data, all twelve year olds, roughly 2500 males, 2500 females. As I said, 93% have access to a television, they watch three hours a day, television is the dominant cultural force around the world. Here's a chilling – my brother-in-law's a movie star, but I'm not sure that 88% of the world's children would recognise him, many of them would, I don't know, his name is Christopher Reeve, but 88% of the world's children do recognise Arnold Schwarznegger. Many children, in fact boys from high aggression areas, these may be war-torn areas of the world, or it may just be poverty areas of the world, more kids from high aggression areas want to be like Schwarznegger than boys or girls from low aggression areas, countries at peace. Action heroes and pop stars, the favourite role models for 12 year olds around the world.

These are significantly stressed children. As I said, all 12 year olds, nearly half, report being anxious a great deal of the time, 9% have actually had to flee their homeland, 47%, nearly half, would like to live in another country. So this is not Britain, this is not the United States, this is really a representative sample of the world. People see killings in their neighbourhood, many of them have used a weapon against someone else. What the findings were from this report, were that in fact, twelve year olds' views of the media, of real life, were influenced by their media experiences, they tend to see media as being real, as teaching them that violence is natural and necessary, and they see in the media that aggressive behaviour is in fact worthy behaviour. It's necessary, it's justifiable, again, if you want to teach people to be violent, teach them the notion of justifiable violence.

Many of you in this audience will recognise this picture, no-one in this picture is alive today. These are the children and the teacher in Dunblane, Scotland, who were all killed by a mad gunman toting rifles and handguns to school. Certainly, the media, the world's media have become quite violent in terms of guns, and I want to show you the first clip from the American show 'The Simpsons', where Homer gets a gun:

Homer Simpson: Now I believe you have some sort of firearm for me?

Gun seller: Well let's see here. According to your background check, you've been in a mental institution –

Homer: Yuh

Gun seller: - frequent problems with alcohol –

Homer: Oh ho ho, yeah

Gun seller: - beat up President Bush!

Homer: Former President. Potentially dangerous?

Gun seller: Relax, that just limits you to three handguns or less.

Homer: Woohoo!

(Later)

Homer: Close your eyes Marge, I've got a surprise for you!

Marge: Mmmm

Homer: Okay, open your eyes…

Marge: (screams)

Homer: Hey, it's a handgun, isn't it great? This is the trigger, and this is the thing you point at whatever you want to die –

Marge: Homer, I don't want guns in my house…

Bart: Hey dad, can I borrow the gun tomorrow? I wanna scare that old security guard at the bank.

Homer: Only if you clean your room.

Marge: No! No-one's using this gun. The TV said you're 58% more likely to shoot a family member than an intruder.

Homer: The TV said that? Well I have to have a gun. It's in the constitution.

Lisa: Dad, the Second Amendment is just a remnant from revolutionary days. It has no meaning today.

Homer: You couldn't be more wrong Lisa. If I didn't have this gun, the King of England could just walk in here any time he wants and start shoving you around. You want that? Huh? Do you?

Lisa: No.

Homer: All right then.

Marge: I'm sorry Homer, no weapons!

Homer: A gun is not a weapon Marge! It's a tool, like a butcher knife or a harpoon or… uh… an alligator. You just need more education on the subject. I tell you what, you come with me to an

NRA meeting, and if you still don't think guns are great, we'll argue some more.

(end of clip)

It's interesting that again the United States leads the world in this particular issue and that's the availability of handguns to children and adolescents. I would caution you to learn from our example, and that is that as the density of handguns goes up, the number of teenage homicides and suicides goes up as well. There's no question about that linkage, the data are quite clear. We're the only country really in the world that reverses this particular item when we export our media for example to Britain, they take out violence and they add nudity, or sexuality, we have the most violent media in the world and unfortunately we export a lot of that violence to the rest of the world. If we could at least eliminate the way guns are used in media, those movies, those television shows would be healthier by far, but since they are uniquely American media, we don't choose to do that.

The next subject is sex in the media, and it goes well with what was presented this morning. Think of the media as - we all acknowledge the peer group as being extremely important and you saw data this morning attesting to that yet again – think of the media as a super-peer. You watch television, you watch movies, and the message you get is, you are the only virgin left on the face of the planet. Everyone is having sex but you, sex is fun, sex is sexy, there are no bad consequences to having sex. Soap operas, whether they're British soap operas, or American soap operas, are notorious for using sex to get high ratings. We use sex to advertise, and this is worldwide, in fact there are more examples from the continent than there would be from American media where this is concerned. We use sex to advertise everything from beer and wine to shampoo to vacations, and then when our young people turn around and start having sex at age 12, or 13 or 14, we go 'tut tut, why don't you abstain from sex, just say no', when we are beaming thousands of advertisements at them a day, and we are showing them programming where everybody is just saying yes, where there are no negative consequences.

This is a current Calvin Klein underwear ad, 'what begins with a T' – I'm not sure what begins with a T, I've never asked Calvin Klein, is it t-shirt, is it tits, is it titillation, lots of things begin with a t. But

why use this in a way that's irresponsible and then when people try to do the right thing, and be responsible and teach kids sex education in a reasonable way, they get voted down. Here's the ultimate Calvin Klein ad. Now the Europeans are far better at this than the Americans, clearly, advertising works, so one way to deal with sexual content in the media, is to use it in such a way to promote reasonable, healthy sexuality. This is a print ad. You'll find many more of these in Britain and Europe than you will in the United States.

Does contraception increase sexual activity? There are now four studies in the medical literature which say no. Finally, people have done this work because it has been a sticking point not just in the United States but in Britain as well, that if you give kids access to birth control – this was argued in the House of Lords several years ago – should young fifteen year old girls have access to birth control pills in Britain? – the answer is that if you make contraception available to teenagers they will use it. It will not tip them over into earlier sexual activity, but when they begin having sex they will start using contraception. There are remember 1000 studies in the world medical literature about violence. There are four on sexuality. What's wrong with this picture? 1000 studies on violence, four on sexuality. This is not something that people are comfortable studying, or allowing to be studied, these four studies are all more than ten years old. No-one has ever done the kind of studies I showed you with the violence looking longitudinally at a group of eight year olds, following them for ten or eleven years. No-one has ever done that kind of study looking at how young children learn sexual attitudes and then put them into practice of sexual behaviour.

I'm sure many of you are familiar with the Guttmacher report which looked at rates of sexual activity in Europe and Canada and the United States, and lo and behold, the United States has the highest teenage pregnancy rate in the Western world – not in the world completely – some of the old Communist countries have higher rates. But in fact these kids are all having sex at roughly the same ages and in roughly the same numbers. The only two explanations here are either American teenagers are incredibly fertile, or, they don't use birth control. Sorry to tell you it's the later because we don't teach birth control in media, in schools, at home. Clearly, if you teach kids to use birth control, when they become sexually active, they will use it. You did not see, in that list of why

kids start sexual activity, you did not see anywhere – access to birth control as one reason why they started sexual activity. They need access to it, but it does not tip them over into earlier sexual activity.

I want to show you – I don't think this has made it to Britain yet, has it? Oh, it has, OK. Good. This is the current favourite among American teenagers and I am sure will be a favourite among British teenagers too, this is the most widely watched show in America among female teenagers and I thought I would show you two clips from it, Dawson is the main character and his mother is a newscaster on television and in the first clip he has the day before come home and found his parents having sex on the coffee room table in the living room, he is about to go out and his father has a little chat with him and in the second conversation one of Dawson's friends PC is discussing the curriculum with his high school English teacher. So why don't we roll that.

Dawson's father: Your mum's on. Watching her work is the best foreplay.

Dawson: I'm outta here.

Father: Have fun, play safe.

Dawson: The condom chat is premature.

Father: Oh, it's never too early.

Dawson: What is up with this sex? It's all anybody thinks about anymore. Sex! Sex! Sex! What is the big deal?

Father; Sex is a very big part of who we are as human beings.

Dawson: Does that mean we have to go hump the coffee table? If sex is so important then how come Spielberg has never had a sex scene in one of his movies? He keeps it in his proper place in film as should we in life.

(Bell rings)

Dawson: I'll be home early.

Next clip

PC: What are you reading?

Teacher: Oh just the approved tenth grade reading curriculum. I'm trying to choose the next book for our class. Any suggestions?

PC: How about something with a little action in it this time?

Teacher: Action?

PC: Yeah, sex. I mean what is our school board so afraid of - we're practically adults now, we can handle this stuff. A few blue novels are not going to kill us.

Teacher: PC, every piece of literature you're going to read this year will have sex in it. Everything you read last year probably as well.

PC: Yeah, but it's not real sex. I mean sex as a cautionary tale, sex as a warning. I'm not kidding about this. Every time somebody in one of those books has sex, something bad has to happen to them. Romeo and Juliet. They have sex, next thing you know they're killing themselves. The Scarlet Letter, Esther has sex and the next thing you know she's an outcast for life. The Greek one -

Teacher: Oedipus?

PC: Yes that one - that guy sleeps with some chick (who, granted, is his mother), he's so freaked out by it, he pokes out his own eyes. Hey, that's not real life. Correct me if I'm wrong, but it has been known to happen, that every once in a while two people sleep together, they enjoy it, and afterwards everything works out fine.

Strasburger: Now what's interesting about that is in the second clip, the two of them are having an affair. They're having sex together. She's 37, she is his tenth grade high school English teacher and the series used that as a way of gaining ratings. It is based on Mary le Tourneau who is a Seattle teacher who had sex with her in fact 12 year old student and has now just delivered her second baby from him. She's in prison.

But the first clip is actually more representative of the show once it got going and got good ratings. Because now you have a very interesting phenomenon, you have a father telling a son to play safe, the son saying ‘the condom chat is premature’. In fact Dawson is not sexually active, he’s a virgin, although the rumour is that this second year of Dawson’s Creek he and his best friend who is a girl will lose their virginity. But it’s an interesting placement of abstinence. Abstinence belongs in programming. It is not designed to overwhelm programming, anymore than it should overwhelm sex education programmes. But it can be incorporated in a very useful way.

Let’s move on quickly to drugs and then I’ll try to leave a few minutes for questions. A raging debate going on: does Hollywood sell drugs to kids? And Hollywood doesn’t just mean America’s Hollywood, Hollywood means the world’s Hollywood. A study just came out from a researcher at the University of Pennsylvania, showing the presence of drugs in most prime time shows, movies, half of all music videos. Drugs, tobacco, alcohol, illicit drugs, are wide-spread. This is a so-called content analysis. It doesn’t give you cause and effect, but at least tells you, there are a lot of drugs being portrayed in the media. Many of you will recognise the Budweiser frogs, many of you will not know that there is actually a study looking at the impact of the Budweiser frogs and finding that they were almost a powerful a cultural icon as Bugs Bunny. Bugs Bunny. And this is 9-11 year old children could recognise the Budweiser frogs. Readily. This is a beer being manufactured on the Eastern seaboard of the United States.

About two weeks ago I was supposed to testify in a lawsuit because the government is trying to ban advertising of this beer - this is bad frog beer and you can see he’s flipping the bird here, and the state of New Jersey wants to ban this kind of advertising so that young children and teenagers will not see it. Notice the things designed to attract teenagers. ‘He just don’t care’, ‘bad frog beer’, ‘there goes the neighbourhood’, all those kinds of things to make it anti-establishment, more appealing to young people. It remains to be seen whether this kind of advertising will be banned or not. Here’s another 30%. This is a recent study in the Journal of the American Medical Association, the first longitudinal study of the impact of cigarette advertising. Having a favourite ad, having a promotional item was highly predictive of smoking among teenagers, three year study - one third of all teenage smoking

could be chalked up to tobacco advertising. Thirty per cent. In the United States there is a direct relationship between the amount of money you spend advertising your cigarette and the preference among adolescents. We spent $6 billion a year just in our country, advertising a product which kills. And what's going to happen in our country in the next five years is that as we ratchet up the demands on tobacco companies to be truthful in their advertising, as we shut down their ability to promote their product, we're going to export our problem to you. Because the tobacco companies will try to remain profitable, and they are already expanding well into the third world, to market their products. So in fact, cigarette advertising, alcohol advertising are far more important subjects for the rest of the world than they are in the United States, because we're about to largely get rid of it or at least confine it to the adult population. You ain't seen nothing yet.

What we are doing with alcohol advertising, with tobacco advertising, is here's the Frobush paper mill and the Frobush water purification plant and the caption 'we create it, we clean it up'. Business couldn't be better. There are probably 10 or 15 studies showing that exposure to tobacco advertising, exposure to alcohol advertising increases the likelihood that kids will smoke or drink. Why else would people spend so much money on it? Why else tobacco and alcohol manufacturers spend so much money advertising? As a counter-deterrent, we know in fact that there are good programmes that can be implemented in schools that will cut the rates of tobacco, alcohol, marijuana, even hard drug use, dramatically by as much as to levels that are 25 or 30%, what they ordinarily would be. These are programmes that are not 'just say no' programmes, however, you need to teach peer education, you need to teach social skills, you need to teach media education. Maybe during the questions we'll talk about the Internet, I want to give you a few conclusions though.

The Internet I think is reasonable to discuss in terms of chat groups, also in terms of alcohol and tobacco advertising, also, obviously in terms of sexuality.

Now, what do we do about all this? Well, clearly, clearly, it is up to parents to control television better than they've been doing. And it is up to Hollywood to produce a better product. If you ask parents they say it's all Hollywood's fault, if you ask Hollywood, they say 'there's an off switch on the TV, it's all parents' fault'. It's both.

Many people are, and I know I have friends who have thrown the TV set out or locked it up in a closet, I would not advocate doing that because there is perhaps 10% of mainstream television that is frankly good for children. It will take them places they will never see. It can show them things they will never see in person.

Co-viewing is extremely important, and again I'm talking now about younger children, but the benefits are gained during adolescence. If you sit and watch television with a younger child, although you can certainly do it with a teenager and it's worth doing for sexual content or for drug content with a teenager, it's an excellent icebreaker, but if you sit as a parent and watch television with your child, and you discuss the content, your views then take precedence over whatever's being presented on the television screen. And critical viewing skills are an absolute necessity. Some countries do a good job of this, most countries do not. Australia has led the way, in critical viewing curricula, it is virtually mandated in all states in Australia in schools, you can teach kids that the media are not real. But you have to do it in an intensive, school-based programme in addition to doing it at home if you're a parent. Here are my kids, they are very media-literate, this is the last time they were seen hugging each other, about a year and a half ago... So television is not just part of the problem, it may be part of the solution as well. If you include media education with drug education and sex education, that gives you as leg-up on everyone else who's doing this, this is extremely important stuff to counteract. And we need to get over this simplistic 'just say no' philosophy, whether it's with teen sex or with teen drug use. It is more complicated than just say no. We have an industry which is constantly beaming messages to kids to just say yes. Clearly making birth control become available is important and many countries have recognised that; many still have yet to recognise it.

So, no-one in his or her right mind would invite a stranger into the house to teach their children or teenagers for three to four hours a day, that's precisely what the media do. The question is, are you going to control it or not, the question for Hollywood is, what's the best thing to watch on the old television tonight? Still, probably, the goldfish bowl. Thank you.

We have a couple of minutes for questions or comments.

Question - the role of the media in sex education

Strasburger: I wish I knew the answer to that question because I'm involved in some research right now, trying to get funding for a longitudinal study of teenagers' attitudes and beliefs and their sexual practices, and I can't get funding for it. I think if more parents recognised the role that the media play in sex education of their children, they might be willing to allow their children to participate in a study, but so far I haven't solved that problem.

Q. Does the media have positive effects?

Strasburger: Well I'm glad you asked that question - do the media have positive aspects? Well again the balance is greatly in favour of the negative, or I wouldn't have stood up here all this time talking about it. It's interesting because if you go to Hollywood, which I do a couple of times a year, and talk to people, they will hold up things like Schindler's List or Private Ryan, which I guess just opened in Britain, as being the best of Hollywood. This ennobles us, this teaches us the horrors of war in the case of Private Ryan, it teaches us the horrors of the Holocaust, which in fact I believe both those movies do, I think they're great movies. But, if you say what about this movie which is just violent, just mindless: 'oh no no no no, that has no impact, that's just entertainment'. So, even Hollywood will say 'we do the good things and we do it awfully well, but the bad things have no impact'. I would say yes, there is a positive relationship with the media, and the media can teach very positive values whether it's about violence or sex or alcohol or smoking or, as I said, racial tolerance, respect for elders, you can teach a great deal of things, there's almost an Orwellian context to it if you take it far enough. We haven't even come close to that.

Plenary P3
Teenage Pregnancy

Chaired by Pamela McNeil - Jamaica
and Christine Ferron - Paris, France.

Diana Birch: I would like to introduce two of my great friends who are chairing this session, Pamela McNeil first of all, who is from Jamaica, from the Women's Centre, but now it's the Women's Centres of Jamaica Foundation because they have become very big and they have branches in a lot of towns and centres in Jamaica, and also in other parts of the Caribbean. In fact their model has been copied in all different parts of the world, Africa and so on, and Pamela will tell you more about her programme tomorrow. The other person who's chairing this afternoon is Christine Ferron, who is now in Paris, but I met her when she was in Chicago, and then two years ago she came to speak at our conference on drop-outs and delinquents, and at that point she was working actually in Lausanne in Switzerland. So she is truly an international person, and she is actually a psychologist and she's worked with young people and done a lot of good research, so I'm sure that the session will be very ably chaired. I hope you enjoy it.

Pamela McNeil: Good afternoon. Before we start, I would ask if you could hold your questions until all the presenters have finished their presentations, and then we would have the questions and answer period then. I'm afraid Senor Girard will not be with us because he is not well, but putting on one of her many hats, Diana Birch is going to speak today on adolescent fathers, a very topical and interesting subject.

Adolescent Fathers

Diana Birch

I would like to begin with a quick view of a couple of teen fathers. Teen fathers can give a good impression or a bad impression, and some of the ones we work with have enormous problems and don't bring a lot of positive into their family, although I'd like to emphasise that generally speaking obviously it's much better for a family to have a father and we need to encourage teen fathers to be very much involved with their families. These examples are in fact very much involved - the one on the left is a young father whose partner was aged thirteen when she was first pregnant and fourteen when she was next pregnant, fifteen when she was next pregnant and he in fact more or less abducted her from a children's home and we had enormous problems with him, he was a very needy individual and we need to remember that when we are looking at teen partners we often do therapy with the girls but we also need to do therapy with the boys as well and include them in all of the work.

The other couple look slightly older but these two actually got together when they were thirteen, and now we are seeing them five babies along. She first became pregnant by him when she was at school and her child was then adopted by her mother and he's now eleven, and in fact, this guy was OK, he was upset about losing his child. She got pregnant again and she had an abortion. And over the however many years it was, he never forgave her for the fact that she had the abortion and got rid of his child. So in fact this morning in one of our workshops we were talking about the aftermath of abortion and the effect on the girl; and I think we need to remember the effect it also has on the man and on the boy who loses their child as well.

Now just a few facts and figures. Looking at girls and boys at the moment. There is a scatter of the age of first sex of the schoolgirls who were in our first survey. In fact the average age of first sex there was about thirteen and a half, average age of first pregnancy was fourteen and a half, and average age of first child was fifteen and a half at that stage. But with regard to the average age of the fathers - the average is really a couple of years older because the average is about seventeen and a half, and that's about typical, although we have a group where the fathers are much older and

there's sexual abuse involved in there also, and a scattering of younger boys.

So what about these boys? What are they like? Well most of them had known the girl for more than six months, and in fact three quarters of them had been the boyfriends of these girls, had known the girls rather for more than six months. So they're not sort of fly-by-night, predatory boys like we tend to think. There's an awful lot of scape-goating of the boys in these situations because after all the girl's left holding the baby. We do a lot of work with the girl's family and the boys tend to get excluded and if we can say it's their fault, then we can deal that much better with the family.

So what about the degree of support? Now we have to remember a lot of these kids actually want to support their family, their baby etc., but they're not allowed to, or they're too young, they don't earn. So this is emotional support not financial support. So most of them, nearly 90%, were notified about the pregnancy. Some of them weren't, sometimes they met their girlfriends in the street a while later pushing a pram, and said 'oh, what's this?', 'oh it's your son', and I've counselled a few boys who are really in quite a lot of stress, suddenly finding out they were fathers and not knowing about it, and also feeling guilty because if they'd known, they'd have wanted to support their family. Only 50% involved in the decision-making. But as you see, 59% emotionally supportive, and 18% were actually present at the delivery. Now we have to remember, this is fifteen years ago at the start of the longitudinal study, because we're looking at progression with all these figures, fifteen years ago it wasn't *that* common for fathers to be in on deliveries, you know we were trying to do it but it wasn't as common as it is nowadays. So to see that nearly 20% of these young fathers were actually there on the delivery actually shows that they were quite supportive doesn't it? And of course we had 40% who were just unsupportive, but as you'll see they don't all disappear totally.

When we're looking at decision-making and what the girl decides, what the boy decides etc., very few decided to adopt, and in fact about similar numbers of girls and boys decided either to go for an abortion or to keep the child. And in two thirds, the decisions tallied, the girl and the boy thought the same thing. But in the third where they didn't, there was a lot of problems. A lot of guilt, a lot of pain, a lot of emotional stress. I've put this picture in here (girl

holding a baby and being held by a YSH staff member) because I think we're often talking about containing the girl and this is the slide I use to talk about containment with our families. But how do we contain the boy? Because very often we can't even meet him. With the girls that I've followed up I've tried very very hard to see the partners at various stages and even by trying over a fifteen year period, there were still some that I'd never clapped eyes on. And so, there's a lot of grief and stress around there that we are failing to contain.

Another point of this picture is what about the abusive boys? Well this was a very disturbed family because this girl got pregnant and she had had an incestuous relationship with three of her brothers, so we never knew which of the brothers was the father, so I'm jumping about a bit but I'm trying to give you both ends of the spectrum. And there again, she was with us for therapy about it but what's happening with the boys, because obviously there's a disturbed family background there, disturbed boundaries that makes those boys have sex with their sister. So we need to look at both sides.

When we're looking at how long boys stay in touch with their children and partners. When I looked at the subject in the first part of the study, going up to two years, I divided the findings into unsupportive, supportive, and the number which were living together. And after two years, about 45% were still in touch with their babymothers and their children, but the ones who were unsupportive at the beginning of course, as is expected, more of those fall out. Very few were living together, even after two years. Obviously a lot of the girls were living at home with their parents to start with and so it's difficult for a boy to move in, but that number always stays low. And also it's different boys at different stages. The interesting thing is that there are a few that live with them, even when they're under sixteen, and I was always amazed to see the number of families who actually did condone having a boyfriend there, sort of sleeping under the same roof with a fourteen year old girl, and we don't need to talk about definitions of illegal sex and all that, we don't want to get into that here, but I'm just telling you that's what happened.

Continuing the study, that's the fifteen year data, you can see as I say, that at two years about 45%, but it falls off with time so at fifteen years though, still 20% are still in touch with their kids. And

that is a pretty high figure really although you know it's bad that it slopes off, after fifteen years it's quite a high figure.

And if you look at the number of fathers that are still in touch, it's also very dependent on the background of the girl. The girls who had families, were more likely to have their boyfriends be in touch, so they're more likely to be stable relationships. And the girls who had families, the couples that had families, they were more likely to stay together, where the girl had been in care, when their partners had been in care things were very different. And in fact at fifteen years, 20% of the whole population were in touch, but only 2% of those where the girls didn't have a family. So we're really perpetuating the problem there. And looking at the childbearing patterns of the girls, it very much depended on the boys. We had some who constantly repeated, had pregnancy after pregnancy after pregnancy, which was the majority, and they tended to have more partners, so there were more boys moving from one relationship to another fathering children.

Some girls just had a single pregnancy, one boyfriend. And then we had ones where she just has one boyfriend, one pregnancy, and leave it at that, and never really had many boyfriends, so her boyfriend never really figured in the family. Then we had constant repeaters, loads of kids, loads of partners, but all very happy. So looking at the number of boys, this was interesting, because half of the girls, just under half had multiple boyfriends, like we said, and were repeating pregnancy. 39% had only one boyfriend, one sexual relationship over the fifteen years, which I think is pretty amazing really, because as I've said previously, how many of us in fifteen years can really put our hand on our heart and say we've only had one sexual relationship? I mean it's not really that common these days is it? So these girls are not promiscuous.

What interests me with the fathers is, the 12% 'early sub' I call it. What this means is that you often have girls who come and they're pregnant, and their boyfriend has dumped them. And another boy comes along and he wants to be a father, and he has a real need to be a father, and he takes on this ready-made family, the girl and the baby because he's the sort of chap who needs to look after people, and is a carer, and interestingly, these were the boys who were much more likely to stay over the period of time. Of these early substitute fathers they were nearly all still there at fifteen years. They were much more likely to stay than the natural fathers,

which I think is very interesting and it just shows the need that some boys have to be fathers is very similar to the need that some girls have to be mothers.

And this is an example of a boy who stuck around for a number of years, actually I was quite embarrassed when I gave a talk at the University of the West Indies in Kingston a few months back, and I showed this slide and one of the doctors in the audience jumped up and said 'that's my cousin'. Shows how many families intertwine.

One of the problems is that a lot of these boys grow up fatherless, and that is what is causing the problems. These are all boys that grew up fatherless and have got big problems. What is the family pattern - we have family structures involving mum and child; some mum and children; some mum, children and dad; some mum child substitute dad; some mum child multiple fathers, and so on. Mother child adult father because the mother herself needs a father.

We talked for a long time about how girls maybe get pregnant because they come from single parent families, they don't have a father and so they need to go out and find a boy because they don't know how to relate to men, they've got an absence of a father figure in their lives. But, what the fifteen year study showed was how important it was, especially to the first born male children, this absence of father. And I'll just show you quickly, behaviour problems in the girls - 20%, in the boys - 70%. This is the children of the teenage mums at fifteen years. More boys bullied than girls, more boys having minor crime than girls. The relationship with the mother, worse for the boys than for the girls, as you might expect. Smoking is about the same, alcohol more in boys, drugs more in boys, sex education - the girls are more likely to talk to mum so they're sex education's better. Sexual activities - the boys had more girlfriends, the boys had more sex, and the boys - OK they used a bit more contraception but there was still a big gap.

So just finishing, I just want to point out the stairway to a baby that I put in my first book, Are you my sister mummy? You see how it's even, both sides. Both girl and boy, emotionally immature, social problems, feeling unloved, feeling a failure, being lonely, being drawn together in ignorance of sex education etc., no contraception and having a baby. And I think it's important to

remember this, two sides for that, and there's the same problems for the boy as the girl. I just put this picture here really to remind you that families need fathers, and especially young families need all the support they can get and young families need young fathers. And we need to give much more support to young fathers.

McNeil: Thank you very much Dr Birch and I think the emphasis on the need to encourage the fathers I think was excellent. And I'm very glad that she has become Jamaicanised when she talks of the babymother and the babyfather. That's very Jamaican.

Teenage Mothers and their Children.

Nona Dawson

Hello everyone. Just to pick up that point that Diana was making, about sons, it doesn't actually come in our research but certainly the literature will tell you that the sons of young mothers don't fare as well as the daughters. I'm going to briefly report to you the results of a study that we've been involved in at the University of Bristol, along with the Institute of Child Health. My colleague Sarah Meadows and I are at the Graduate School of Education and we've been working with the ALSPAC team. ALSPAC stands for the Avon Longitudinal Study of Parents and Children. As I say there, it's a longitudinal cohort study, designed to investigate the effect of the physical and social environment on the health and development of children, and it's based at the University of Bristol Institute of Child Health and the Director is Professor Jean Golding. This longitudinal study is still going on, it started in '91, '92, with 12,000 women who were pregnant, and now we've got 1400 babies and there's been very little drop out. So the kids are all now about seven or eight, that sort of age.

The study that we did though, was based on the women's pregnancy and up until the babies were two and a half, and we aimed to analyse the ALSPAC database as I say to the age of thirty months and to clarify the characteristics of teenage mothers and older mothers to reveal the factors which might lead to vulnerability and resilience in the development of the young mother and her child, and today I'm just going to talk about the data on the children, and it's the first look at the data, there's still more statistical work to do it, and logistic regression, there's still issues of parity and social background to take into account. And what I'm going to do is to report just very briefly on the characteristics at different stages. The actual real report will be coming out soon and I'm sure you'll be rushing to read it, it's part of the NHS Mother and Child Initiative, but it will be coming out soon so look out for it.

I should make a point about this type of data, it's highly quantitative data, it's based on questionnaire response, so inevitably the results - we're looking at trends, so it's quite depressing when you're looking at trends, we're not making any points about individual differences because I'm sure you'll know, some young mothers and children turn out jolly well, whereas

others have difficulties. When we look at the baby at four weeks, the variables which show significant differences between age groups at this age are a fairly small proportion of the total, but which include ones which could be deemed ominous. So for example, the teenage mothers were much less likely to breast feed their babies.

We divided the sample up into the under-seventeen year olds and the seventeen to nineteen year olds, and mothers in their twenties, thirties and forties, and there were some signs of parenting practices which were less responsive to the child in a minority of young mothers, but interestingly, when they were asked to rate their children's development, the younger mothers tended to be skewed much more towards positive evaluations than the older mothers. Mothers were asked at this stage about their reactions for example to the baby crying, and they were asked to choose one of these options, you know that they'd pick up the child immediately, they'd let it cry for a while but if it didn't stop they'd pick them up, or they'd never pick them up until they were ready to do so. And you'll see, again, if we use this as a sort of indicator of some types of parenting, essentially there were differences there.

When we look at the baby at six months, there were some signs of potential problems then for teenage mothers and their six month old babies. For example, while there were no general health differences with the babies, the children of young mothers were more in need of medical attention in the home. There was still less breast feeding and routine sleeping and feeding were less established with the younger mothers. Also, as we found actually from the data during the pregnancy, our teenage mothers smoked much more than the older mothers during pregnancy, after pregnancy and as did their partners. And when we look at the children, they were spending time in a smoky atmosphere the children of older mothers were not experiencing smoke to such a great degree as the children of younger mothers.

The children of the younger mothers would be much more likely to have had an accident than the children of older mothers. Again, looking at things about ownership of books - I mean the child is very little it's true - but again we see a difference - here - 'child having own books'. It's the children of older mothers who are going to be introduced to books more than the children of younger mothers. There is other data too which I'm not going to be able to

present now, there's all this questionnaire data but there are also children in focus clinics that the Institute of Child Health established. I think it's just 1200 children that they're actually watching, how parents work with their children and so on, and they're seeing all sorts of things that we already see in the literature. And again at this stage, it was the younger mothers' rating of their child development which tended to be higher, and their expectation of development was more optimistic, they thought their children would be able to do things more quickly than the older mothers.

Analysis of maternal age combined with parity will clarify whether some of these differences are due to practical experience of parenting. You'll have to wait for that result to happen.

If we look at the babies at fifteen months, you'll see there that there was considerable variation on each of the variables examined, but where there are significant differences between age groups they are typically in the direction of the younger mother, showing more problematic behaviour. The children were more exposed to smoke, and sometimes more overt difficulties, for example accidents and feeding difficulties. Differences in the mothers' rating of their children's social development were not related to maternal age at this point. And younger and older teenagers differ on their ratings of their toddlers' vocabulary and non-verbal communication. We're really looking forward to looking at these children from when they've started school too, to see what differences there are here.

If we look then at a toddler at eighteen months. At this age, there continue to be some indices of some more mild problems in parenting and development in the children of teenage mothers. These toddlers seem to have somewhat more difficult relationships with their mothers, to be less involved with their mother's partner, and to have fewer positive amenities such as books. While some of the teenage mothers report good ratings for their child on each variable, and some of the older mothers report problematic ratings on each variable, no single factor could justify a strong diagnosis of problems for the child and mother. The teenage mothers, however, show a fairly consistent trend towards being at the worse end of the variable, on a large number of the variables, which we believe have implications for the health and development of the child. The data suggest that it may be necessary to regard these

families as being at increased risk of problems in the health and development of the mother and the child. It's still possible that the worse socio-economic circumstances and more adverse life events typically suffered by the younger mothers could account for much of this, and we're going to look at that statistically. It's probably significant that the oldest mothers, those whose child was born when they were over forty, showed an increased rate of both socio-economic and child-rearing problems over the mothers in their twenties and thirties. Parity, which will generally be higher in the older groups, may also account for some of the trend towards problematic ratings in the younger mothers. Children with older siblings may benefit from both what is provided for their siblings - books or whatever - and from having a more experienced parent. Further analyses will help to clarify how such variables combine.

At thirty months there continue to be small differences between maternal age groups in the experiences and achievement of the children. Children of teenage mothers are somewhat more likely to have had problems with health, more contacts with doctors in the surgery and on home visits, differences in hospital admissions, and accidents are not statistically significant because of the smaller numbers but are still in the same direction. These children are less likely to have a sleeping routine and to cry, fuss and have tantrums more than the children of older mothers. Their mothers find it harder to calm them when they cry, and use less conciliatory methods of dealing with their tantrums. Teenage mothers are more likely to say that their child often cries or has a tantrum for no reason than older mothers do. The few children who are said to show signs of anxious or avoidant attachment behaviour after separation from their mothers are disproportionately from the teenage mother groups.

There may be more signs of minor strain in the relationship between teenage mothers and their children. Older mothers are more likely to engage their children in activities such as going to the local library, learning nursery rhymes, while the children of teenage mothers are more often taken on shopping expeditions. The television is on more in the households of teenage mothers, and children watch more of both children's and other TV and videos, but less children's videos. This suggests an environment which has fewer intentional modifications towards being child-centred rather than adult-centred. This raises issues for those working for young mothers and their children in enabling this situation to improve.

‘Pregnancy, Parenting and Playtime’.

Muriel O’Driscoll

The title of this presentation is intended to aid your reflection on your thoughts and attitudes towards young parents and to challenge professional help programmes, so I’m not giving you answers, I’m probably giving you more questions.

I am a midwife and family planning nurse who was a principal lecturer in midwifery at a university. I also work with young people in various outreach projects and am a stress manager and psycho-sexual therapist in my spare time.

My concern and the reason for choosing this subject is from personal observation of young parents and also from perusal of professional journals, government reports and intervention programmes that seem to have various levels of success. I am not providing answers but just beg you to consider the most effective interventions to give young families where you are the best possible start in life.

Can I start by saying that professionals don't always help, and I hope you’ll agree with me there. Research is generally undertaken by professional researchers who may also be social workers, teachers, midwives, doctors or nurses. Simply by virtue of their own background, educational attainment and their own success they have their own cultural baggage which influences both their interpretation and presentation of research findings. I am not against research in principal but its limitations *must* be acknowledged. Having lived most of my life in the infamous Toxteth in Liverpool I know the feeling of living in a goldfish bowl as views were sought from the poor unfortunate residents. At one time three separate researchers were investigating mental health problems in the black community and no feed back was ever given. This is an important point for researchers to ensure co-operation with further research there must be feed back given to those who have been studied or whose opinions have been sought.

Researchers and workers with young people must recognise where they are coming from and realise that the aims and objectives are owned by them and are not necessarily the study subject's.

Let me give you some examples of this to show where things can go very wrong. A school nurse was asked to draw up a programme on health education for girls in the lower sixth form. It included the usual topics of STIs, contraception, pregnancy, drugs, smoking.....you know all the usual subjects. When she asked for our help at Wirral Brook we thought that most 16/17 year olds were already accessing our services and persuaded her to let us do a questionnaire to find out what topics the students felt were needed in this programme. We started with a broad menu that included stress as well as many other women's heath topics. The most interesting area was the space left for 'other topics'. These included 25% of responders asking for a session on eating disorders and diet. 20% wanted to discuss suicide attempts, coping with death, depression and self harm. A further 15% asked for how to deal with parents' problems including divorce, alcoholism and depression and a few wanted sessions on looking after themselves, cooking, legal things about renting, living away from home. After this it seemed a bit naff to talk about condoms when the students had other more pressing problems.

Another outreach programme included a session on 'planning a romantic night out'. The organiser obviously had her own ideas but these were totally out of synch with 15 year old non-achievers who had no role models of romance, meals out or the imagination to realise the concept behind this session. Needless to say it went down like lead balloon. I only use these as examples of bringing our background baggage into working with young people.

Now I want us all to reflect on being a child so as to see if we can see how we learn to be parents. You can talk to your neighbour as long as you promise to stop when I ask you to.

Think back to being a teenager:
Who was your best friend?
What did you talk about?
Can you remember your favourite pop star/ group/ anyone admit to being a Bay City Rollers fan?
What was your 'must have' fashion?
What were the row topics at home?
How did you spend your leisure? Why do we get so annoyed when teenagers say they're 'just going out, hanging around'?
Can you remember your first kiss? Boy/girl friend? would he/she

have made a good life partner or parent of your children? Sometimes memory plays tricks and we only remember parts of our experiences.
Go further back. What was your favourite toy, games when playing out? (We used to have seasons where I lived, there was the skipping season, the two ball season, rounders, football, whip and top, yo-yo, hula hoop.)
Dolls houses? Action men? Was anyone else disappointed when they got a post office set for Christmas? I still think that Tippi Tumbles has a lot to answer for. First she needed batteries, not cuddlesome and fell over a lot!!

So how and when did *we* learn to be parents? We need to remember this fact: language development and self image are patterned from birth. And how do we learn to be parents? First of all we learn as children from parents and other role models and this may not always be the best way or not always a good example. We have all heard children and young adults repeating phrases heard at home and repeating patterns of speech and behaviour. Some children do not have parents to learn from or parents may be inadequate and role models are sought elsewhere, maybe from the television. We learn through play, nowadays often from computer games. I was fortunate to teach briefly on a child care course for school leavers and also on a Nursery Nurse Course. A lot of these students on Nursery Nurse courses needed to be taught how to play and it was obvious that some had never had that privilege before.

We also learn from our peers and from their experiences and whether this is selective sampling that our developing awareness screens for us is debatable, whether we only learn from the peers whose images and thoughts fit in with what we want to do anyway, I don’t know. Mel Parr (PIPPIN) writes that there has been a systematic abolition of the 'woman's network during the latter part of this century'. So we don’t have role models at home supporting young women when they become parents. We learn from our grandparents if the extended family is accessible as their memories of old fashioned values may drip into our consciousness.

Later we also learn from professionals, and this is where I take issue with professional teachers, midwives and health visitors at the wrongly named parentcraft classes when really these classes

only prepare for labour and childbirth and not for parenting. In research undertaken by midwives there is an identified need of new parents for a 'trusted confidante' and Underwood in 1998 states that there should be early professional intervention in parenthood to assist new parents. Government and voluntary projects exist in some areas to support these research findings. In recent research undertaken by midwives Kelly and Belsky (Royal College of Midwives) the main disagreements of new parents were over money, work, chores and the change to social life, none of which are discussed during preparation classes and are ignored by the professional carers in most areas.

What should young parents know? What would be useful to them as parents who want to do the best for their children? Well first of all we should ask them!

Secondly, let young parents play. In one of our outreach projects on the Wirral, we employ a community arts worker who allows adolescents to play with paint, making collages, making models. In one centre for excluded pupils the teachers and the Ofsted inspectors were amazed to see a group of excluded pupils, a group of young men asking each other to lend the scissors or the paste and helping each other to find the necessary pictures in magazines to complete a collage.They enjoyed a very happy hour as they became engrossed in play and produced a work of art at the end.

Thirdly, let young parents learn to play with their own children. Can you remember the rhymes, action songs and games? If we don't pass them on they will disappear and that ties in with what Nona was saying just now. And fourth by being an example in our interaction with children from birth onwards, because that is the role of all of us. Our attitude towards babies and children is being noted and if it impresses then it is copied. This means good and bad examples.

Parenting classes and formal or informal education are about supporting children and must include topics like child safety, child development, and the important and ignored subjects of developing coping skills and a sense of control over family life. This is vital for those whose income and lives are controlled by the benefits system. Research is presently being carried out by the Living with Children Project on how to optimise children's coping

social skills and how to boost their self image. Some of the suggestions highlighted today may assist these two areas.

I cannot leave this topic without referring to a book I recently read called 'The Myth of the Money Tree' by Collette Dowling, an American, who also wrote the Cinderella complex which some of you may be familiar with. There has been extensive research with adolescent girls in America and she believes that no-one can be truly self confident and in control of their own destiny unless they have learnt to control money and their own budget, however small their income is. Inability to do this is not confined to age, class or ability but learning how to be in control of this vital area will have major impact on other areas. Even for young families on benefit this area, I believe, is vital to build self esteem, but it is another area *never* addressed in parenting preparation.

So I leave you with this message. We must find out what we can do to help young parents enjoy their children by: asking them what they need to know, helping them to learn through play how to play, helping them to develop social skills, and helping them to manage money. Finding methods to provide this is up to you and it will be different for each area, each culture and your personality and attributes but remember that the best way of teaching anything is by example and enthusiasm. Thank you.

McNeil: Thank you very much Muriel, what a refreshing discourse that was.

Adolescent Pregnancy: the Nepean Experience

Kaaren Dudley

Thank you for asking me to speak today. I'm Kaaren Dudley and I'm going to talk about programmes we have set up at Nepean Hospital in Sydney, Australia, to actually show you how we became adolescent friendly in our division of women and children's health. This is a scene of the Blue Mountains which we consider very beautiful and it's just up the road from our hospital. The Nepean Hospital is the major hospital in the Wentworth area Health Service. It is a tertiary referral centre, with 420 beds, with 57 beds in Maternity, for antenatal and postnatal care. The hospital services a catchment area of 301, 000 people, with an annual birth-rate of 3000 at Nepean Hospital. The birth-rate is up to 4900 in the catchment area. The hospital includes a six-bed Level 3, and 22-bed Level 2 neo-natal intensive care unit. Nepean area is the site for the rowing, canoeing and kayaking events in the year 2000 Olympic games.

The New South Wales midwives started collection of information from all confinements in the state of New South Wales. The need for specific services is highlighted by the high percentage of adolescent confinements, when compared to other areas of Sydney. We have the highest percentage of adolescent confinements at 6% in the Sydney metropolitan area, well above the New South Wales state average of 5%. Contrary to popular opinion, confinements in young women generally occur without significant medical complications, when there is provision of appropriate antenatal care. The only pregnancy-associated complications which are statistically significant are pre-eclampsia PE, and threatened premature labour, TPL. It is quite significant, that when compared to the state average, young women have a high number of normal vaginal deliveries - 80% compared with the older age group of 60%.

The literature suggests that the profile of adolescent pregnancy includes lower socio-economic class, lower educational and job attainments, large families, history of adolescent pregnancy in the family, low self-esteem, and women who were themselves adopted. Of course, this is a generalisation, and adolescent pregnancy can and does occur in any social class, cultural group or geographical area. The main issues or problems associated

with pregnancy in young women includes homelessness, mobility issues, financial problems, isolation, mental health issues, such as depression and behavioural problems and family problems. There are other issues or problems associated with pregnancy and young women that will not be included in this short presentation. The Nepean Hospital has implemented a variety of innovative services offered to young pregnant women. The adolescent pregnancy and parenting programme is a multi-disciplinary team called co-ordinating the various services offered to young women. This multi-disciplinary programme utilises an adolescent friendly approach to support young women, their partners and families through pregnancy, birth and the immediate post-natal period. Team members include the adolescent support midwife, obstetricians, perinatologist included there, obstetric registrars, social workers, community nurses, clinical psychologists and psychiatrists, genetic services and the drug and alcohol team. I am employed as the adolescent support midwife and the major focus of my role is to co-ordinate services for young women in the division. I provide antenatal consultations, direct care and support in the interpartum Period and postpartum, consulting and crisis management as required. I refer the young women to other services as necessary. Finally I provide education, support and debriefing on working with adolescents to staff in the division of Women and Children's Health.

A midwifery antenatal out-reach clinic is serviced weekly at a youth health clinic called the Warehouse. Additionally a midwifery hospital-based clinic is provided in the antenatal clinic for young people to wish to attend there. Postnatal care and lactation advice is provided as needed to the young women. Childbirth and parenting groups are held in the evening. Pregnant young women may bring with them to the groups and clinic anyone that they would like, partners, friends male and female, parents, siblings and grandparents have all attended at different times and often all together.

A lot of the young fathers or expectant fathers often bring their male friends along and do the pregnant women. So often one young couple may bring four or five or six extra people along. All are made very welcome and some learning is had by them all including myself as I continue to learn. Topics included are many including health and life style, conception through to birth, labour, delivery and pain relief, parenting and interesting tours. Some of

the tours are undertaken by the group into the delivery suite, near-natal intensive care unit, mother craft unit and the emergency department. Contraception is discussed at length with much humour, especially the different colours, textures and flavours of condoms and how to use them.

The neo-natal intensive care Nepean adolescent parent support group NICNAPS was initiated by young parent and babies admitted to the neonatal intensive care unit. These young parents did not feel that the support group in place to parents of NIC unit admissions would meet their needs for peer support. I facilitated the development of the group with a focus on health promotion and child protection issues. The meeting of NICNAPS have been very informal and lively discussions are common place. The parents have requested guest speakers to provide additional information on parenting and infant care practices. These speakers provide demonstration and stimulate discussion and debate. The initial group visited the emergency department and children's ward to familiarise themselves with the services provided in these areas. This was a very popular activity.

The babies in our initial group were all breast-fed with some mothers expressing for many weeks before breast-feeding was possible. The young parents are very proud of their babies especially as they have all made their developmental mile-stones at the appropriate corrected gestational age. Parents have formed friendships and some mothers have commenced employment. The initial group now acts as peers support for other young parents who have babies in the NIC unit.

Major goals have been in developing an adolescent approach to young pregnant and parenting women in our division. The Buddy programme was designed and implemented with significant input from young women. The aim of the programme is to familiarise staff working in the division about the special needs of young women and their partners . The programme has a primary health care focus promoting a holistic view of the adolescent, the special needs covered in the programmes are social, medical, emotional and economic.

Twenty four midwifes and nurses from paediatrics, gynaecology, maternity and the near-natal intensive care unit have become Buddies. All these midwives and nurses have the education

programme focusing on the need of adolescents. These Buddies are advocates for young people and complement the services provided by the adolescent support midwives.

Some of the more interesting outcomes of the young women in our programme will now be presented. In 1997 to 98 there were a 120 deliveries to women aged 12 to 19 years. 8.5% required delivery by Caesarean section. The indications for Caesarean were antepartum haemorrhage of unknown cause, breach presentation, pre-eclampsia, foetal distress and placental prolapse in labour. One mother with a pelvic congenital abnormality required a Caesarean section. This compares favourably with our rate of 16% in the older age groups. In 1994 the state average for admission to the special care or near-natal intensive care units was 17.8%. At Nepean Hospital in 1997 there were only 12 or 9.3% of babies born to young mothers required admission to the neo-natal intensive care units. The majority of these babies required treatment for respiratory distress. One interesting admission was for an ovarian cyst which measures 10 cm which ultimately we actually aspirated and withdrew fluid and the baby was fine.

The rate of breast-feeding at the time of discharge for this age group was 56%. This is a particularly difficult group of women in which to encourage breast-feeding. There are many factors that affect the young woman's decision to breast-feed for example body image, peer group pressure and a history of sexual abuse. I often feel quite guilty about this as I am also a lactation consultant and I feel I could do much better encouraging young women to breast feed. Successful programmes do not adhere to traditional professional boundaries but adapt to meet the needs of those they serve. Successful programmes not only improve the health status of youth but improve social outcomes.

In conclusion the Nepean experience is an example of an innovative and adolescent friendly services which is continuously adapting to meet the need of pregnant and parenting young people. And a final view of our magnificent Blue mountains. Thank you.

The Prevention of Teenage Pregnancies.

Ellen Rome

I am honoured to be here and I am grateful to each of the prior presenters for outlining the issues so eloquently. The statistics have been so well laid out already this morning by Gail Slap and everybody else who's spoken. Sexual activity is a problem in teenagers in that there is too much of it without adequate contraception. We'll talk a little bit about why this is going on and we'll talk about the medical model or one-on-one in the office and also the public health model, how to prevent pregnancy on a more global front.

First of all I come from the United States where we are not doing that well. Our teen pregnancy rate is appalling when you look, at the UK, France, Netherlands, Canada, Sweden, we are just way worse on this front. It's not that our teens having sex more than other developed countries, it's that we are not adequately contracepting, we are not teaching them to choose abstinence and we are not teaching the use contraception effectively when they are choosing to have sex. We also have better access to services and supplies than other countries by just as Gail Slap's example with the person with HIV our teens are not necessarily choosing to use those services or access those supplies. We also unfortunately are very behind on the sex education end of things. Sex education in many other countries such as Switzerland and in other developed countries is mandatory. Ours is theoretically happening in every school but every school requires it.

Why our kids getting pregnant is more theoretical it's not so easy to put one finger on one thing and say, That's it. Three quarters of the births are unintended. But it's really a nebulous number because if you really press many of those teens they very intentionally did get pregnant but they don't necessarily want their mother to know that they were planning so or their partner, or whoever. And it is a sharp contrast in the United States at least between a society which promotes sexuality through our media and TV and MTV and everything else and yet resists access to contraception and family planning services. So it's kind of a schizophrenic message, sexuality is pervading society yet when we don't want to talk about it with our kids. And physicians and patients both overestimate the risk of contraception. The risks to a pregnant mum far outweigh the risks of taking oral contraception,

or Depoprovera or using a condom or whatever else. But we overestimate the problems that go hand in hand with using contraception.

What are the developmental factors that forces, pushes kids to get pregnant? First, there is a delay in obtaining contraception, kids in the United States at least will start sex and not access contraceptive services for up to one year and in one study it was 24 months. In that first year if they are starting sex below age 14-15 or by age 14-15 they are likely to have three or more partners and the longer they wait the more likely they are to use contraception. We have a lot of patients who feel that they are immune to pregnancy, can't happen to me. In that planning to use contraception and planning to use sex implies that you are thinking to have sex and in our schizophrenic environment, if I don't think about it then I am not guilty of doing it, it's kind of happened. It's basically an adolescent mind set, "If I don't think about it - it's not my fault". And also the lower the self image the harder it is to access contraceptive services and again a pill every day or getting your Depoprovera shot or buying the condoms or all of the above requires motivation on the girls and the boys' part.

We also have this disclosure, many people do not access health care because they are afraid that in the neighbourhood clinic Daisy is going to be behind the counter and their confidentiality is going to be breached. They also may not even understand the concept of confidentiality and that can be a very big obstacle. We also have a lot of people who don't seek access to care because they are afraid of the pelvic exam and we know those who hold teens hostage and will not give them birth control pills now without first pelvic exam, it's not absolutely that they have to have that first exam to get those pills started and then that gives you a little more time to educate and help them to get over the fear of the pelvic exam just as we hopefully get them over the fear of going to the dentist, something that kind of a necessary part of life and shouldn't be a big deal.

How do we change teen's behaviour? First of all we need knowledge, information skills, beliefs, but it's not enough, so we also need resources, supplies, alternatives, access to care, adolescent centres of providers. That's not enough, we also need to help them with motivation, meaning positive incentives for healthier choices. Peer approval for healthier choices and social

sanctions and then also helping them build the skills so that they can practice it and I remind my patients if they come and say, Oh yeah, I have another partner, that they did not learn to ride a bicycle overnight, they had training wheels to help them practice, they may not learn to build their own self-esteem overnight, it may take a little bit of time to figure out how to say “no” time after time or to figure out how to get a condom used between kid and a partner every single time, this goes for the boys as well as for the girls.

How to identify adolescents at risk? We look for the hidden symptoms, in the hidden agenda, that is, Oh by the way, at the end of your visit with them. School problems, anyone who’s had a lag in grades, or if you have somebody who is 17 and in a lower grade, where did they miss those years, what’s going on. School failure and what we call push-aways or throw-aways, it’s no longer dropping out of school, society pushing them out somehow. If you have an older sibling who’s had a kid you are much more likely to do so and the more partners the more risks and if they are using drugs and alcohol the likelihood of condom use decreases significantly as well.

Why do they say they are not using condoms? Common lines that we hear is, I am a virgin so I didn’t need one; My partner is a virgin; I don’t use drugs, assuming that HIV is the only thing they have to worry about and that if they are not using drugs they are not at risk; I am on the pill, and we are telling them they need belt and suspenders, they need two methods to keep those pants up which we like to have them doing literally of course but the pill or Depoprovera or a barrier method spemicidal jelly, spermicidal foam, local barrier method plus a condom, so that they are preventing disease and pregnancy, we are making sure that kids are not relying on condoms alone whenever possible. I’ve been tested for other diseases and I am clean, or You don’t trust me.

So how do we prevent teen pregnancies? The classic medical model is on-in-one in the office setting, but the public health model is in the community, including schools, health centres, through religious organisations, through family environment, use of the media proactively and other causes. And now in the 90s it’s worthwhile combining both: getting access to patients in your office and also being an activist in the community and helping all the grass-root community initiatives get on their feet and running. An

example is ‘Ask Doctor Whoopee’, tonight’s topic is Teens in Turmoil, in this age of promiscuity what you kids really know about the risks, we are getting answers from some actual teens, look Andrea here, Andrea! And she says, *Well like I know AIDS is a totally bad thing to get and so my parents are like paranoid and it’s like my life, you know, also like, I don’t know, but I heard sex is totally excellent, my friend Jennifer* …, and he cuts her up and saying, Remember, these are actual teenagers.

Communicating with the adolescents you have to get past that sense of invulnerability, it can’t happen to me, and the concrete thinking that teens have. If you talked to them about AIDS and being sick or dead about ten years from now, that’s irrelevant, that’s like talking about lung cancer and the risk of smoking. They are much more likely to relate to the here and now. And you want to get them thinking as far as opening the lines of communications. And if they are thinking about sex or considering sex what are their views on contraception and abstinence, how you even ask the questions becomes crucial. For instance, in the United States if you ask a teen, Are you sexually active? Dealt with concrete facts they say, Oh no I just lay there, my partner is active. True statements, that my residents have gotten these responses, you have to ask, Have you ever had sex? And are you intending to have sex? Make sure you are asking them in a way that they can answer. As far as the concrete thought process, we also have teen who also will take your word literally, I had a partner who had made sure that her patient appropriately named Surry was condoms every time she had sex with her boyfriend. Sure enough Surry became pregnant. Doctor Collin said, But Surry I thought you were going to use condom every time you had sex with your boyfriend, she said, But I did, Doctor Collin, I did, and my partner said, What happened? And she said, I wasn’t with my boyfriend. Concrete thinking.

We have something called the Heads exam, popularised by Richard Mackenzie who is another one of our speakers this week and we ask these questions confidentially, that means without a parent in the room having defined confidentiality for patient in care and parent if they are both coming to your visit together. Who lives at home? What happens when there is an argument at home? Oh, it’s fine except when my mum drinks. Oh, and what happens when mum drinks? Well, she beats up my brother and I. Taking the questions to the level where you need to know what’s going on in

the home. Education, what grade are they in, what's their level of functioning, do they have a learning disability. Again markers for low self esteem can be a pathway to sex. Activities and attitudes, do they have any friends, do they carry on in a gang, which has been a risk, and in some of the female gangs in the United States you have to have sex with at least three people in the male gang to get in, in one gang in Cleveland a couple of years back you had to have sex with somebody with HIV, known HIV without a condom. They are taking willing risks to be part of a certain peer group sometimes.

Do they carry a weapon? If they do, are they carrying it now and can they not bring it into your office for their next visit. Do they use drugs, cigarettes, alcohol? How much, how often? And an easier way to get to this is to ask, do your friends use? And if they say, yes, do you use, no, oh, and what do you do when your friends are gonna use, you are getting a chance to use a little role-play without telling them, OK we are going to do a little role-play now, you're giving them a chance to practice refusal skills. And then sex. Do they have a history of physical or sexual abuse, if they are using condoms, are they using them sometime, most of the time or all the time, and have they ever traded sex for food, clothes, drugs, shelter, we call that survival sex in the United States in adolescent medicine circles, it's not really prostitution in their minds, it's staying relatively safer than they think they are, than where they think they are.

Yeah, I just think making these decisions is hard, there is not one to discuss them with, How about your folks? No way, they live in a dream world, Are you sure? Have you and your parents ever sat down to discuss sexual responsibility? Well, yeah, once when I was about 14, And? They just weren't ready. Maybe you are rushing them, some parents need more time.

So helping the parents to communicate with the child is very very important. And that should start at birth and that should be continued on and new as roles as a care provider doing anything in the home of adolescents can help parents find the words. Help them to organise their own thoughts first and then to share those with kids. And this reflects the heart problem we have with these messages says, *Let me get this straight, mum, sex is healthy, natural and lots of fun, but at the same time it's frightening,*

dangerous, upsetting and potentially life-threatening. We are giving them tough messages right here.

So what's a physicians' role, you could substitute nurse practitioner, clinician, school nurse, psychologist, etc. As an educator we are perceived by teens as being a very authoritative source on HIV yet only 13% of them counsel on AIDS at a last visit in United State data. Encourage abstinence, but tamper with practical tips, for instance, I'd prefer all my patients to choose not to have sex but if you are going to choose sex I'd love you to use a condom as a second method. When prescribing contraception to your patient, if you have somebody who does not use tampons the odds of them to be using an insertible method are going to be very low. If you have somebody who is afraid of needles Depoprovera is probably not going to be a good option.

Now how do you expand the medical model to the pelvic health realm? Ryan Howard did a study looking at 8th and 9th graders using peer leaders just as A PAUSE does and found that at the end of the 8th grade those who's had the programmes were 4 times less likely to be sexually active than those who had not had the programme. The programme worked, it decreased the risk of those having sex and at the end of 9th grade a year and half after the programme they were still a third less likely to be sexually active if they'd been on the programme, and if they were given both contraceptive and abstinence counselling they were more likely to use protection when they initiated sex. In the same way Kingston found that if teens were more likely to use a condom if they thought that it decreased the risk of HIV, if they thought that is does not reduce their pleasure, if they thought that they themselves were at risk for HIV, and if they were not embarrassed accessing them or using them. If they discussed it with the doctor they were twice as likely to use condoms, and 50% less likely if they were simultaneously using alcohol and marihuana.

Clementi in San Francisco looked at junior high school students and found a two fold increased use of condoms if they thought they would prevent HIV and lower social class and more partners less likely to use. Those at most risk with more partners were using condoms the worst or the least. So have them accessible. Again found that talking about sex goes not make kids do it. This is a message that at least in the United States parents need to hear over and over. They're afraid that if they are talking about it they're

condoning it. Family planning counselling does not promote sex, it actually will delay sexual initiation and get them using condoms more effectively when they start.

So what do you do in school? First generation programmes - the goal was to increase the knowledge, that was just done, just know, k-n-o-w. And we found no behaviour change. So the next generation we decided to increase the knowledge, plus role clarification, decision-making skills, communication skills. That still didn't work. So next they tried a regression, they decided to go to just say "no" in a Reganesque view of things and not only there was no delay in onset and frequency of sexual activity but there actually was kind of con-committant flurry of more activity than anything. So then the fourth generation the goal was really to delay sex as a healthy delay, postponing sexual activity is now a good goal, as a short-term goal and if you can't delay sex have them using a condom.

The fourth generation is based on two theories: the health belief model where a teen acquires a belief about personal vulnerability either through their own action or through vicariously watching their friends experience and incorporate this belief as something they need to worry about or change their behaviour. We also use a social learning theory, that you learn from yourself and other's experiences and this requires knowledge, motivation and skills. Michael Carrera at Hunter College guarantees his students that he picks up between 6th and 8th grade and follows them through high school, teaches them how to do a bank account, teaches them skills like squash and tennis and golf where they, as he says, don't succeed by throwing around their weight but succeed by skill and guarantees them a four-year college tuition if they finish the programme. And he said the best birth control we can provide is to make a young person feel they are something special. The programme was called The Pregnancy Prevention Programme, but it it's a substance abuse prevention programme, it's a drop-out prevention programme.

And how do you prevent teen pregnancy? Educate early and often. Build self-esteem from birth onward and over and over again. Help instil a sense of hope. And re-enforce the messages diffusely and everywhere that means at home, in the religious organisations, at school, through the media, in the doctor's office, anywhere. And help them improve access to medical services it's

clearly that there's a barrier to teens health care. When you are talking to a teen ask them about their feelings on pregnancy and address each teens individual needs and myths, so you're counselling them in contact. For instance the kid that feels that he's never gonna live beyond 19 may very well like to father a child, so helping them take care of themselves so that they can live beyond age 19, help them to make healthier choices. Again that gets back to the fathers as well as the mothers. And then never underestimate the strength of a individual relationship between an adult and a kid. You are one of those factors that can help them instil hope and continuity of care really helps. Just to keep it in perspective here, if there are 600 million women reproductive age and 39 trillion numbers of acts of intercourse at any minute in time given 12,000 ejaculations per second and 60 million sperm per ejaculate we are combating a total world-wide sperm release of 720 trillion sperm per second. This is global and magnificent problem. I am going to end there and leave it to he next speaker, thank you very much.

Adolescent Pregnancy, Sexuality and the Welfare Debate

Peter Selman

Thank you very much. I'm going to move on to rather different level of discussion in that I want to talk about the politics of teenage pregnancy following on what Ellen was saying I am going to be talking about how not to be effective at preventing teenage pregnancy which I think what her government and my government have tended to do over the last ten to fifteen years. So although we heard words about the high rates of teenage pregnancy in America I think it's worth starting by remembering that this is not so very different in Britain. Yes the level in America is the highest of the developed world but the bold figures in there for England and Wales since 1971 show that we share with America phenomenon having had rising teenage birth rate in the 1980s, in the Thatcher - Reagan years as we like to think of them, and that we are now about 4 times higher than the level for example in the Netherlands.

It's less often that we compare these figures in relation to other parts of Europe and what I've done here it just remind us that in England today and America we are more like Eastern Europe than the countries of Southern as well as Northern Europe shown before. And this is pleasing to find that the whole solution to this was summarised very nicely by a former Prime- Minister while visiting United States yesterday. So some of you have seen this. Mrs. Thatcher sums up all this long British-American approach to this problem, the obsession with sex: the belief in chastity is the answer and the way of getting people off welfare. This is not just Mrs. Thatcher, this is a theme that ran through British politics for the last 7 or 8 years, here are some example I've taken from the Tory party conference of 1992: these are yesterday's people repeatedly have these lively idea of young ladies seeking council houses, the minister of housing explaining that we really have to stop helping people who didn't get married first to have housing and that was the source of most of our problems. And that is the theme I want to come back to, the way in which Britain and America uniquely in my experience have blamed the welfare system as the main reason for their high rate of teenage births.

We in Britain have also been obsessed with the idea that its a symptom of all that's wrong with society, so I will show you how we have handled the teenage birth issue in the last few years.

An article in the Daily Express seeing the end of the family due basically to teenage birth. The extraordinary thing about this story was that although it did indeed pick up some issues about changes in marriage and divorce if you have a closer look *Scandal of teenage mothers*, this was based on story taken place seven years earlier of a school master who remembered as he thought that all his 15-year olds when they left school immediately got pregnant in order to get a council house and that' s the way we subscribed completely virtuously to part of a theme. Inside the same issue the point was made that they had cynically by these teenagers that to get a better life rely on the dole and the portrayal of teenage parents was typical of what was happening at that time.

Worst of all was the picking up of people who were very very exceptional as being the norm. So here is Sue Simco who has got five children by three fathers who is pregnant again with the fifth and she's going to go on ripping off the welfare state like mad and she started as a teenage mother. That quite extraordinary panorama actually maintained that the whole theme of welfare dependency was dominated by teenage mothers who went on to have 6 or 7 children, these are very very rare indeed. The extraordinary thing however is coming back to why we've been so obsessed in the last few years about this particular problem. This incidentally is theme that's also true as I recall it of much of the American figures.

The greatest concern about teenage births has arisen when actually the level of such births is much lower than it was in the past. OK, so 1966 - 86 thousand, 1995 - 42 thousand. So half a level, twice the fuss. Partly that's a distortion of numbers of teenagers, there are now relatively few teenagers in comparison with the number there were ten years ago, because of the rise and fall in birth rate. But actually when you look at it the real issue of course being that the growth of births outside marriage and in particular the proportion of births outside marriage which of course is as much a picture of the reduction of births inside marriage most of which were forced births resulting form pregnancy that was unwanted. So in the past we accepted this because pregnancy was solved, quotes, by early marriage followed by divorce or it was

solved by adoption or it was solved in ways that didn't cost the state. Therefore we've come on to the theme I want to end on which is looking at this question of why we have become so obsessive over the cost of teenagers that we actually, it should be welfare as the cause, that is unique in my experience to the thinking of Britain and America.

So let's have a look at that particular theme. The argument goes like this: we in America and Britain have introduced benefits that enable people not to starve and die if they are teenage unmarried mothers therefore lots of young people are saying, wait, if we become a teenage mother we needn't starve, that's living a life of Riley and there is a mechanism of thinking there which I find so inherently implausible that I find it almost a waste of time to have to argue against it, but argue against it we have to do because everybody will find one person who will come forward and say, That's why I did it, in which case the question we should be asking is, and what on earth is the social situation that can cause people to have that mode of completely absurd thinking.

Let's have a look at what's happening at the moment. The issue in America has gone on for many years, talk about the epidemic of teenage pregnancy, the concern over the perverse incentives cause by issues like the introduction of FDC and yet when we look at this rationally America of course stands out of all countries as being the least generous in term of welfare support and therefore the last place where one be in any sense taking this as an incentive to have children. But even with the move from the Thatcher-Reagan years which I'd hoped we'd see a change in attitudes things are not that different. So I am going just end by looking at a few features of new America and New Labour.

This is President Clinton by-passing Congress to impose reform which would slash welfare payments to teenage mothers. So whole series of changes have been brought in by individual States as a result of presidential wave in the United States which are putting burdens on to encourage teenage mothers or force them really to live at home, to continue school and to defy them of basic role of benefits, the argument is that is will not only save the state money but it will also revive a new approach that will be rational that people not have perverse incentives and therefore teenage births will go down. What a marvellous solution. But this is not one put forward only to America. Here is New Labour deciding also

that they are going to get tough on single mothers. And the Home Secretary putting out again the belief that the benefit system created an environment in which what he calls natural checks the checks of stigma, of blame, of shame I suppose are now gone. The image there is of two things: first of all it seems that this is encouraging people to have children but also the words "and keeping them", and so the theme that hovers around comes back to the one of would we not be going back to the 1960s when one in 5 of all births outside marriage ended up in adoption. Now I work in adoption much of my life and I am a believer in adoption but I've also worked with mothers of that generation who gave up their children and believe me it's one of the most tragic things to hear somebody who pressured into that. Which brings us back to Mrs. Thatcher. We used to have things called mother and baby homes and mothers would go there and they would earn their keep and they would then be persuaded to give their child up. So there may be a further agenda. We made a mistake back in the 60s because we started giving them money so they didn't sort of die, we gave them housing so that the children could be kept warm, you know, what a bloody mistake. If only we'd thought, so there it is. Now the sadness and I will end up in the next few minutes, about it is that of course to some of us even if we accept all this concern we say, well there is an answer and it lies in what we've been talking about most of today, better sex education, better access to contraception, right to abortions but I am afraid like America we share it seems at least at the press and government level a complete inability to get our act together on this.

This story was reported in the Sun a few years ago - the story that shook Britain is interesting but of course what is most interesting is that the real issue is sex at 11 rather than at 12. Incidentally at the moment at 12 one is not going to get welfare as a matter of interest but I mean different stories at different times. So when we try to move forward on sex education what do we find? A few years back and I thought possibly that was something that was changing, the Health Education authority came out with a fairly explicit but rather readable book for youngsters on contraception and sex education, absolute outrage. And the government adviser said that it was unacceptable. You see who the government advisers are: Ester Ransen and Chris Acabusi. Absolute shock at this. And it did a world of good, actually, because the government minister banned it, Penguin promptly published it and they sold many more copies, you know, we learn this back in the 19th

century the Riddle of Bizantiles but that was the absolute classic, well I thought that was fading out and then I picked up the Scottish Sunday Post this Sunday, we've been here before I remember the nurse who was sort of castigate for going in to a school and talking about oral sex and lots of dreadful things like this. This was not even, you know, tea talk as they say, this was emergency contraception which it seems to me to be one thing that was really very important, the variability of this further opportunity to make a decision. But no, absolute outrage that this should possibly be suggested.

This brings me on to my two final points and then I will stop. And that's OK, I am being very negative, I am saying that we are very bad at sex education, we've got it wrong about the welfare, so you know, what about this, what are you going to do instead? Well, I want to end my two points and one is to go back to actually look at the situation in this country in regional terms. This nice, if everybody has got time go and see there is a nice poster display from Sheffield on the teenage pregnancy programme, is anybody representing that here? Anyway, it was jolly good, go and have a look at it. But what struck me when I looked at it was that actually the figures that were concerning Sheffield were far lower than some of the extremes here. So first of all there is variation across regions.

So what happens when you get down to really small areas. Two points quickly, one is when you get down to areas Sunderland and Manchester we are talking about the level of births that are twice the national average. And the range across the country is much wider than the range we are seeing within Europe that causes concern. So there are big problems in Britain in particular areas, most of those areas are areas of considerable deprivation. And the arguments that most of us will put forward is that you cannot explain that in terms of welfare access nor can you actually explain that in term of quality of provision of birth control services. What is also interesting is almost an iron law here, that those areas with the highest conception rates also have the lowest abortion rates. So where there are most pregnancies more are going on to keep the child, and takes me back to my final point which is about thinking about the motivation and what is it that people are looking for.

I come from the North East and believe me the abortion access up there is pretty good. There is NHS access and that is not the key thing, it's not that they are being denied abortion. But of course abortion before I go on to the final point is not one something that we can dismiss, because we in America and Britain do have much lower use of abortion in relation to teenage pregnancy than the countries of Northern Europe. I was pretty struck by this that in Denmark in 1991 there were 2 births to women under 15. I was talking here, I don't know whether he is here, to a colleague from Switzerland at lunch and he said that they just discovered a young teenage birth in the hospital, so there are some countries for whom this is seen so unusual that it's permeating the whole culture. So that's very striking. But coming back to theme that I want to end on, I am simply saying that I think governments have got it wrong again and again, that the media that we were talking about at lunch time has distorted and represented a very antagonistic approach to many of the rational solutions, but in the last resort we have to come back and ask about what it is that leads so many people, so many young people in Britain and America especially in poor areas to feel that there is something to gain for them in going on. And I feel that it is rooted often in the sort of situation we left them in, in another words that the high rate of teenage pregnancy in Britain and America reflect two things: one is our totally confused position of sexuality and secondly the fact that we have especially in the Thatcher - Reagan years develop more social inequalities than any other developed country.

I'd like to end up with a quote from my favourite book on teenage pregnancy which many of you may know and that's Christine Lucas book "Dubious Conceptions", where she says one thing which I think can be applied equally to my country as to America that we shouldn't be going on about epidemics of teenage pregnancy, but start thinking of the social context within which these arise. This does not mean we don't need also to go on to provide the best contraception services we can and so on. And then reminder that we are not in that category in England of most European countries, we share with America a very real problem in terms of some aspects of out society and I believe that that's the key reason behind our continuing high birth rates.

Christine Ferron: I want to thank all of our speakers for their really brilliant presentations..

Plenary Session P4

Disability, Education and Employment

Chaired by Anne McCarthy - Dublin Eire
and Richard Brown - San Francisco

Richard Brown: Welcome to the Plenary session Disability, Education and Employment. We have a variety of people this afternoon, six in all, and we want somewhere along the line to be able to have some question time.

Anne McCarthy: Well, ladies and gentlemen, our first speaker is Ueli Buhlman and he is going to speak about adolescents with cystic fibrosis, transition issues. He is the chair of the department of paediatrics Triemli Medical centre in Zurich, Switzerland.

Adolescents With Cystic Fibrosis, Transition Issues

Ueli Buhlman.

The last speaker this morning said how tough it was to be the last one before lunch, I think, it is tougher even to be now after lunch, of course, it's harder to speak on something that 2 speakers in the morning session have already dealt with. So my task this afternoon will be to talk about the same issue chronic disease and I picked the subject of cystic fibrosis because it is cystic fibrosis that brought me into adolescent medicine. The additional points to my talk are transition issues or the question how to bridge the gap between childhood and life as an adult.

I didn't know actually what people in this room knew about cystic fibrosis I thought I would briefly read you about the disease, it's a genetic disease, it's the most frequent one among the patients, it's a disease that occurs in 1 in 2000 new-borns in Switzerland, it's a disease that affects severely the lungs, pancreas and the sweat glands and it is the lung disease that in most cases responsible for the limited life expectancy. I think when we talking this morning Dr Suris was introducing the topic by saying how things have changed and I think it is very much true when we look in that particular disease of cystic fibrosis. The first description has been made in a dissertation, in a doctor's thesis in Switzerland in 1935,

it was then further published in the United States about the disease adding the sweat glands, infection as well, and the important thing was, was it curable when it was first defined with a very high mortality in early childhood. It was shown again this morning in the 70s life expectancy was around early teenage youth somewhere between 12 and 16 years, and then in ‘89 there was an important discovery it was gene defect that was discovered, the CF gene was first described, the first mutation, right now we are in a situation where over 800 different mutations on that particular gene are described, so there was a lot going on in these last 10 years. And as it has been shown earlier today life expectancy is now somewhere about 30 years of age.

What does that mean? It means that life expectancy is better, the age of our patients has changed quite a bit. You see that age range in just about 60 patients that we see on a regular basis in my centre there is about half under the age of 15 and the other half, 50% are older than that and a few patients are into their early 40s. So, we have a disease where from training we knew and from the history we know that that occurred in the early childhood and now I just come back the most recent North American conference about cystic fibrosis that took place last week, now we talk about going into 30s, 40s, 50s, nobody knows. And the question is what does that really mean to grow up to adulthood with a chronic disease. Because we cannot expect neither from the patient or a physician that in such a short period of time with so much research going on that this is going to be an easy step to take.

It has implications during early childhood. I had talked to many of my adult patients about what they heard from their parents, when they were informed about the disease, we have to change our approach to the parents of a child with a chronic disease being very careful in predictions of life expectancy. Parents in fact have to be prepared in early childhood that this is not a disease that will just be a problem to them during childhood but that the child will move on into adolescence and to an adult life like everybody else. I think it’s important to teach the children very early, in fact as early as they can understand as much as you can about therapy. Taking the example of cystic fibrosis and medication they have to take perhaps 5 times per day sometimes even more frequent, I try to teach the kids as early as possible to do that on their own, to take their own responsibility, because the earlier the children are involved in therapy and also in decisions they have to be taking,

the less they will use medical issues during adolescence to rebel against the grown ups, being the doctors and the parents.

It is important that the kids grow up in a peer group where there are other children with chronic disease but also, like Bob Blum has shown it in one of his studies, also within a group of healthy peers. That means it depends a lot when we talk about school and how well the child has functioned on a social level in his first 10 years because it's the basis for adolescent functioning and then moving to adult functioning. Which means that we should not always talk just about what we should do during adolescence to make lives easier for our patients but that we should think of cases during childhood and then look forwards carefully into the age of adolescence.

What roles do we have? Adolescents want to become independent, they have to become responsible adults. There has to be satisfactory integration of the body image, there has to be a way that healthy adolescents find their way into sexuality and as I just mentioned before how important it was to help them find their peer group. It is important and I work with many adolescents and now adults who did not plan their careers because all they knew during childhood was that probably in their teenage years they were either going die or would be so heavily disabled that they would not be even thinking of finding a profession or doing a job. So this is a very important point that specific goals are set and goals that can then further be implemented and of course on the level of cognitive development it is important to have them go all the way through these developmental steps.

There are of course limiting factors, it has been mentioned this morning and I mention it again that disability and mobility will play an important role, the more mobility the patient has during adolescence the easier it will be for him or her to really adjust into adult life. It is a question of the energy level of course with lung disease this level is sometimes low so we have to find ways to help the patient like with oxygen or whatsoever to find the energy needed to make the steps. There are questions of physical appearance and of course as it's been discussed widely and I think Gerben, next speaker is probably going to talk more about it, psychological issues like self-esteem on the affective stage and of course social integration all these factors can be very limiting, and it is important when we see a patient on a regular basis in the

centre that we carefully evaluate where the patient stands in terms of his well-being even with a chronic disease. Well-being is so important it has to be checked every time we see a patient.

The better the patient feels in terms of independence the more he'll adhere and it's been shown in several medical studies the more adherence or compliance to the medical treatment will be better, there will be less depression, less other mental disorder issues, there will probably be less rebelling behaviour and will have a patient who will also comply with a health care system that's set up for him and it's important. I'd like to just say a few words about the peer acceptance. I think that it is probably one of the areas where at least in Switzerland we still have a lot to learn. We do not involve the peer group of our patients enough here at the hospital or even making sure that in their schools that there is a strong peer group there for young patients with a chronic disease. There is a risk if that peer acceptance is not good enough there will be an overprotection tendency of the parents and there is a risk of social immaturity with further problems in the peer area - a force that can either lead to depression or to failure to actually move on to adolescence.

When you attend a cystic fibrosis conference in Europe and in America and you listen to the doctors there talking about extended life expectancy what happens is that we go away with the idea how well we are doing our job with new treatments new medication. But there is a lot more to it, there is a lot more to the emotional health of a patient with a chronic disease and when we look at the development of cystic fibrosis and the lives of our patients as nowadays it's not just to be explained by the advantage of antibiotics or new treatments in inhalations but it has a lot to do with how well we manage our patients through childhood and adolescence into their adult life.

Anne McCarthy. Our next speaker is Gerben Sinnema who is going to speak about chronic ill health in adolescents. Gerben is a clinical psychologist with the Wilhemina Kinderziekenhuis in Utrecht, Netherlands.

Chronic Ill Health In Adolescents.

Gerben Sinnema

Thank you lady chairman, dear colleagues, As you all know adolescents are a special branch of people, a special species, they are young attractive and healthy. Well, at least most of them are and as you heard from colleague Ueli Bulhman from Switzerland many of these young people are not so healthy at all. About 10 to 20% of all young people in population suffer from some sort of chronic conditions seriously affecting their daily life activities. And about 3 to 6% have serious conditions with serious consequences for daily life.

As is true for cystic fibrosis and it is true for many childhood conditions that treatment improved over the last decade and life expectancy went up. Nowadays it is estimated and I quote from an American study of Bob Blum, that about 90% of all children with chronic conditions survive into young adulthood. So we should be very aware and the previous speaker already said that, that it's not only the quantity of life counted in years but also it's very important to look at the quality of life. We are talking about chronic illness and since the 70s the studies of Stein and Jessop there is a general trend in the literature that consequences of the chronic disease can be generalised to many diseases. And of course this is true, the social consequences, the risk for social isolation, the risk for problems with mood and acceptance and things like that but we should keep in mind that for the young person him or herself the social and psychological consequences of the disease are linked to that particular disease.

So a young man or a woman with a diabetes considers the consequences of daily life as a consequence of the diabetes mellitus. Chronic illness comprises a lot of different diseases from the medical point of view with difference in ideology, clinical expression and prognosis but there are difference from the psychological side. As I said for a young person himself it's that particular disease that is causing trouble, from the psychological point of view there are differences between these diseases as to the point of whether a genetic disease opposed to an acquired disease. We think that adaptation and coping with a genetic disease goes a little bit more smoothly, it's there, the disease is present from birth and it's going more quietly and smoothly as opposed to the acquired disease, for instance juvenile arthritis

when a kid is 12 or 13 and is confronted with a serious and crippling disease and there has to be a period of sorrow because of the lost health and lost normal life expectancy.

We are talking about illness and treatment on the one hand and growth and development on the other hand and of course as Ueli Bulhman said before the more serious the disease manifests itself the higher the severity of illness the more chance you have for some problems, but the opposite is also true. We see a lot of young people with only mild forms of the disease for instance the juvenile arthritis with only a few joints involved where there are a lot of psychological and social problems. Probably because they compare themselves and they try to compete with normal healthy adolescents. I am glad that Ueli Bulhman spoke already about self-esteem so I can be a little bit shorter on that. Positive body image of course is difficult to acquire when the body feels or is hindering you with impediments. As to autonomy we as health care workers have to teach young people that it is not shameful to need a little bit of help of your fellow people. So the development of independence in the emotional sense is quite another thing than have to be dependent in the physical sense. But that's a long story before young people and adults grow up to that point.

As to education most of young people with chronic illnesses go a regular school, in our country it's up to 85%, but sometimes they are somewhat delayed in educational process and as doctors or psychologists we have to be aware that some diseases as well as some treatments, schedules go along with cognitive problems. As is true for some types of cancer treatment. And to social adjustment, integration would be a better word, the more seriously the child or the adolescent is affected the more chance that the range of social activities is restricted. Well, it's true that a lot of conferences about chronic illness in adolescence last years stressed the point of resilience and coping abilities. We should keep in mind about 85% of all adolescents with a chronic condition adjust very well. A few groups might be at risk, in the first place youngsters with invisible handicap are often inclined to keep the condition secret, this has some advantages, for instance you can avoid reaction of pity or misunderstanding, but very often the price is too high because the youngsters are permanently afraid of disclosure of other people noticing their condition. Youngsters with the unstable condition as the arthritis, youngsters with juvenile arthritis, as well as with a progressively worsening disease it's very

difficult often for peers and adults to react and respond adequately. And the last point that true for cerebral palsy for instance when the brain is involved or central nervous system, you have a double handicap.

All chronically ill youngsters and this is a familiar issue should be family oriented. We have to focus on the stress of the disease as it is affecting the work or the relationship with the parents and now and then and we do that in clinical practice we should have a little talk with the siblings as well. And the literature tell you that most brothers and sisters of adolescents with chronic conditions don't have so many behavioural problems or problems with social adaptation. That maybe true but still they may suffer not so much from lack of attention of the parents but they may feel for instance a little bit guilty that they don't have the disease, for instance they may feel a little bit anxious about the genetic side of the disease and may feel anxious about their own offspring and so on and sometimes they develop psychosomatic complaints. On the other hand when you speak with these siblings you will be struck by the huge amount of solidarity and social support they give to their affected sib. Well, family even in adolescents remains very important for the social and emotional support of the adolescent, open communication within a family is very important, but the communication between the treatment and the family is very important too. And you have to enhance the coping skills of the family. This is very important because one of the major coping skills is of course the power that allow them to stay in control because the disease goes on for many years, lifetime, there should be a balance demands of treatments dictated by the disease and the demands of the normal daily life activities. And you have to negotiate between these demands.

As to social integration, as the afternoon goes on we go more to the practical side and what can we do to help and support these youngsters and tomorrow in our workshop on chronic illness we'll focus more specifically on these points, there are a lot of services to support young people for this social integration, focus independently on special services, focus at education, training and employment. So what's clear is that it is a joint effort between the adolescents, family, health care workers and society. And as health care workers what we should do is educate young people about practical consequences of the disease, we do that as a rule, educate them on the emotional and social consequences, it's a

little bit less the rule, but we still should do that and nowadays we focus a lot on skills training. It's not a point to assess to social difficulties for young people with chronic condition, what you should do is reverse, you should teach them skills.

Well. This is problem when I speak for my own country I can say that the unemployment rate is very low and the productivity is very high. That's good to say and that's marvellous form the economic point of view but the other side of picture that a lot of young people with physical handicap are not able to get into the labour market, so they are put on a disability allowance. What appears to happen and it's a sad story that we buy our disabled. What we should do from the society point of view is create facilities for social and economic participation otherwise it's useless to train people and support people to be young adults with a lot of facilities and abilities and then they will be stuck in their development process. We should do that so not only healthy people but also young people with physical disability can face the world proud and self-assured.

Richard Brown: Thank you for that very cheerful summary of a very complex problem.

Question regarding talking to siblings.

A: Well, it's an ideal, we tried to do that, but in a hospital setting it's often difficult because there is no registration number for a healthy seat you have to say what you are doing because of productivity in a hospital these days, but we ask parents how are the sibs doing and if we sense a problem on a clinical radar we say bring them along sometime and you don't need to talk for hours here you need quarter of an hour just to scan the daily life of a brother or sister and give them a little of explanation it's very worthwhile to do.

Chairman. Thank you again. I am pleased to introduce our next speaker, Doctor Helena Fonseca who is a paediatrician from Lisbon, Portugal, she is a head of the adolescent out-patient clinic in hospital De Santa Maria since 1994, she has trained with Bob Blum at the University of Minnesota in adolescent medicine and she's got an MPH. Her topic is chronic illness and youth.

Chronic Illness And Youth

Helena Fonseca.

Good afternoon. I am sure that working with adolescents with chronic illness is not easy but undoubtedly it is very stimulating, I have been doing this for many years. I have always felt that the effects of the chronic condition on the adolescent very often outweighs the impact of the illness itself. We have to keep this in mind when we have an adolescent with a chronic condition in front of us even if the chronic condition is not very serious, it's impact can be huge. It has been quite interesting for me thinking the impact of the chronic illness on the adolescent not only thinking about the age of onset of the condition, the nature of the condition but also trying to think about the first impact about the development of tasks of adolescents.

So thinking about autonomy and identity I will go a little bit through all of these, I will try to be clear and just beginning by the age of onset I do think this is an important point just because if the chronic illness starts at birth or in early childhood what happens is that sometimes this leads to ultra parental expectations so what we see and this is really very usual we see that parents don't have the same expectations towards these kids as they have towards another one. And this is quite serious when the start is at early adolescence. At this stage what happens is that the adolescents is very concerned about his or her body and chronic illness may lead to extra concerns. Also at this stage because the adolescent has yet to separate from his family what happens is that this can lead to little struggle for independence. And you can see adolescents at this stage feel very dependent from their parents.

When the beginning is at the middle adolescence stage this age may be the most devastating time for a chronic illness to start. And the reason is because during this period the adolescent is intensely involved with parental separation with peer involvement and concerns with his or her own sexual development and so a chronic illness appears here and the adolescent will no doubt face extra difficulties in all this process. If it starts in late adolescence I do think that the main problem is that it will disrupt vocational plans, it will disrupt prospective of leaving independently and things related with this. Of course it is important to look as my colleagues said previously it is very important to look at the nature of the illness. And of course its course, the chronicity, the side effects of the medication all this is very important, the prognosis of

course but I would like you to stop a little bit at this second point, the visibility.

I have been noticing that visibility is really very important. And from our experience highly visible disease even if it is less serious may cause more disruption than a very serious one. I have some adolescents with dermatological problems and these problems which are not so serious for instance eczema but they are really disruptive. As clinicians we have to be really aware about this point.

So as I promised and this framework has been very important to me at least it was developed by Laurence Neinstein and I like it very much so thinking about identity and autonomy the adolescent with a chronic illness may have difficulties with his or her developing identity. And this is linked with a body image. Adolescents are highly concerned with their bodies and either because they have delayed puberty or because they are carrying some kind of malformation this can lead to a lower self-esteem, so segregation from peer and increased anxiety over sexuality and like at the end of this continuum sometimes depression and really very negative feeling. So I would say that a chronic illness at this point can severely interrupt the whole process and the whole movement towards independence. Especially if it takes place in the early or middle adolescence as we have already said this can be a problem much more than the disease in itself in my opinion.

As far as autonomy is concerned sometimes they feel tired, sometimes they feel like and this is a reality for most of the cases, they spend a lot of time in medical appointments, so they do miss school and they do miss activities. So this problems may of course lead to fear of peer involvement and can also lead of course to social segregation. If we think about autonomy and this is the like the nice way I like to look at it if we look at autonomy as the adolescents capacity to take responsibility for their own behaviour to make decisions regarding their own lives, what is so so important, to maintain supportive social relationships, if we think about autonomy in these terms I do think that we can agree that the development of autonomy is perhaps the major goal for adolescents with a chronic condition.

As I have already said this adolescent will face additional difficulties especially related with sexuality. Because of the

delayed development, having of having too protective parents, because of feeling uncomfortable in expressing concerns about this field, they are very often seen as asexual, and I do think this is huge problem and I do think that paediatricians as me because perhaps we were trained for dealing, for working with little kids we are not sometimes aware of these problems and really need to be.

Talking a little bit about the adolescent girls I would say as many other people said that these adolescent girls living with a chronic condition as Juan Suris and someone else this morning addresses this issue very well, she will have an increased health risk if becoming pregnant because of the main chronic illness but also she is an increased risk of becoming pregnant. And this because perhaps she wants to prove herself that she is able to and there might be many other reasons, we can discuss this later.

So I shall say that the social and sexual aspirations of adolescents with chronic diseases are not different from the rest of the population. And the other point which I think if very important is that this kind of adolescents are really specially sexually vulnerable. And if we think about sexual abuse all the research point to the fact that these kids are much more sexually abused than the rest of the kids of the same age. OK. So I would like now at this point to talk a little bit about the family and efforts we have developed to work together with the family especially in Minnesota where I learnt with Joan Paterson about the FAAR model I will talk a little bit about it if I have the time. I learnt that if fact that having a family with us is really very important and much more important if we are working with adolescents in early and middle adolescence. And I do think that we have a very important role in preventing something crisis that could be unnecessary if we have provided a sympathetic guidance. If at the right point we would have been able to talk about the right things, to discuss the right things to give the right help I do think that some problems would not happen.

If we look at the family as a important resource we can understand how much a successful adaptation to a chronic illness can best be promoted by focusing on the family system. If the family system will be our unit of intervention and not the adolescent individually I do think we are working better. And of course all of us are aware if the family is happy the adolescent with a chronic illness will do better.

So what I'd like to point at this stage is that if we think about poor outcomes as feed back increasing demands we can also look at good outcomes as feed back to family systems that increases their repertoire of capabilities. What I mean by this is when I talk about good outcomes I am thinking about having been able individually or as a family to make the right decision at the right time or having been able to take responsibility for a particular behaviour, I do think that this gives power to the family, this makes the family feel that perhaps the nest time they will be able to do the same or even better because they have a positive previous experience.

So as clinicians we really need to pay attention beyond the somatic aspects to emotions and this was already very well discussed here today. So what kind of emotions does the illness raise inside the adolescent and how is the adolescent dealing with his or her chronic illness and also how does his or her personal and family history influence all this. And at this point I do think at least for me the FAAR model, FAAR as the initials for the Family Adjustment and Adaptation Response, this model has helped me a lot for understanding the family dynamics and learn how to manage with the family. You have here the balance with the two plates and you can see that when a crisis appears what happens is that strain becomes really heavier and this upsets the balance. So what happens for balancing the system again we have to put more strength in the other plate, and I do really think that we can help indeed. We have already this morning talked a little bit the possible behaviours of the chronically ill adolescents I would only like to say something we listen this morning and I do think it's very important is that we are aware that in order to be able to cope with difficulties and frustrations the adolescents usually have this kinds of behaviour first ones or the second ones but the important thing here is that as we said this morning not being compliant either way of showing that the adolescent is independent.

Sometimes we are tired about the adolescent who is not doing the medication, we are concerned about the increased risk-taking behaviours, I understand all that and I have that personal experience but the problem is that if we look at this as a healthy way, a healthy process of autonomy I do think it's a good way of thinking and of working on this. Sometimes the adolescent who copes very well with everything sometimes because she was able to reframe the situation and of course developing coping

mechanisms, sometimes this is done at the expense of lots of autonomy.

Just to end I would like to say that behind the physical face of the adolescent's medical condition consideration of the adolescent's psychological development and tasks is very essential as I have already mentioned and this could be bases on this list of principles by educational process I mean informing the adolescent and the family of the nature of the illness, its course, possible limitations of the treatment. and something that is very important is to adapt our language to the kind of adolescent or family we have in front of us because we physicians we are not trained in that, we speak with very difficult words and sometimes we are not able to reach the audience. The other important point already stressed is the continuity of care. When we think about physicians, issues I do think that we really have to think about the continuity and how to deal with it. Of course I have already talked about involving the adolescent and the family and the evaluation of the impact of the illness on the needs of the family. I would only like to say something about the multi-disciplinary team. Something actually I discussed this morning after the chronic illness presentation. I do think that nowadays we are aware that we have to involve in the team many health care professionals and I could like issue huge list but I feel at least in my country that communication sometimes is not easy among these people and this is really a point I think we need to improve. And I say this just because sometimes I do feel that this makes the difference. OK. Thank you.

Dick Brown. We maybe have time and discussion a little bit later to keep on schedule. I am very pleased to introduce my co-chair Anne McCarthy who is a historian by background, she told me and also has a degree in education. She worked with Ronanstown Community Training and Education Centre in Dublin, Ireland. Her experience is with youth, with learning disabilities and education and employment needs of youth with special needs and with behavioural difficulties. Her presentation is entitled Job retention.

Job retention

Anne McCarthy

Good afternoon, ladies and gentlemen. I am going to talk to you about the research project that I did last year and I hope that you'll find some interest in it. You've all heard of this wonderful Celtic tribe in Ireland and the economic growth in Ireland is the second highest in the OECD. Three quarters of all growth are in small and medium-size enterprises. The private sector services are up by 20% since 1990. So we are really growing faces. And from this programme programme-led interventions we are going towards objective-centred initiatives. New integrated approaches advancing everywhere as I am sure they are in your countries as well. And from the national level partnerships they are developing local community level partnerships and never before has the national ethos been so fertile for new initiatives and present centred strategies to emerge and succeed.

Despite this the vast bulk of unemployment is experienced by 20% of the population and one of the worst unemployment black spots in the country is very near to where I live, where I work in Ronastown And these were the statistics brought out by the Partnership Area Action Plan of '96 which were the local government thing. So I was commissioned to do some research. My research briefly is that Partnership commissioned me to do some research and the research brief was to find out why many trained young people from the Llandollan area where there are plenty facilities and lots of training programmes going on were leaving their jobs, many were good workers and yet they were all dropping out of the system. This envisaged enterprise culture that we were hearing about in the new year, somehow there was an imbalance between that and the local workforce.

Training centre graduates between 17 and 23 years were not staying in their jobs and over 40% under 25s were unemployed over 1 year. I know it's an appalling statistics because it was all out there for them. Now the scene was, we had low participation on all the education and training programmes, little motivation to avail of the services. And what there appeared to be was a lack of and a need for a psychological infrastructure and a community mind thirst to match the business and industrial structure that was developing. The demand of the late 20th century and new millennium they were not equipped to meet them. So what were

these barriers to participation and success? Many of them are very bright young people. Has industry changed? Have people changed? Was there correspondence or was there conflict? So that was what I set out to do. So the first thing I did was delve into the literature and it was totally depressing. And first of all you had the usual establishment literature. The statutory provision, the wonderful government publications were all wonderful, and very much the new vocationism and the expression I like and I think it described very well what's happening "All these new programmes that we are hearing about: extra training, staying on in school, all these incentives hold the new vocationism."

At the other side you have these lone researchers who nobody listens to and nobody reads were doing these wonderful researches listening to the young people themselves. And what is coming across is a separate culture, a whole cultural identity that was very strong and was not going to be changed no matter what you did with it. And there is also evidence of a responsibility delay, was this new vocationalism here developing a responsibility delay in young people and this youth culture with all its side effects with the result of this? Industry and capital definition were the mould of the perfect trainee, the perfect product. What are the motives for this? There was a clash between careers and identity, did they identify with careers or just with jobs? There were a huge kind of clash there. Education was not considered schooling, school and education are not synonymous. You can be educated anywhere. Education is an approach, a development, it does not have to be in a building. We were talking about giving them qualifications yet all the young people were interested in was wages, you know this paper qualifications had no meaning for a lot of them. You had all the OECD, EFO plans, government publications, ESRI which is Economic and Social Research Institution, over here, now I've got some sheets of paper over there which I'd like to call the alternative bibliography and I have them there is anybody's interested.

But these were the people I discovered who were showing that there was a fierce cultural identity there and in fact a lot of young people that we're talking about are no different from what they were a hundred years ago in the industrial revolution, it's a society that has changed, no necessary the young people. And the two different view points and clashes that I found was youth is the problem within one side of the literature, youth has a problem, so

I'd like to approach from the view point: youth has a problem. So that was the way I looked at it. Now, my units of study. I took the target group and my target group are going to be trainees who've been placed in training centres in the area between 1/1/95 and the 31/12/96 and then I had the secondary unit of study which were the employers because I'd had to get a match there. And these employers would be referred by the respondents. My sample frame was seven registered in the area and I said registered for those of you who were at my workshop this morning know that our clinic centre has about three registers because we are totally integrated centre, so you see the OCT there's actually one training centre with three registered. We have the Llandollan Youth Switch system, the St. Oliver's is for travellers, young people, in Ronastown we had young people with learning difficulties and also early school leavers. Link was employment based training. We had those, entire project is a project which is run by the Department of Justice, of which some of my past pupils attend and it would be for people who had been in a risk for crime and the youth service as well. So that was my sample.

Now, the questionnaire, we decided to do it by questionnaire, and we matched the two questionnaires. We had identification factors for both the target group and employers, and then we looked at the attitude and the psycho-social factors, the age of the mothers, numbers going to work and leisure time, etc. And then we matched this side with the employers to see if there was a correspondence between the two, where the clash was, what is the problem. The support, who is the most trusted person, quality and quantity, manual work, job image and what necessary skills they think, what abilities and disabilities of the employers feel. So kind of did it like that, satisfaction, aspirations and strategies and then the interview factors and I was going to see if there was clash or if they matched.

I wanted to bring a point about the administration because it was really, it told us an awful lot about the community we were dealing with. We had first of all the contact problem. The training agencies, we had to go to the agencies to get the co-operation for the units of study and to get the registers from them. Then the units of study were the target group and the employers, we had to do that numbering and coding and piloting, that was quite a while. However, we were very very restrained by time and money and the rest of it, I had to do it in 6 months and I had the other job as

well, so it was very very intense. Now, this was the key to the whole thing. The response rate was unbelievable, there was a big black hole out there, they just would not be interviewed, we couldn't find them, there was all this intangible and the name of the research name by the way is the Elusive Workforce because that's exactly what they were. Now, of the entire population which is a very very large area only 96 people had finished training because I registered with the people who actually been placed in jobs, 96 which was merely very very low in itself, then when we went to sample them we got 32 and we had to get a substitute sample of sticks, I am going through it very quickly because it's an afternoon and I don't want to go overtime. Now, these were the samples. The numbers were much smaller than we thought, though it did help us to do a more in-depth study but the low numbers were very significant in themselves. Because they didn't want to be contacted, they felt threatened by it, also they got lost in the system which is very interesting as well. Now, the field work, I just wanted to give you an example of the field work, it was a nightmare which we had not expected, we thought the difficulty would be in the research itself, but it wasn't it was in finding. It was very funny actually. Here is a target group problem: contact difficulties. Many of them we approached and asked them didn't want to, they felt threatened, so many of their ex-training centres said that they could come back and visit them and we did interview them on this in their territory and we wrote letters, phone calls, agency appointments. Agency appointments mean that they could come to their agency have a cup of coffee and answer a few questions. We wanted to make it as unthreatening as possible.

So 46, as you can see the approach was 46 and the response rate frighteningly was 22. And a non-response we, multiple approach means we went out and we knocked on the doors and it brought it up a bit. So that was it. The reason for the noncompliance they didn't keep an appointment - 5, no response to the letters or phone - 8, they just didn't answer them, and 1 had emigrated, so we were told refusal and working on a lorry. And the employers: we only had 5 non-responses from the employers, didn't have time, didn't know the client, not for a month later, don't want to know, so we only had 5 of those.

Now I am going to go very quickly over the areas of correspondence. And by areas of correspondence I mean the things at the areas where there are mutually advantageous

systems and there was no great clash between the two cultures, cultures of work and the culture of the young person. So the 8 profiles of correspondence where they dove-tailed, they weren't the same, but they did dove-tail were recruitment, induction, mobility, skills, conditions, supports, disability and manual work. So there is no problems with those areas, there is interesting findings that there is no problems.

The three profiles of total incompatibility and where the problem is where there is no dove-tailing whatsoever was in the personal, educational training and then in retention. So we hold it down to those three by confirming that there was no problem in the other areas. But the two areas of the nature in age difference and I wish to stress that I was not looking for an age differences I found them, were between males and females, manufacturing and service sectors, very subtle little differences which were very important.

Brief summary. Significant key factors were the eight profiles of correspondence and I am going very briefly through this. Target groups: significance of personal approach when you are trying to recruit somebody from a disadvantaged area. It must a very personal approach, they are terrified of interviews, paperwork, the whole lot. From the employers point of view the service sector found qualifications less important. Manufacturing is far more difficult, coming far more difficult now than the service sector and the future for many people will be in the service sector industry, the types of jobs and everything like that.

The induction to work: 71% have had enough training, they didn't want any more training when they went to work, they just wanted to do the job and the most important people to teach them how to do anything when they went to work were their peers, nobody else, it's the only people they wanted to hear. From the employers point of view on the job training was given, support from the supervisor was very important and the employers found that the training centre wasn't an option at all, they much prefer to train their own people, they didn't see why people went to training centres at all. So that's weird. Now, the most important skills and this really depressed me enormously, the fact that they both agreed on this, up to top four out of 11 most important skills they agreed on attendance, time-keeping, safety and awareness, ability to communicate with co-workers for the target group. And then for the employers attendance, safety and awareness, time-keeping,

dependability and reliability. So it shows that trainees are aware of what's required and what they need to do and in fact they are very well trained, so there is no great clash there, but the bottom two were dreadful to adaptability and flexibility, good behaviour for the employer but the fact that both employers and trainees and graduates said that basic reading and writing didn't matter. Now, I just found it very very depressing, as an English teacher I thought it was horrendous, but basic reading and writing that the employers don't consider it important and there's 2 or 3 ways of interpreting this whether they haven't got enough respect for their employees to think that they need reading and writing or whether it just wasn't important for the job that they gave them, there is a lot of different ways of interpreting this but nonetheless I thought it was a very interesting statistic and pretty depressing one.

Now, mobility was an interesting factor as well. It's well known in the literature as well that really in the disadvantaged areas three miles is about the limit that people are willing to move to get a job and this statistics bore this out that they won't really move beyond the community very much and when we went down and asked the employers they were not opposed to recruiting the local workforce. The reason for the preference of the local workers was the practical nature rather than their commitment to a particular locality easy access and that they wouldn't be late was one of the things that I got. The negative responses concerned the lack of education, experience and qualifications in the locality, because I am sure it is the same over here in lots of disadvantaged areas there is a lot of industry is coming in from outside and it would be great if they would employ the local workforce. One manager said he didn't consider this point at all, but an awful lot of them do. But they won't go far away for a job.

Now, the most important working conditions. There was no great clash here at all, human factors, security factors, both the employers and the target group agreed that things like good conditions, good wages, all the security factors were important. So that was interesting.

Now, the disability issues. You may have noticed that I didn't particularly highlight disability. I purposefully didn't do that and I thought some factors, they were all young people together, I knew from the registers who had a disability and who hasn't but I didn't do anything special for them to see if something came out and it

did. Employers had little doubt about the performance rating of persons with a disability and by that I mostly mean their learning difficulty. It was really in the areas of work pace and ability to comprehend instructions that they in fact thought that there would be a problem. But there was a cautious willingness to employ a person with a disability and provide on the job training, but a clear willingness to enter into partnership with a service provider for support and back up. So the employers clear willingness to enter into partnership with a service provider was quite definite. I'll go very quickly now, I'll go to the next one. They were willing to do support with support systems and this is interesting about manual work. There was very little difference between manual work but the employers said they didn't think it was physically hard whereas the workers found them physically very difficult and demanding.

Now the areas of incompatibility I want to deal with very quickly where there was no dove-tailing personal education and training and retention. They all lived in house holds where there are only 5 or 6 six people, there weren't very large and the women were more independent than the males. Now the most trusted person was interesting, that they all, the power of the mothers came out very very strongly which I had not expected, the person that they confided in the most was their mothers, very little confided in peer groups. The legal history wasn't anything too outstanding. But most of it, the legal history had to do with car crimes. I am just trying to hurry this through now because the findings that are last are important. Now the night classes. Many of the males didn't want to know about the night classes they were too shy to go but they all expressed the desire to learn reading and writing. And what came out very much out of the whole thing was that the need for the males to be given responsibility says image and training I think we are probably putting a little bit too much into females because a lot of them have babies and they develop responsibility much more quickly.

Now here is a disability factor that came out. When I asked them how many training centres they'd attended the only people who'd attended one training centre through the whole course and the only the people who in school to 18 were all people who happened to be in special services none of the others had. The employment profile: slightly more than half of the respondents were employed. Among the employed only three had stayed longer than 6 months in their jobs. Two of these jobs had ended because they were

community employment schemes that had come to an end. So what came out of that was that the females weren't working they had successful careers but they had to leave their jobs because they lacked child care facilities. They couldn't attend because the child care and the jobs had come to an end because they were employment schemes. The males had left for other reasons. They had left due to boredom and all the rest of it. And there was really between 4 and 6 months was the time when they would leave their jobs. And I just deal with unemployment cohort here.

Seasonal work: no job available, that's usually a way of sacking somebody anyway, they say it is not available, so you could lake it that the are fired really. The females stayed on and it was really outside their control. So what we found was that there was no work shyness, what there was was an ability and a willingness to work but a total no bonding with the workforce at all.

Positive conclusions: well-trained in work skills, well-trained to respect supervisors, correspondence between work-force and employers, no work shyness, motivation very good, employers were willing to bond with the training, to bond with training system and train them on the spot. The major influence is mothers who are terribly important and a positive attitude to employment of people with disabilities with correct support and a strong social class identity and that's social class identity has to be given much more attention, it's very very important.

The negative conclusions were: there was a huge confusion and cultural incomprehension, a black hole in this large drop-out rate, they just didn't understand the things that they were meant to be learning or they didn't know where to get them. The education and training is far less important to young people than employment. Wages, not qualifications is what they want. Low general education base, need for a mind set and a psychological infrastructure was confirmed. Young men need confidence employment responsibility. Young women need child-minding services, and the huge possibility of a hidden disability was there.

The conclusions were denying the development needs of responsibility, confidence and personal identity. We need to simplify the system, it is too complicated for the young people to understand and it was very very clear when we were doing the research. The challenge to reduce unemployment is to bring out

quality skill level while retaining a sense of cultural identity. Young people need to see a clear chain of connection between worthwhile job, training and qualifications, they don't see the connection and they are confused between the role of learner and the role of worker and we need to bring the three paradigms of work, education and training more closely together.

My recommendations were structural and developmental. The structural recommendations were to develop longitudinal research and to continuum of contact, the trouble is you go to one service and then you go to somebody else for something else, they need one support worker who will link them all to various paradigms like medicine, social work, welfare. It's too complicated for them. The package approach to education, training and work. And I think they'll only work if they are having a job as well, if the identity of a worker they will learn.

The developmental ones, Package approach, the power blocks problem. The medical power block, the education power block, the employment power block they are all fighting their own ends and the poor young person is just lost in the middle. So the intertwining and restructuring of those paradigms. We are trying it in own training centre and it's working very well, but I ensure you the difficulty was at the power block side and not the interacting of the young people with each other, that was easy compared to the politics. So these paradigms at the moment and I am sure you have it in England here the structure, the communities, the partnerships, the agencies and the statutory bodies are getting together. But we also need to bring the paradigms together of medicine, education, sociology, they need to get together unemployment so that one person has one united system and one contact person to reach it. Thanks very much everybody.

Chairman: The next speakers are Mark Boyce and Daniel Forer who are programme co-ordinators with a group Chronic Illness Peer Support in Victoria, Australia. They are programme directors for the centre for adolescent health there in Victoria. Welcome.

The Power of Positive Peers

Mark Boyce and Daniella Forer

This paper draws on the presenters' experience of working with adolescents living with chronic illness and their parents. The paper aims to present a snapshot of what it's like to be an adolescent living with a chronic illness and what it's like to be the parent of that adolescent by presenting two innovative programs which have been designed to offer support to these young people and their parents.

The Centre for Adolescent Health in 1992 established the Chronic Illness Peer Support (ChIPS) program which has been successfully offering support to young people for the past five years. More recently a parents' support group has grown out of the program. Both programs combine traditional peer support with the unique philosophy that regardless of illness type similar challenges and issues will be experienced. The program is non categorical, meaning that participant live with a range of conditions such as Asthma, Cystic Fibrosis, Epilepsy and Chrons Disease to name a few.

The ChIPS program operates on a five tier model of youth participation with the initial component being an eight week peer discussion group co-led by a trained peer leader (young person with a chronic illness) and a health professional. These sessions run for ninety minutes one evening per week for eight weeks and cover topics such as school, hospitalisation, stress, family, relationships and social skills. Within a ChIPS group there is a large component of pure peer support with the young people sharing their ideas, and methods of coping to help each other adjust to living their life with chronic illness.

Evaluation of the ChIPS program over the last two years suggests that the potential impact of the program includes enhancing coping skills, positive peer relations and emotional well being as well as decreasing isolation from peers, decreasing social and recreational restrictions.

The parents' support group was established in 1997 following an exploratory study examining the issues faced by parents of adolescents living with chronic illness. The group has been set up by a committee of parents who have an active role in the planning,

promotion and facilitation of the group in conjunction with two health professionals. The group aims to provide opportunities for parents to support one another, to share information and provides education around adolescent issues. Through the examination of research and review of video taped interviews with parents and young people, the presentation will provide an opportunity to hear what young people living with a chronic illness and their parents feel about their experiences, in particular what gives them hope, encouragement and support.

Mark Boyce First of all I would just like to say the last four speakers have gone through with us a lot of issues concerning young people with chronic illness, they told us about increasing isolation of those young people compared to their healthy peers, they told us about decreased self-esteem, decreased resilience, poor body image, lack of peer group, the importance of peer group to these young people. What I am going to tell you now is about possible solutions or one positive programme that you can implement and it is very implementable in every community to help address some of these factors.

The ChIPS programme - Chronic Illness Peer Support. It's a peer support programme run by young people for young people and it's non-illness specific programme and I have it on good authority that there are none non-illness specific programmes running in England or Europe at this time. And by non-illness specific it means anything, Asthma, Diabetes, Cystic Fibrosis, Reumoarthritis, for young person who's had CVA, stroke, young people who had cancer – anything you can possibly think of, all in the one programme. We work on a 5 tier model of youth participation and starts off with a eight week peer support programme, which is followed by ChIPERS – leadership trying-in, co-leadership and a reference group membership. Only one adult as such employed in the programme, everything else who does work on the programme does so on a small voluntary basis if they are adults, as it's mainly run by the young people themselves. Imagine what it's like to a young person who have Cystic Fibrosis or Arthritis and everywhere you go people know that, they know that you have a chronic illness or condition, your doctors know it, your parents know it, your brothers and sisters know it, all the health professionals know it, but for them there is no one really you can talk to, who can really put on their shoes and really understand what it's like apart form other young people who have

that condition or illness or similar conditions or illness. And at the peer support eight week group they come in to the room and in a group with another eight people with another chronic illness and condition and they know that everyone in that room has a chronic illness and condition of one type or another and they leave the illnesses outside, it's not an issue anymore, and they can actually get to talk about real adolescent issues without their illness being an overpowering factor.

The eight week peer support group one night a week for eight weeks, meet for an hour and a half each evening and there are 6 to 16 young people of similar ages as you can imagine a 13-year old would have slightly different issues to talk about than an 18-year old. We are trying to keep to around three years age range: 13 to 16, 17 to 20. And what we at the end of the first night after we've done some get to know you sort of stuff and broken down some of the initial barriers that are always there because the young people don't know each other, we do a brain-storming session and we get them to talk about the things that really really like, the things that they have been able to do because of their illness that they wouldn't have been able to do otherwise, and the things like camps, we have a make-a-wish foundation and show them throughout the world as well and makes them able to do various things. Get to talk about the things that piss them off, the thing that they hate the most, whether it be hospital food, doctor's appointments, friends as school using them to us their illness to get out of schoolwork, lack of peers, lack of friends, as I say those things there and what we do for the next eight weeks, for the next seven weeks we talk about one issue in particular and go through it in depth.

The structure of the next eight weeks is also very important, if you have a group that has a lot of issues around, perhaps family issues, then you would schedule that for further on and you would do a friendly topic, perhaps school, for the first school After the eight week programme we found that these young people had all met and made friends with a group of people that they could really relate to, they could talk to about issues that were really bothering them and they wanted it to be on-going but we really wanted to avoid it of creating a group of young people that have a chronic illness or condition who are dependent on a group.

So what we do then in ChIPERS, ChIPERS stand for Educational ChIPS Education, Recreation and Social. And regular social activities at the end of each school term, so that's once every three months there is a social activity, couple of training workshops helping throughout the year on things like first-aid training or perhaps we did an art workshop last summer, we do writing workshops, those sorts of things, they also receive a regular newsletter, which comes at the end of each school term and a magazine that comes out once a year. And this way they are able to continue their involvement with the young people that they've met in their initial programme as well as meet other young people with chronic illness.

Leadership training. When the group is actually run, it's run by a health professional and a young person with a chronic illness who has gone through and done a leadership training programme. The health professional takes a back seat and is there purely as a backup for that young person and it's the young person who actually co-ordinate the group. The three-day training programme focusing on presentation skills, group dynamics leadership roles and at the end of leadership training all participants are eligible to join a reference group and also of course to lead a group themselves. Who are leading up the group although it's unresearched it's been found by the young people to be the most rewarding factor of the ChIPS programme. After going through and being part of the group and realising that there are lots of other young people out there who have chronic illnesses won't be the same that the issues that they are facing are similar, it's challenging and rewarding for the young people themselves actually go on to lead the group. It forces them to look at themselves, how they are adapting, how they are coping what they are doing about certain things with their illness and then opening up and sharing that with the group of young people and helping them to come to terms and being to speak about their illnesses. Had a young lady recently who is 15 years of age, she has epilepsy and had not told anyone apart from her closets friend, and her mother and family obviously know about it. Now she's on medications and is a bit delayed and hasn't spoken at school about it or anything like that. After 7 weeks in the group she actually came out and spoke to her group and said that she had epilepsy and for her it was really a big step, there was actually her being able to speak about her illness with other people and she

seems to have gone on from there to actually do a talk at her school about it and she's actually doing a lot better from that now.

The reference group. The reference group is a governing body of the ChIPS programme, it's a big body, it's divided into three subcommittees as well as a regional representatives and I'll talk about the regional bit in a moment. The subcommittees are the publications committee which does the newsletter there every three months as well as a magazine once a year. The magazine, it's the first one right there, we actually just released the first 1997-98 ChIPS wrap-up and that goes to all the young people in the programme as well as the health organisations involved in the ChIPS programme. The social committee is the second committee and just have a look at the group over there, all the difference body shapes and sizes and we were talking about body image before. There is a beautiful beach just an hour's drive out if Melbourne and we went out there this summer and on the way back I was talking with one of the girl and she was saying it was amazing that se actually got into her bathers and went out into the water today. If she had to go to the beach with her family there was no way she would have done that. It's the power of the group of peers when everyone there that look different, there is a girl with a plaster casts, there is a girl walking with aids, there are people who have various ostomies and bags and stuff in the group as well and they all went out into the water, they all were in the water apart from the girl in plaster of course. And it is a very powerful thing that they felt OK to do that in this group, if they were just there with the mum or dad or the peers they wouldn't have felt that comfortable to do that. So it's really rewarding part of the programme.

The ChIPS programme as I said before with the reference group has regional programme that's being set up at the moment. The programme was being researched over two year period by Craig Olsen at the Centre of Adolescent Health and he found that one of the most significant factors of young people with chronic illnesses that they had one or no friends that they can speak to about their chronic illness, that they felt comfortable talking with. So the Department of Health in Victoria has funded us for 12 months to set up a programmes across Victoria on the thought process that if people in Melbourne, the capital of Victoria, didn't think that they had anyone to talk to, how much more remote will those people be in the regional areas outside of the capital where supposedly all

the good resources are. So we've actually set the programme up in those areas and in the next 12 months we estimated that 200 young people with chronic illnesses will do the ChIPS programme.

I'll now hand over to Danielle Forer who is working alongside me with this programme and she is setting up a programme which is called the Parents' Support Group, just also want to mention that someone mentioned earlier that a siblings programme, they are actually undergoing a sibling research project and at the end of next year we hope to have a sibling programme running along the same lines so we'll have chronic illness support for the whole family. Danielle.

Danielle Forer
The Parent Project that I am going to talk to you about now is a follow on from the ChIPS programme. Since ChIPS was running from 1992 there were a lot of requests from parents wanting support, they wanted ChIPS for themselves saying that they had issues they wanted to talk about with other parents as well. So in 1996 we began to look into the possibility of offering the support to parents and the aim of this project was to establish support network between parents who adolescent son or daughter living with a chronic illness. We at the Centre of Adolescent Health take a holistic approach to health and recognises that support is needed not only for the young person but for the entire family unit as has been stated today recognising that illness certainly affects the person who is living with the illness by the entire family unit. The parent project was set up in three stages and I just briefly run through it with you.

The first was research looking at the needs of parents. The second, we formed a reference committee similar to the ChIPS programme getting parents involved, and at the third we established a parent group at the start of this year. Just in terms of research which was conducted we did qualitative interviews with the parents of 10 young people to gain understanding of the kind of issues they are faced with and to look at what their needs were. These parents had children with various kinds of chronic illnesses including asthma, diabetes, epilepsy, cystic fibrosis and neuro-intestinal displasia which is a rare bowel condition. The findings were similar to the ChIPS programme in that there were a lot of similarities in issues faced by the parents regardless of the type of the illness that their son or the daughter had. Medically there were

differences in terms of treatments needs however on a social and everyday level there are a lot of issues which were similar for the parents. The next slide ahead highlights what some of the issues were that parents identified. The first one – helping their son or daughter come to terms with adolescence and their illness. One parent called it the double whamy, looking at not only having illness but adolescence at the same time as the huge issue. And letting go, that was another one.

Following on from this doing a research from looking at the issues the parents were adamant that they would like some kind of a support group for themselves and having identified some of issues we next looked at the kinds of support groups that were available looking at models of service delivery. And look at whether there were any other groups available or not, not to re-invent the wheel. And what we found is that there were a number of illness specific support groups for parents focusing on things like groups for parents for kids with diabetes or groups for kids with asthma, however there were no non-illness specific groups available and there were none that focus on the issues for parents of adolescents, most were for parents of younger children. And the parents were quite forceful in wanting a group that was for parents of adolescents because they felt that there were a lot of significant issues that were different once they became adolescents than when they were younger. So the next step was to set up a reference committee and the reference committee is made up of seven parents and 2 health professionals. Again it focuses on parents being involved in the groups that we run.

The parents were strongly involved in the planning, facilitation and promotion of the group. And I think it is a very essential part of this process my role and Meridith's role who is another health professional involved in this project is mainly as facilitating and organising speakers and things for the group. So we set up support group on March of this year and what the objectives of this group that the reference committee came up with were provide opportunities for parents of adolescents with chronic illness to meet and to provide support for one another, to share information and to provide education and adolescent development. And as it came to the group the parents really wanted information about adolescent development, any information about day to day living with an illness. They felt that on a medical side of things they had a lot of information, however on a practical daily living side that

was where they were lacking. For the structure of the group: we meet on the first Thursday of each month, its nightly group with new parents able to attend each month, so we're also having new parents coming along, and parents said that it was important because they needed flexibility with their life things so chaotic it hard to commit to a certain set period of time, so having the flexibility of being able to attend one night and maybe not the next was important. And it's very much a topic-focused group. And the kinds of topics and things they are interested in include managing health care, looking at working with their kids around complaints and transmitting things like that noting what their role can be in that, looking at pain, stress management, adolescent development, know what's normal adolescent development and what's behaviour just associated with the illness, that's the common question that we are asked and asked by the parents.

Looking again sibling issues and further education – that's the huge one and we had 27 parents turn up to our further education night when we focusing on what support available was once their kids sort of reached the end of their higher school education. Just to give you an idea of the demographic of a group: we're having equal numbers of mothers and fathers attending these groups which sounds quite unusual for support groups and I think a large part of that is because we are providing information. We're having an average 17 parents coming along, and they are travelling quite a long way out to attend the group. And the majority of them of Anglo-Saxon background and main issue that we are hoping to look at next year looking at whether they made access issues for parents from other cultures. And just to I guess conclude I'd like to read to you some words that one of the parents from our group wrote to me, I said that I was coming along to this and I wanted to get some feedback about her experience of being in this group and I get just to highlight for anyone that's contemplating of addressing issues for kids wit chronic illness or their parents, involving parents in this process because it is very powerful. She titled it - "Two storms and a rainbow":

"For the past 18 years of my life I've been like a lone weathering the harsh realities of my daughter's chronic illness. That has been a tough enough call in itself, but when my daughter turned 12 I began to simultaneously weather yet another storm, the hurricane of adolescence. The tree battered against the bitter winds of frustration, the torrential rains of loss and hopelessness, the fogs

of confusion and the thunder and lightening of anger. The elements took their toll, despite the support of family and friends who have they tried could never comprehend the nature of chronic illness. I have been and for as long as I live I will always be there to care for my four and support my daughter. I love her, however through the years the endless storms have stripped my tree of bark and fruit. I have been a member of the parent support group since its inception. There I have found a place of shelter and refuge. At the parents' support group the tree became a thriving forest. For me the group is about sharing, caring, growing, learning, and laughing. As I am writing this there's been an update on the weather: storms will continue but a rainbow will be ever present in the sky. Thanks to the parents' support group I now have a rainbow in my sky. I hope that one day all parents of chronically ill adolescents will see that rainbow."

Chairman: The last speaker is Gillian Turner from Northumberland Young People's Health Project, based in Northumberland. Her presentation is Establishing Young People's Health Sessions. Thank you.

Establishing Young People's Health Sessions.

Gillian Turner

I am a consultant community paediatrician with a responsibility for teenage health in Northumberland and actually focusing not on the needs of young people with chronic illness unlike everyone else I'll be talking about establishing generic health services accessible to all young people. But I do hope some of these messages will be relevant for all of us working with young people, they are not exclusive to any young person. I am actually presenting on behalf of particularly the young people that have been involved with the Northumberland Young People's Health Project and also Ann McNulty, the project co-ordinator.

I'll be covering all this so that you can see it. The project as a whole is much bigger than what I am going to talk about today, it's a two-year funded project to really work with local young people, to involve them in developing the appropriate services and particularly involving them in decision-making, in training and also in research as equal partners. I'd like to start with what the young people actually said, " We do have problems like everyone else and we do need to be able to use services easily. Service needs to be welcoming otherwise the young people will go away lonely and upset." It's a very strong statement.

So why do we need to do something. Firstly, we know that young people have significant health need those with chronic illness and those without. Young people's health, young people themselves define it very very broadly, There are all kinds of things influence their health not solely physical health or traditional mental health. Young people do access traditional health services, we know that 80 to 90% go to their GP in any one year, lots of young people access casualty. However they don't go about the things they acknowledge influence their health, they go about more narrowly defined physical health concerns. Young people need both information and services ideally in a combined facility so they go for both at a one stop. Particularly perhaps young people we mostly worry about not accessing services, they are the ones that won't go to one place for information, one place for services and then be referred on to someone else. They just won't make that transition.

So on to cover a bit of a research we've done with Northumberland young people. To explain the methodology we actually did single gender focus groups to begin with very broadly getting young people to explore issues to do with their health and access to health services and from that we then designed a questionnaire so the questionnaire was not professionally driven. So young people themselves were identifying what influences their health are the kind of thing in the 80s and 90s, the things that we as professionals are getting concerned about particularly drug use physical conditions tend to be much lower down so we do need to take a very holistic view point to meet what young people are saying their needs are. They want information about a wide range of things, these were the top three that came up in the very high 80s and 90s. What do they want from us as health professionals? I think it is relevant to all of us no matter where we are working. Most importantly the ability to respect confidentiality, to be able to listen and not be shocked by what young people say and not to judge young people. Age of the health professional, gender of the health professional was very very low down the list.

From the focus groups four issues, themes arose in terms of what young people need from services. The first one they described as safety and that includes confidentiality as part of safety. The first two quotes are actually from young men, as you can see, "If you are seen going in you are accused of being strange and having problems. You get abused, the rumour is going round". The last three are from the focus group of the young women, "Wherever you go (and this is a small rural place in Northumberland), wherever you go in this place you're bound to bump into someone you know", and that's particularly true for us in rural community but I would argue that actually in some urban communities there are pockets where young people have the same experience, that in your particular estate everybody knows everybody. Confidentiality has got to be 100%. And confidentiality is the whole point of going because you know it's confidential and it can't go into other parts of your life. That was the big fear of the young people we were speaking with that they worry that they go somewhere and it would then spread to their friends, spread to the school, spread to home and they really wanted to be able to separate and say it will not go any further. The other three major things will be: the young people wanted information. They wanted clear information about services, about the young people's services, but also about other services so that they could then make their own choice about where they

wanted to go for the problems that they identified. But also clear information about what is confidentiality, what are the limits of confidentiality and that should be not only be just talked about verbally but a clear confidentiality statement should be up and visible in every health venue.

They wanted to sense a choice and control and that means choice in who they are going to see but also choice about how the service is delivered. And throughout the process of accessing the service that they continue to feel in control, that they do not feel swept along and out of control. And lastly respect. And here are some quotes about what kind of respect they want, I like the third one that “the professional should be able to have a laugh but not laugh at you” so that’s a very nice description.

So, now on to some practical details about how to go about setting up the young people’s health sessions. Just to give you a flavour of the experience I am talking from over the last two years we’ve established now 10 young people’s health sessions around the rural county of Northumberland and it’s been actually over 5000 visits of young people to these health sessions just over the last year. I am delighted to say half, 51% are male and that was a key achievement moving away from the old sexual health model where it was girls going in for sexual health, it’s very broad, young men are very welcome, it seems to work well. The style is very different from the traditional health settings, and it is shown by the fact that more than 70% consult with friends, we are not talking about one young person going in and seeing the doctor, we are talking usually about pairs of girls coming in to support and having a peer consultation and usually groups of boys, three, four, five, six boys coming in together for support. And that I think is very good for young people, it can be quite threatening for health professionals and we are training around that.

The kind of thing that’s coming up about sexual health is important particularly condoms. So you can see a quarter about physical and emotional health concerns. The age distribution of the young people attending, so model age being 14, we have a high school system in Northumberland, young people aged 13 to 18 and these sessions by request of young people were set very close to high schools, so I am sure that’s why we have distribution that we have.

OK, so the key message that underpinned all our work firstly we have to be accessible to all young people but acknowledge that young people are not the same, they are not a homogenous species, they are all different. We need to involve the young people throughout the process and again quote, young people saying, “the project has to value young people and not exploit them.” That young people themselves have busy lives and there has to be enough in it for them. And then we need to support their involvement, it’s not necessarily easy involving the young people, we have to work at it and I believe that young people deserve payment for their involvement. Young people were very involved in designing our publicity and making it accessible for them particularly developing little cards that had to be white, if they are brightly coloured card then people they reckon would know what it was all about, it has to be a white and discrete card but very much a credit card that flipped into your pocket. And we have a system of on-going audits, so the young people actually come round the centre and do their audit of the centre and feed back to the staff.

So practical things if people are wanting to set up such sessions. Firstly is to consult with young people before you set up a service. I think a lot of us as health professionals have a wonderful idea and want to do something and we whiz away and set something up with our enthusiasm and we forget that we actually need to ask young people first, what do they want and then respond to that and really tie back our own professional enthusiasm. Out of our now 10 sessions none of them are in health venue, the young people that we work with say that what venue seems appropriate and all of them are in youth clubs or centres, one of them actually was actually chosen to be on school premises and it really wasn’t appropriate to have them in health venues. Timing - which day, what time of day a large proportion of young people bussed there from school, so it has to be a time when they can preserve their own confidentiality but access a session. And I’ve already mentioned about the advertising. In each place, it would have been very easy for me to have one questionnaire and use it in all the 10 centres, in fact what we did in each place we got the local young people design their own questionnaire, they delivered it and they did the evaluation. And that seem a very important part of the ownership.

I want to highlight the bit about advertising. We work quite hard to get young people to design their own posters and again not one

poster county-wide it's ten different posters for different sessions, ten different credit cards for what they thought the local need was. And I think that worked well. And you can see the vast majority of young people actually heard about the session through word of mouth and that's what young people trust, they trust what other young people say, that's place is OK to go to or it's not. And what's we've learnt is that good news travels really fast among young people, if it was a god service they'll go because they will tell their friends but also bad news travels fast, you just need one breach of confidentiality or one disrespect for worker and that goes round very quickly too. So we have to set really good standards and stick with it because bad news travels really fast as well.

OK, so next thing is key ingredients for success. All of the key things to do with atmosphere. And it has to be friendly, respectful ,welcoming, non-judgemental atmosphere, has to be relaxed, but also young people say they want a professional service, so we need to get that balance right between being relaxed but professionally trustworthy. We found that youth work involvement was absolutely essential, that health workers are not trained in how to provide a really young person friendly atmosphere, how to get that right. And also youth workers have that outreach facility of bringing in particularly marginalised perhaps young people who are excluded or out of school to bring them into the service. A sexual health doctor or nurse, as I said they need information but also services, all of our sessions have a full prescribing service in condoms, pills, emergency contraception and general health advise as well as other information. But the sexual health doctor doesn't need to be there for an hour even if you have quite a long session, you don't need to have a sexual doctor there all the time. We also have a generic health worker who usually has counselling skills. We found that, we developed a sessional document which I will talk about later on, because we found that there is a lot of professional anxiety about working in this kind of areas, particularly with young people of under 16 and to have very clear guidelines about where you stand and how you to go about doing things it's very important in reassuring professionals and also there 's a confidentiality statement that each team developed their own version of a clear confidentiality statement what the limits are and it's very clearly displayed. There is also rights and responsibilities for both workers and young people that displayed at each session.

I would also take a bit of time on what the issues for workers are. The multi-disciplinary team particularly including youth work does seem essential but what we learnt before the project was that without youth workers it tended not to work certainly in the long term. However, although it's essential it's challenging I think there is a different philosophy and a different training from youth workers compared to health workers and to try to bring those two cultures together can be challenging. And it particular brings up issues of power and authority and equality between health worker and youth workers and among health workers but also between adults and young people and this is one of the challenges that we had to work through to make the multi-disciplinary team work well in the long term.

There are feelings ambivalence about offering a full sexual health service to young people particularly young people under 16. And I think that sense of ambivalence must be acknowledged and also needs to be resolved and worked through. Particularly clear information has to be given about the legal framework and also about the information that we've heard a lot today about the availability of contraception and information does not increase sexual activity because it is a confident worry that some workers bring to their work. There is professional anxiety that we need to be aware of the feeling, am I doing the right thing, what will happen if. So the solution to those challenges. Firstly it is training that we did multi-disciplinary training very regularly over the two years, and that training yes, provided information, but also provided a space for worker to check things out with each other, particularly in this multi-disciplinary forum and to share their different approaches. Information was critical as we are dealing with a large rural county so circulated information to all the work of all the multi-disciplinary teams and this seems to be an important part of holding that sense of anxiety about working in a new setting. Protocols and guidelines I've mentioned, support happen both in the local teams but also on this county-wide network and finally we developed actually supervision whereby on a by monthly basis we have a group supervision which is externally facilitated and again level of professional anxiety is such that I think it is actually very important and should be considered.
So, finally Northumberland Young People's Health Project has two publications, I've only touched upon a bit of our work today. The first one is our final report. Tomorrow Ann McNulty and some of the young people will be here to present it at "Meet Professor

Lunch", I think is what they are doing, they are not professors neither am I but they will have more copies of this final report which has more details in, it is also available from us if you don't get a chance to get one tomorrow. The other thing we developed is much more practically based sessional document which is kind if you like the bread and butter of what protocols and guidelines we found useful in assisting worker teams to work in a supported fashion that's also available.

Chairman. Thank you Gillian Turner, it's very good and thank you all for covering all these complex and exciting programmes that have been initiated in many places. Thank you very much.

Keynote Lecture Chaired by Diana Birch

Protecting Youth from Harm - Lessons Learned from Adolescent Health.

Robert Blum

DB - I would like to introduce a good friend of mine who has is somebody who I have admired for a long time. And I am sorry if I sound repetitious because I said this about a number of people today but it is the truth. Bob Blum is one of the people who I discovered when I was doing my first study on teenage pregnancy back in the 80s. I was reading these papers which I was just managing to get from America, it was quite difficult to get papers from America in those days, and this name kept cropping up, kept cropping up and when I first went to a meeting in America I saw him in the flesh I thought, wow, that's Bob Blum, you know, so I am really proud that he is actually able to come to one of our meetings today. Bob is Professor in Adolescent Medicine from Minneapolis and he has done a lot of work particularly on data bases about young people, I think in Minneapolis they seem to have the largest data base in the world I think on school kids, and he's done a lot of work on risk-taking behaviours and this sort of thing in young people and over the last few years particularly he's done a lot of international work and looking at global trends in adolescent health. So I very much welcome Bob Blum.

Robert Blum

Diana, thank you very much, and it certainly is a great treat, a great honour, a great pleasure for me to be here, certainly seeing many friends and colleagues from throughout Europe, the States, around the world and a particular honour for me to be part of not just this conference but a celebration and acknowledgement of the work that Diana you have done and the work that Youth Support has done, it has been a pretty loud and a pretty consistent voice on behalf of young people, congratulations to you, it's a pleasure for me to be here.

ADD Health - The title probably means little to most. ADD health is the study that's being undertaken in the United States. It is the largest single study ever undertaken in the United States and I've had the opportunity over the last four plus years now to be one of

co-investigators on that project. I'll tell you about some of the things that we have learned. But I want to first put that discussion in a context of what is happening with young people 12 years up and in fact around the world. Because we have an understanding of trends, we have an understanding of morbidity and mortality, we have an understanding of risk factors and we are increasingly developing an understanding of protective factors.

What are some of the demographic trends, what are some of the things that we are seeing? Today 30% of the world's population are between the ages of 10 and 24 years. In fact the majority of those young people are in developing countries, 83.5% are in mostly countries South of the equator. In the number of countries in sub-Saharan Africa there are 5 times the number of people who are under 15 than there are people over 55. Think about it, in a country like Kenya half of the population of Kenya is 15 years of age or younger. In many developing countries they make up 20 to 25% of population and compare that to France - 13%, Japan - 11%, China - 16%, so we have a skew in young people, and a skew in the developing world. Much of the developing issues of adolescents have come under the screen as a function of child survival. We've come to see dramatic improvement in infant survival rates. And so we now have a larger cohort of adolescents for example in sub-Saharan Africa and parts of India, parts of South East Asia than we have had before.

There are also a number of social trends that have a substantial impact around the world, one is migration between countries and that certainly has had an impact throughout Europe, very definitely seen in Northern Europe but the creation of a European community has allowed for much more heterogeneity than existed a generation ago. We see much more migration within countries and not only that - there's always been rural to urban migration but most of that migration historically has been men. Men who came from the countryside into the city, worked, sent money home and went home once a week, once a month, periodically. But now what we are seeing is more and more young women migrating from rural areas to urban centres. And we see it very dramatically throughout South America.

Around the world there is a tremendous increasing priority being given to education and while women still lag far behind men over the past generation the rise and increase in education of women

have far outstripped that of men in many developing countries. But what you have are young people that are now not in the fields, not in work settings but are being kept in school. You have a whole cascade of events that begin to happen when that starts to happen. You have a shift in the age of marriage because schooling becomes more of a priority and it's difficult to marry at the age of 11 or 12. Historically early, high infant mortality, high pregnancy rates were a common and often repeated pattern. But now what we are seeing is with the delay in age of marriage and that is occurring across the developing world and the industrialised world as well we are seeing a tremendous rise in the out of wedlock births.

And we have also a portrait in industrialised countries and developing countries alike, where ethnic minorities are disadvantaged, whether it is, the Laps of Scandinavia, the natives of Canada and the United States, or South America, or whether it is ethnic minorities in other countries, the history is told over and over again. Well, there are some of the social trends, some of the mortality trends that we've seen, some good news. Mortality in the second decade of life is many countries of the world has begun to decline. We see in the last decade 1980-1990 a 13% decline in the United States, 3.5% in Latin America, but 7.5% in France.

What we're also seeing is that a number of the trends are beginning to correlate from across the countries from across the world. For example, we see a reduction in juvenile motor-vehicle deaths, we see that over the last decade throughout all of Europe, all of North America. So we are seeing this decline in juvenile vehicular deaths. What we're also seeing is that in many countries of the world a rise in violence related deaths, from homicide, from war, from suicide are all continuing to increase. And clearly it's disproportionately male.

So when we look at suicide rates for example, 1970 - 1986 you see for almost every country of the world suicide rates have increased and increased dramatically, it's true in Britain, it's true throughout Europe, the exceptions are probably no longer the exception, Western Germany was an exception. But since unification that trend has reversed. Venezuela had a decline in juvenile suicide but since Venezuela has gone into an economic tail-spin over the last decade that trend has reversed. What we're seeing in this is I think a pretty significant measure of social unrest.

Maternal mortality presents a leading cause in many developing countries. About half of all maternal deaths are due to abortion complications. Abortion complications and septic deaths occur only in the countries where abortions are performed in clandestine manner. A second cause for maternal mortality is cephalopelvic disproportion, haemorrhage, toxaemia and sepsis all are associated with maternal deaths. What we're seeing throughout part of Africa associated with maternal mortality is ritual genital mutilation and increasingly we are seeing this in the United States and I would imagine in Europe as well as population from Ethiopia, from Somalia and from other African countries where RGM is practised these folks migrate to Europe to Canada and the States we're seeing now the issues that we never historically had to deal with. And in Eastern Europe high rates of deaths from abortion complications.

Violence and homicide are increasing concerns. Certainly in the United States of epidemic proportion and our rates when they have begun to decline still are in excess of all of the 25 industrialised countries of Europe. In Columbia homicide rates account for 28% of juvenile male deaths, Jamaica is increasingly concerned about gangs and gang violence and gang-related deaths, in the new independent states of the Former Soviet Union homicide accounts have risen 850% - 850% excess mortality. And I remember distinctly when people used to say that homicide was a distinctly American phenomenon. It no longer is. It is a global issue and a global concern.

What are we seeing throughout the world for better or worse, and sometimes it's for better. The vehicular death trends for example, for better or worse we're seeing a convergence. with morbidity likewise. HIV sero-positivity 30% of all adults in Uganda, 1,000,000 people in Latin America are HIV sero-positive, half a million people in the United States.

Another trend that we're seeing that is paralleled around the world is earlier age of sexual debut. 40% of kids in El Salvador and in Brazil have had intercourse by the age of 15; 45% of males in Spain have had intercourse by the age of 15, 50% of all girls in Nigeria have intercourse by the age of 16; the trends and patterns are somewhat different, I mean certainly you can compare Britain and the United States and we see some real differences and

subtle differences, in male/female ratios in the age of first intercourse, but overall the trends are very very parallel and they are moving in the same direction with earlier age of sexual debut.

What we're also seeing concurrent with that is another phenomenon that is just parallel around the world and that is the rise in out of wedlock births. In the United States between 1965 and 1995 out of wedlock births increased from 10%, one out of 10, to 3 out 4, 75%. You could take the graph of increase of out of wedlock births for the United States and take the graph of rise of out of wedlock births for Chile and put them one on top of the other and they would look identical. In 1970 10% of kids in Chile who gave birth were out of wedlock today it's 75%, identical to what we're seeing in the United States. As we have heard Tony Blair's offices now said that teen pregnancy and out of wedlock births are a major issue for England and here the rates are double that of other countries in Europe.

Throughout the industrialised world over the past decade we have seen a decline in abortion, a clandestine abortion throughout Africa, throughout Latin America, I don't know as well the data for Asia, but in those 2 continents clandestine abortions are rising and rising dramatically. 2 million abortions are estimated to occur in Latin America annually and for those who are interested in about 6 weeks the Allen Gutmacher Institute in New York will be publishing the chart book on world-wide abortion trends, it's the first chart book to come out in about 15 years at least, maybe 20 years. And it will document in detail those trends in abortion in countries where it is legal and in those where it is clandestine. In a 6 nation study of adolescents in East Africa between 18% 1 in 6 and 1 in 3 girls knew someone who had had an abortion. Abortion is common, not surprisingly if your option at school is your out to success if you've a delay in marriage and if you get pregnant you are left with few options and it isn't surprising that even given the risks kids would opt for abortion.

Alcohol use rates continue to rise among youth. In Latin America use has increased 400% in the past 25 years, juvenile alcoholism is a major issue in a number of countries. I see that we have here some of our colleague from Australia, 47% of 11th graders in Australia drink at least weekly. Heavy drinking in the United States has steadily declined over the past 4 years but other drug use, marihuana and cigarette-smoking has increased.

Tobacco persist as a major health problem. Not only that but tobacco industry has been targeting, specifically targeting South East Asia, Africa and Latin America where as income increases the sale of cigarettes goes up. You know, it's very interesting, I'll be talking in just a moment about the ADD health data in the United States. One of the things that we have seen in the United States, US data however, is that as income goes up overall, take the whole US population of adolescents, as income goes up, cigarette smoking goes down. But we have segregated that, broke it out for ethnic minorities, for kids of Hispanic origin and African-American teenagers and what we started to see was that as for those populations as income goes up, cigarette smoking goes up. And putting in an international content it sort of dawned on me the other day you know, it is the same phenomenon, you get this rise in cigarette smoking with new wealth, you get rise in drug use, and that's well what we're seeing certainly in Latin America, until you begin sometime down the road to see a decline. 43% of 18-year-olds in France are regular smokers. 28% in Chile. China is the largest producer of tobacco.

So these are some of the trends, these are the context then, that I'd like to talk about some of the things that we've come to understand that protect young people from harm. And I am going to talk about it using US data, because that's what I have. But I have a strong sense knowing what I do about adolescent health studies in other countries that many of the same factors that are protective in one context are protective in another. Let me tell you first of all a little bit about this study. It was undertaken with the team which was based at a centre for population studies at the University of North Carolina Richard Eugene is the principal investigator, we have collaborators in up state New York which is over there on your right, University of Arizona, Batel, which is a large private research group. In Seattle, Washington, University of Minnesota, and NORC, which is National Opinion Research Centre who actually undertook the study, carried out the logistics of the study. It was a very complicated and a very sophisticated study that started with an in-school sample. And what we did, we identified 80 high schools around the United States, and the high school was defined as any school that had an 11th grade and had at least 30 students, OK. From those 80 school we then identified the feeder school, the middle school, the junior high school that fed into these schools. So we now had diode, a pair of schools, but

in fact not every high school has a junior high or middle school, so what we wound up with is a 139 schools that were heart of our original sample and in fact what that represented was about 85%. We went into the schools and we surveyed all the kids who were in the school on that given day. That accounted for over 90,000 teenagers. A whole lot of kids, 90 thousand. We also surveyed a school administrator, like a head-master or principal of the school, so we had a 139 of them and there's 90 thousand kids. We then got the school roster, the list of everyone registered in the school, because we know that anyone at risk for anything bad, you can name it, is less likely to be in school on a given day. So we wanted to make sure we included those kids as well. So from that 90 thousand plus this other roster we identified a core sample. A core sample we invited about 15,250 kids to participate in the in-home phase of this study. Of those about 12 thousand agreed, so that's about 80% agreed. Of the kids who agreed to an in-home interview which was an hour and a half in-home interview - of those 86% had a parent who agreed, almost all of the parents who agreed were mums, probably not real surprising. So we have parent data and teen data.

We also - and I am not going to be talking about it have a number of fascinating special samples, we in two communities in the United States we went in and interviewed everyone, everyone in the whole community, we know the entire community network from everything, from who lives next to whom to who sleeps with whom. We have a sub-population of higher educated higher income African-American kids because one of the things we tend to do in the United States very problematically is use race as a proxy measure for income, we talk about whites this and blacks this as if it were something to do with colour of one's skin. So we had the ability to desegregate that. We had 800 sets of twins in that study for genetics, We have a disability sub-sample, we have a Cuban sub-sample, we have a Philippino sub-sample, we have many sub-samples that are unique in this group. But what I'll be talking about is based on the core sub-sample or the core sample. And the core sample is a representative sample of all kids in the United States. Just to give you a sense this is what the ethnic breakdown is of that sample.

One of the things that we looked at. What I'll be talking about is 8 risk behaviours. And the factors associated with increasing risk and the factors associated with demising risks for these 8

behaviours emotional distress, suicidal thoughts and attempt, cigarette use, alcohol use, marihuana use. Violence involvement, age of sexual debut or first intercourse and pregnancy. These are the 8 outcomes, what is often talked about as risk behaviours. Then we were interested in what are the things that are associated with protection. Well, we looked at family factors. Family factors such as connectedness, the relationship young people have with a parent, parent presence in the home, we looked at 4 times of the days, on waking, in the afternoon, dinner time and bed time. Activities with parents, going, kicking around the football, going shopping, taking a walk, watching television, things of that nature. Parental expectations for school, completing school, higher education, doing well at school. We looked at families suicide attempts, we looked at families, we looked at family income, family structure, like one- parent and two-parents families, things of that nature.

We looked at a whole set of school factors asking what is it about schools that make a difference in the lives of young people. We again looked at connectedness, and I'll come back and talk about it more specifically in a moment, we looked at grades, we looked at how many kids are held back and what's the impact of being held back in school, not passed on the next year is, we looked at teacher characteristics, such as whether they are male or female, whether they got higher education degrees. We looked at the rules schools have, what are the rules about drinking, what are the rules about pregnancy, what are the rules about sexual behaviour. I don't know if in Britain and in Europe there is the same fetish that many institutions in the United States have, but there is sort of this notion that there ought to be a rule in that somehow a rule will have a significant impact on behaviour. And we looked at parent involvement in school.

We also looked at the whole set of individual factors: self-esteem, maturational dis-synchrony, being early mature or being late mature, being out of synch with your peers. We looked at employment, being paid for work, we looked at sexual orientation, school performance and learning problems, gender, ethnicity age and a gazillion other variables as well.

What are some of the key findings? Well, turning first to family, what are the things in family that mater. In the United States recently there has been much press given to a book written by an

individual called “The Nurturence Assumptions” that claims “parents don’t matter”. All parents provide are genetic makeup and a roof. I would strongly suggest that is not true. What we saw is that for every single risk behaviour that we looked at independently kids who felt connected to their parents, they felt that they had a relationship with their parents, were much less likely to participate. They smoked less, they had later age of sexual debut, they attempted suicide less, they drank alcohol less, they did every negative behaviour less. That’s connectedness. And that connectedness was not predicated on whether the parent did something with their kids, whether they took them places, did activities with them and in fact what we found is that it didn’t matter.

In fact for emotional distress what we found is that for all the connected teenagers decreased levels of emotional distress. Now adults had a hard time understanding why that trend might be true but kids had no problem at all. We actually went out then and had focus groups with young people and said, what does that mean, how do you know when you are connected. And the examples we heard were wonderful. You know, my dad does not say, who was that guy you were out with on Saturday night?, he says, You went out with jimmy on Saturday night, you had a good time? He knows who I went out with. My mum says, how did you do on that test last Thursday, the math test you had, I’ve been wondering about it. There is a note on the refrigerator, I am going to be home late but made a snack for you. The neighbour stops over to check in on me because my mum does not get in until 5.30 or so. My mum calls during work after I get home just to make sure I am at home and to see how my day was, we always have dinner together. These are endless examples that aren’t predicated on physically being present all the time. But there is this sense that the parent is watching and the parent cares. And I will tell you it is more powerful in reducing risk than anything. And it does not diminish for all the teenagers. It in fact is no less for 16-17 years olds than it is for 13-14 year-olds.

We looked at availability as I said at key times during the day and while being present more is better than being present less there is no preferred time of day. And this is particularly important I think again perhaps uniquely in the States, but I don’t think so, for working women, where there is this sense of guilt that I am not home until 5.30 6 o’clock, being home after school was no more

sacred than being home in the morning or dinner time and the evening, and in fact some data coming out of more recent analysis is suggesting if there is one time of the day that perhaps somewhat more protective it's around dinner time.

Parent expectations for school is profoundly protective. Parents who expect kids to complete school and give them that message day in and day out, these kids smoke cigarettes less, you want a teen pregnancy prevention programme - there it is, in school expectations, and violence prevention, these kids are involved in violence less and they understand their parents expectations around school.

Parents expectations about sexual behaviour. If a kid believes that her or his parents think that for them to have sex now at this age is wrong they are less likely to have intercourse. Now what we have also looked at recently because as I said we have a capacity to look at parent data, OK, and to look at kid data, so an interesting question to know what a parent is saying they say and what a kid is saying they say and what's the inter-correlation between the two. Well, the inter-correlation between the two is pretty low it's about point .15%. Now one of the things that is really interesting is I think is that mums are pretty smart. My mother told me that but you know she did not have the data to substantiate this so I didn't really ever much believe it. But it's true. The degree of accuracy that mothers have about their kids sexual behaviour is awesome. With more than 90% accuracy, and this is independent of what I as a mother believe. I may be absolutely a fundamentalist who believes that you don't have an intercourse before the age of 80, I maybe a social liberal, my personal beliefs I will tell you do not significantly affect my eyesight when it comes to seeing what's going on with my kids. But on the other hand there is a big gap between what parents say they say and what kids hear, a big gap. And it says to me I think in a ways some very important and some very fundamental questions about communications. And it raises some very fundamental questions I think about direct versus indirect messages in both parent-child communication and in health education, hopefully we can talk more about it a little bit later.

We also found that in households where there is tobacco whether or not a parent smokes the risks of smoking go up dramatically. In households where kids have access to alcohol they drink more.

Now I have had this conversation with some of my friends and colleagues who are from France and from Switzerland and other places, drinking clearly in a country like the United States in adolescents has some very different implications when you are a driving age of 15 or 16 where in the countries where you have a driving age of 18 in where you ride cars instead of walk. On the other hand there is strong evidence from what we are seeing that kids who are exposed to alcohol early learn to drink. They don't become responsible drinkers they become drinkers. Much the same way as people who are exposed to guns early don't become responsible gun users, they become gun users. Not only that, kids who are exposed to guns earlier have higher suicide attempt as well as higher violence perpetration. So exposure to these substances predisposes to risks.

The school environment counts. But actually only one thing did we find that was really protective and that was connectedness. That was the connectedness that a young person feels with the school. And that connectedness did not depend on how many kids there were in the school, it didn't depend on the truancy rate, it didn't depend on how many teachers had higher education degrees or how many parents were involved the school. And it didn't depend on how well you did in the school. School connectedness is not another measure of your grades, in fact the inter-relationship is not tremendous. What it is, it is a set of two things: one is that there is at least one adult in that environment who cares. And two is that I am treated fairly in school. And kids have an abiding sense of what it means to be treated fairly.

And then we looked at individual characteristics and what we found was working more than 20 hours per week was associated with every negative risk behaviour we looked at. Kids who work for pay more than 20 hours a week were more involved with alcohol, with cigarettes, had an earlier onset of intercourse, every behaviour. We found that kids who are doing poorly at school, who have attention problems on school, we found that kids who are held back in school and young people who are physically out of synch, early and late matures are all at much much higher risk for negative outcomes. Based on all that we have seen in these data as well as other data would suggest that at least in the US context school failure is a major public health problem. Kids who are doing poorly in school pay a high price not just economically in their

ability to get work later on but a high price now in their health behaviours as we pay that price as well.

The things that seem to have little impact: school rules. School rules don't make a difference, We looked at school rules in every way, shape and form and we can't find a school rule that significantly impacts behaviour.

What parents say they say to their teens about sex does not seem to make a difference and that's what I was talking about before, that gap between messages that get through to kids and messages that go through one ear and out of the other. And I have a sense that one of the necessary preconditions for a message to be heard that there is this connectedness. Because without that connectedness it's not going to happen. It's not going to be heard.

The type of school attended, we've had all sorts of types of schools that don't seem to make a difference.

Well. We have I think some clues as to factors that protect young people from harm. Certainly we have a decade probably a generation now of prevention research to know full well that that is a myth. There are many things that work and many things that we can do. But the reality is also when you look over the landscape of prevention programmes mostly what you see are failures. When there have been rigorous analysis of pregnancy prevention programmes in the United States I would say generously there are ten effective programmes. When you look at drug abuse programmes probably less than 10. Violence prevention programmes there are few that work and a few very dramatic programmes that work. But there are large numbers of programmes where we have invested millions of dollars that don't work. Why? Some fail because they have no theoretical foundation. I can't recall who said it, but a phrase that I really like, that there is nothing more practical than a good theory. If you run a programme without a theoretical foundation the likelihood that it's successful is low. Two is that many programme don't build on the research that's been done. Not only they are atheoretical, they don't have a research base. Three, we often don't evaluate in any rigorous kind of way what we do. A professor of mine once said that most evaluation is based on wing flaps per pound of bird seed. You know, you have your pound of bird seed and you count how many wing flaps occur before the bird seed was eaten. Well,

we often do the same. We count how many people come into our service and use them , how many left-handed kids, right-handed kids, kids that came from that area, but do we ask, does this really matter? Programmes that don't succeed are often unidimensional. They focus on one thing, they don't focus on the broad set of complexities, that really are what's so important. And they tend to focus on problem reduction, doing away with reducing cigarette-smoking, doing away with reducing pregnancy, you name it, you can slot it in. But most kids like most adults don't want to be fixed, they want a thrive.

A colleague of mine Karen Pitman says, problem-free is not fully prepared, and I think that's so true, you know, no one has ever asked me, hey, Bob, how are your kids doing, I've never said, they are really doing great, you know. They haven't killed anyone this year, none of them are hooked on drugs, none pregnant, as far as I know they are sero-negative, so they are really doing great, you know, that's not what I want from kids, maybe that's what you want from yours, but that's not my goals, my goals go beyond that. Our goals have to go beyond that and effective programmes do go beyond that.

Effective programmes include parents and bring parents in because they realise that the effect of role of families do not diminish over time. They strengthen educational involvement, because they understand that kids' success in school is tied not only to their future but tied to their presence, these programmes understand that you have to create opportunities. Christine Lucar a contracepting researcher from Berkley, California, talks about contraceptive use is like money in the bank: you have to be worth investing it, if you have no future, you have no economic opportunities, you don't put money in the bank and you are not going to contracept. And effective programmes understand that it's not just dealing with problems, but it's enhancing young people where their effort needs to lie. Effective programmes understand they need to create conditions for social bonding. They need to create opportunities to bring young people in and to give them meaningful roles, not just as people to be fixed and worked upon, but as team players and collaborators.

The young people need skills to be successful, we saw such a wonderful demonstration today over the lunch hour from a group of young people from Israel, youth actors, who are crafting what they

are teaching, have the skills to do it and huge recognition and reward for a job well done. It's this combination that leads to success. We know a lot about what makes programmes work, we know a lot about what's put young people at risk, we know a lot now about the things that protect young people form harm. For us the task is to put it together. Thank you very much.

Diana B.: Thank you very much, that was a really wonderful presentation, you've covered so much ground. And as you said we have a lot of knowledge now about what young people are doing, and the problems and perhaps what families are doing wrong, and maybe as you say we now we need to go on and put it together and actually make something of it .Would anybody like to ask some questions, we've got just a couple of minutes.

Question - How do we address the question of motivation in teachers?

Robert Blum: Did everyone hear the frustration, did you hear the details as well? Let me address, I could share your frustration, but I will tell you why I don't. I don't because the World Bank for example has said you keep a young girl in school till the 7th grade, no matter how terrible that school, no matter how terrible the teachers, no matter how much maltreatment goes on in the school. And her outcomes are much better. Simple keeping kids in school, are better schools better? - Yes, are more motivated teachers better - yes, but the mere fact that the kid is at school does make a difference. One.

Two is yes, families are sometimes falling apart and families are reforming and redesigning, you know in the United States in 1955 2/3 of all families were an idealised family of 2 parents and 2 children. Today in the United States 7% fit that profile, only 7%, OK! So. We have numerous kinds of families, the premise that I would work on is two-fold: one no matter what else is happening most parents want parent want good things for their kids. They maybe have 2 pesos per that they make, but they want good things for their kids. They may have not a clue how to get it. And two is when most kids don't want to be fixed most parents work very hard, whether they in the street pan-handling or whether they work in a factory, they work very hard. So they not going come to learn things at the end of the day, they are just too tired. But what experience certainly is showing in numerous places is that parents

will come to celebrate what their kids do. And programmes that bring parents in not to work on them, not to fix them, but to bring them in to celebrate what their kids do, parents do come, and there examples not just from the States but from all over. It isn't en easy process, admittedly it's a very challenging process, but my starting point is parents they want good things for their kids so we starting at the same point. They might not have a clue how to get there and what they might think is a good thing and what you might think is a good thing might be different. And we might have to sit and really negotiate it and give up some of our things.

The other thing is and it is very tough, is that we have to be able and willing to de-professionalise, to off our jackets, to take off our fancy clothes, to roll up our sleeves and to really work. Woman who's done some great work in the United States Elizabeth Shore says, you know, she tell a terrific story of a social worker and comes and knocks at the door at this woman's house and she said, "Who are you?", and she said I am so and so, I am a social worker, - "I don't need another social worker, all I have is my life is filled with social workers, I don't need a social worker, get out, what I need is someone who'd scrub my kitchen." She said, "OK, let's start at the kitchen." She went in and scrubbed the kitchen, and when she was done she said, "Do we go to the living room or do we go to the bedroom, what do we scrub next?" And when they were done scrubbing all the floors, she said, "Can we talk now?" That's de-professionalising, that's willing to be where people are at. You've got to be willing to be where kids are at.

Reception - Exhibit and talk by Lancelot Bryan - Jamaica followed by -

Youth in a Multicultural Society

Pamela McNeil
Women's Centre of Jamaica Foundation

Norman Manley, brilliant lawyer statesman and a beloved National Hero of Jamaica said of his countrymen "I affirm of Jamaica that we are great people. Out of the past of fire and suffering and neglect, the human spirit has survived - patient and strong, quick to anger, quick to forgive, lusty and vigorous, but with deep reserves of loyalty and love and a deep capacity for steadiness under stress and for joy in all things that make life good and blessed".

Throughout our history as Jamaicans we have seen those strengths of our people displayed in the fields of medicine, law, sports and athletics, labour and politics. As a people who respect their past we have never looked down on our ancestors -we realise that they too, ran the gamut of human experience and that their experience is just as valid as our own in to-days world.

What of our history? - what makes our young people so strong and vibrant, energetic but with a deep capacity for patience under stress and a determination to be the best at any cost. Their heritage is multicultural and is, indeed, all these varied ancestral strengths which combine to produce such vibrant youth both of Jamaica and of the Caribbean.

When the English carne to Jamaica they found the descendants of Africans whose forbears were established in Jamaica many years ago. If follows that there are distinct traces of the English, Scottish and Irish influences in our culture, but by far the greatest legacy has come from our African ancestors. The early Jamaicans refused to accept the status of slavery and were constantly seeking for freedom and justice. Hence the many slave uprisings and rebellions which are part of our history.

The Scottish and Irish settlers who came after fleeing from oppression in their native lands only served to strengthen the movement. East Indians who came as indentured labourers and the Chinese who became the small shop keepers all these have contributed to our cultural mix.

The legacy of the English can be seen in our system of parliamentary democracy. Also in the language which we share with many different races of people who were part of the British Empire and that body of literature which is one of the finest in the world. We inherited the tradition of freedom and justice for all the people and the preservation of the humblest of citizens from oppression. All this was melded into the traditions which were already here before the English came.

Unfortunately the Colonial experience was in direct opposition to these liberal ideas. The colonies in the West Indies were organised with the large sugar plantations as the base around which all other factors had to be accommodated. Consequently large numbers of Africans were uprooted from their homelands and brought over to the West Indies to labour as slaves on the sugar plantations.

The descendants of the Africans who were brought to Jamaica have been responsible for the development of our unique national culture. In drama and music with the strong accent on rhythm, our love of story telling which displayed our penchant for wit and laughter. The use of language which culminated in the creation of our own colourful patois. The establishment of religious cults which had their roots in various religions from Africa. The tradition of the Sunday markets and the higglers. All these are evidence of the strong African roots which have come down to us.

Although the trauma of being captured and sold into slavery by men of his own race, and the horrors endured on the slave ships during the journey called the middle passage was bad enough, the worst suffering of slavery was, surely, the psychological effect of the loss of identity as a human being. To be bought as a piece of property to work at unfamiliar tasks supervised by men of a different race speaking a different language all this conspired to rob the slave of any sense of personality or dignity.The breaking of the ties to his community and his ancestors and his history was the severest deprivation of all.

In order. to serve the interests of the sugar plantation all spiritual values and attitudes were suppressed. The establishment of permanent unions between men and women was forbidden. Men were used as studs to impregnate the women who were valued as the breeders of future slaves. There was no family life centred

around the "family" unit and the intra tribal discipline which was an important feature of life in Africa was destroyed The young girls born on the plantation were available to the plantation owner for the satisfaction of his sexual appetites when they reached puberty.

No wonder that successive generations produced people who rejected the idea of slavery and the doctrine of white supremacy. From the start the history of the Jamaica people is one of stubborn defiance of oppression.

This love of justice and freedom colours the lives of our young and unless fully understood by the societies in which they now live could result in their attitudes towards that society being completely misunderstood. Believe me, they cannot conform to injustice, racial inequality in any form - they will never be just a “part of the system" if that system is perceived by them as unjust.

In Jamaica, although the power-brokers of colonialism actively encouraged the promotion of a white elite in trade, banking, commerce and the civil service a paradox of the times immediately preceding independence from say, the 1940s, was the election by the people of Jamaica of representatives, who were the embodiment of a multi-racial society. How well did Norman Manley perceive the inherent good sense of the ordinary Jamaican!

Since Independence in 1962 the appearance of the Jamaican society has changed considerably - the change was achieved calmly, undramatically and without any perceived trauma. Instead of a reflection of the white colonial masters, the face of trade, commerce, banking and education has become more reflective of the racial qualities of the majority of the Jamaica people. Throughout, however, is the same multi-racial mix as seen in earlier parliamentarians elected by the people of Jamaica.

There has never been, nor is there now, any serious racial biases in our Jamaican society. Provided that one is prepared to study hard, work hard and achieve, any Jamaica from any social group of any colour or racial mix can reach his/her zenith in a chosen field.

Of course the most vulnerable in our society, the poor will always need additional help to upgrade their own status, and that of their children. But good programmes are in place in both the Public and

Private sectors and in the NCO community to assist. Adequate funding continues however, to be a problem in this area especially in those programmes which focus specifically on young people.

Whatever the problems, Jamaica and most of the Caribbean territories with one or two minor exceptions, present an excellent example of racial harmony and intermix. For those of us who have witnessed racial bias sometimes on the grand scale in the so-called developed societies, the Caribbean truly presents an idyllic picture of racial bliss.

As an important digression let me say that migration to the metropolitan societies has occurred in the main for economic and to a lesser extent educational reasons. In the case of the UK we would like to note here that when one considers the wealth built up in England from the proceeds of the sugar trade in the West Indies that the amount returned, in services and/or education to the small migrant Caribbean - extract society is truly insignificant.

The people from Jamaica and the Caribbean including the youth who have found a place in societies of developed nations whether by their own or as a result of their parents migration have racial equality and justice as an integral part of their history and background. They then should never be subjected to these derogatory terms such as "Ethnic minority". By their racial, commercial, constitutional and political background they are as British as children whose ancestors have populated this island for centuries. They and through them, their ancestors have paid their dues to this society and must be accorded all the rights of a true citizen of this realm. Only then will our Caribbean youth in this society be able to exhibit their inherent creativity, energy, idealism to the full. For, when exposed to a positive caring, protective environment our Caribbean youth achieve wonders. No other nation of a comparable size to Jamaica has produced so many professionals of outstanding ability in the fields of medicine, law, education, politics and sport.

History must be our learning tool or we may well fall prey to another degrading slavery - that of being mere children of our own age.

Day Two - Friday 23rd October 1998

Keynote Address - Chaired by Richard MacKenzie

Richard MacKenzie Good morning. I hope most of you are refreshed after checking-in yesterday's challenges and new knowledge and review of old knowledge. I think coming from Los Angeles I am always refreshed to spend time with Diana and her group here in London because I am often reminded of the basic concept that we as individuals working with young people have to always to remind ourselves of. First of all yesterday we were reminded that problems are really potential for change: when a system is in balance it is very difficult to change that system. It's very difficult for a lot of us to make changes in our life because we are set in our ways so to speak. And adolescents go through this whole series of so-called problems, what we call problems, but they provide us a potential for change and this was repeated again and again yesterday in the various presentations.

We are also reminded that what we often see as a resistance in working with young people maybe part of their resilience, the ability to carry on under very adverse conditions. The ability to survive under conditions that perhaps you and I would succumb. We are also reminded that in what we think of adolescents from the disease model, you know it's very much a position that other medical practitioners think of adolescents, that we must modify that disease model, put a hyphen between the "s" and the "e", it's not really a disease, it's really a dis – ease. And I am confident in that feeling, that they are feeling as they go through the changes of their transition from children to young adults.

We were reminded by Bob later in the day that you know we've got to look at adolescents, the youth from the point of view of their strengths and not their deficiencies. It's like the more you pay attention to the more it's going to grow. The more you pay attention to their deficiencies, and they seem to exaggerate their deficiencies before your very eyes. If you look at their strengths – that's what seems to grow within them. And if you don't believe that just try it on the next young person you see, pick up on something that is strong within them, something that you recognising as helping them to deal with their lives and you'll see how they will grow, they will stand proud, they'll try and exaggerate that for you so they become a better person.

We are also reminded that youth within themselves are a resource. We saw several examples of that with Daniel Hardoff and John Rees's group and we forget that because we tend to see youth as being needy, being somebody that we have to give to something rather than seeing how much they can give back to their own youth and to the adult culture itself.

One of the thing I keep reminding myself and as Bob yesterday says, you know, there is nothing more practical than a good theory. And one of the concepts that I have about youth and when I was up here two years ago providing a keynote I reiterated that concept and I'd just like to re-offer it to you as a way to sort from a lot of the information that you'll hearing today and that you've heard yesterday. You know, Jean Jacques Rousseau once said, that we are born twice over: we are born once into existence and once into life. And that birth into existence is that existence that we all know. You know that baby being born from the mother, the baby was not there, the baby is now there, the world is there for the baby. But then there is a birth into life. And that's adolescence. You exist and then you are born into life, you move beyond the boundaries that were protective of you and now you are exploring life itself and the social toxicities, and psychological challenges become the things that come to affect your very being not unlike the drug that maybe a mother may take when the baby is in the womb may affect that being. What we have around us begins to affect the being of the adolescent.

So as we move into our keynote address with looking at youth conserving our resource for the future it's really appropriate to challenge this second day with that concept. And to keep that sort of framework in the back of your mind as how I am being the obstetrician to the youth of the future, what role am I playing in facilitating that birth and making sure that the product of that birth is the best that I know how to help with.

Our speaker of course, our keynote speaker Diana Birch is not a stranger to anyone in this room. Diana's been instrumental in introducing the whole field of adolescent health to the UK, she has brought it down to the practical level by developing the Youth Support House in Beckenham. She has provided a colloquia for people like you and I to get together by having these conferences, she has provided literature for us to take away and she shares her

experience of working with youth and she has generally just been a spark for all us who come from both sides of the pond so to speak, those of us in the US to hear of what's going on in the UK and for those in the UK to constellate their energies for 2 days or sometimes to spend time with her in some of her programmes. I couldn't think of a better keynote speaker to start off this second day than Diana who has organised this conference, who has probably spoken with most of you in this room, who has interacted with probably some of the more difficult youth that I have seen in her programme, and who has thought a lot about where youth are going, so I will turn the podium over to Diana to address the issue of youth conserving our resource for the future.

Youth - Conserving our Resource For the Future

Diana Birch

Adolescence is traditionally regarded as a time of turbulence, a cocktail of mixed emotions, anxiety, excitement, pain, fear and joy - though as often as not the joy part is experienced as a retrospective emotion something not experienced until looking back and having gone through several adolescence's or life changes.

Do we as unfulfilled adults look back through rose-tinted glasses thinking 'it must have been good'? When I as a teen heard the old chestnut 'school days are the best days of your life', I thought that held little promise for the future. For some, the disadvantaged and abused, this carries no joy and this is a sadness for all of us, marking a sense of failure for us adults / professionals that we have not done more to bring happiness and joy into the lives of young people. - A wasted resource.

Adolescence is a relatively new concept, in many ways self indulgent, a luxury of the developed world that youth has a period of respite before entering the adult world, a period to adjust, to reflect, to learn, to study or perhaps a period in limbo, no-mans lands - not child or adult. As Judy Garland sang "I'm just an in-between". Does this period really exist or is a mythical creation of modern society? (Perhaps of those practising adolescent medicine specifically).

In many societies individuals move from the child to the adult world with no in-between stage, child to mother, daughter to wife, dependent child to worker. The same was true in the western world not long ago, girls changed their short socks to stockings and started work the day after they finished school at age 15. The cult of the teenagers began in the fifties with the advent of pop music, teen fashion, teen culture which was encouraged by commerce who revelled in the new young market.

So society began to exploit the teenager at first in a subtle, relatively innocuous way and then in more pernicious ways. A market for drugs, for sex, for all that's wrong with society. However, in truth adolescence has a dual concept - it is both a phase and a transition, but the phase as we have said is a time to learn - the luxury once afforded perhaps only to university students. But are we also creating an opportunity for risk taking, delinquency, teen pregnancy etc? There is a high morbidity and a mortality associated with this period in limbo, this phase of adolescence. The activities of fashions and cultures associated with higher and higher risks start creeping in to fill this void.

For example, recently one of the children attending our pet shop refuge 'P.J', was to indulge in one of these American import activities after our doors had closed one evening. He went tagging on a railway line and was electrocuted - another life cut short by senseless filling in of spare time. Let me tell you a little more about PJ - he was street wise - a mercurial kid - the little loveable rogue - either on the street or in the shop. He rode the trains - grabbing the back of a train and riding to the next station - he crossed the tracks for excitement - classic risk taking - his friend John did not speak for a week after it happened and then he poured it all out in a group session I held for the children after the funeral - 'I told him not to go - but he would never listen - I told him that when you hear a click the electricity is coming on strong and you have to run - he was walking behind Perry and we heard him say 'ouch' then we turned round and his body was jumping - then it stated to burn and his mobile phone went off - I was scared to answer it because of the current - but I could see the face said 'mum'." We could not bring ourselves to tell his mother that as she rang her son was dying on the track.

This sad event - rather than stop the kids tagging on the railway lines – has encouraged them to put up memorial tags - ORA RIP.

– At the funeral, they could not tear themselves away and physically held the coffin - I'll never feel the same about Eric Clapton's 'Tears in Heaven' which was played over and over again .... Our late night refuge / youth club is going to be called PJs - we have an appeal for that at the moment -

As a transition adolescence achieves more of a level of legitimacy, this is an adjustment and we need to look at the needs of anybody adjusting. There are no other periods of our life when we change so much, at no other times do we change more physically, physiologically, emotionally, mentally and within our roles. In many ways modern life has diminished the other changes, the other adolescence's in our lives. For instance, maybe the menopause male or female does not hold the fears that it once did, it is not linked with reproduction and with new understanding of hormone replacement therapy it is not linked with sexual activity either. Retirement is no longer the threshold phase it used to be, it is now a more of a prolonged phase. Marriage, divorce do not have the significance they had in the past, there are often many marriages and divorces so there are not so many big watersheds in life and for some the role changes in adolescence can all coincide. Who are we? - The pregnant school girl is an example par excellence where all transitions coincide, adulthood, motherhood etc. Interfering with the establishment of identity.

Of course the physical and physiological transition is of very great importance but I will mainly limit myself in this discussion to the emotional and physiological parts of the transition and change. I should not want to sound too depressing or have you going away with a negative image, but we have to look at the problems in order to find solutions. Denial is one of our biggest enemies, so is the very natural mutual patting on the back which can happen at big congresses like this one, but we have to bite the bullet and look the problems full in the face and if we are being honest we will see that the main problems for youths is adults, we create society, we run it, we perpetuate problems because it suits us because we earn money from them and we turn away and don't want to see them,

We talk in a blasé fashion that the universal panacea the "resilience" of youths, but basically you develop resilience by being knocked, resilience is in relation to the assaults and problems in life.

Roger Tonkin writes on his email, “lets create opportunity out of challenge”, this is good and I find it uplifting to see this on his messages - but perhaps we could try to remove some of the challenges. Of course, just as our bodies develops somatic strength from physical challenge, training, weight lifting etc. so our psyche develops emotional strength from learning to survive hurt and pain.
What we need to ask is:-
1. Is it desirable to be “emotionally strong” implying a certain coldness, distancing, blocking perhaps.
2. Is the learning process maladaptive. Each concept, the physical and emotional, can be taken to extremes.

Emotional development encompasses a basic necessity to learn tolerance of frustration, we can’t have everything we want. Mother can’t supply the milk to her infant instantaneously and satisfy the baby’s every whim, thus object relations are born. The good breast, the good mother fulfils the child’s needs, thus the good object. The bad breast, the bad mother frustrates the child and does not supply immediately, hence the bad object, an essential part of emotional physiological development.

However, in order to develop emotionally one does not need to take this to extremes, the child does not need to be abused, neglected or abandoned. It is when this happens that the response to abuse, the survival mechanism, coping strategy, the resilience if you like, can be maladapted - like Ellen speaking of her uncle’s abuse of her “I can take it, he can punch me as hard as he likes, I don’t feel it”. On her sexual abuse “I didn’t think it hurt me until I stopped to think about it, I thought it was normal, she called it just a game, it didn’t hurt me because I blanked it off”.

So looking again at preserving this valuable resource for the future, perhaps we could break it down into looking at early patterns, prevention of abuse, the early childhood with the long term consequences that it carries through into the adolescent phase and then into adulthood. And then at the additional assaults and stresses that we place upon these young people as they go through their adolescence.

Abuse of whatever type naturally produces harm in the present, hinders the development and carries a maladaptive pattern into

adulthood. The child who grows up secure in the relationship with a parent is not so vulnerable to subsequent abuse, the child learns how to deal with emotions by using this relationship with mother or a parent as a prototype for future relationships.

More primitive feelings, profound love, deep hate can not be held by the infant without the moderating effect of mothers reactions, the child projects his feelings onto the parent who mirrors them back in tolerable form. A child learns to love himself from the way he is loved by others, however, the child will also learn to hate him or herself by the way he is hated / abused by others. The child will feel bad about himself, will feel guilty that he cannot make mother happy and be ready to meet the reinforcement of other abusing situations. He may be unable to show his real feelings, may substitute one permitted feeling for another taboo feeling and will learn coping mechanisms and maladapted forms of behaviour.

The main hurdles we need to confront in helping to heal these wounds are the damaged self esteem, self concept, value system of the young person entering the turmoil of adolescence. So here we do have some advantages in that albeit adolescence is a period of turmoil, and also a period of vulnerability to further assaults with other harmful messages, it is also a window of opportunity for the establishment of positive change. The young abused person enters this scenario of adolescence with a value system which is warped by his or her previous experiences affecting the way he or she feels about themselves, self worth, the way he or she judges others who is safe who is good, the way the young person judges the world around him, a code of behaviour and a code of relationships.

Such a young person is also a needy child, an empty vessel who has never had enough of mother, who can be jealous of others, attention seeking, insensitive, develops shallow relationships and be unable to give - hence the difficulty of being seen as someone who is unable to place others needs above their own. This comes up frequently in the context of early parenting, a mother who can not put her child’s needs above her own, certainly she can not until she is also re-parented and given love, affection and being able to fulfil some of her own needs in the safety and security of a therapeutic relationship or therapeutic environment. This young person will also be entering adulthood with no concept of security or of knowing that someone cares about you enough to show you

what's right or wrong. If no one care's about the consequences of your actions then your actions are worthless and perhaps you are worthless too, no one care's about you. An experience of misplaced trust, attempting to trust people who then abuse them, mean they enter the scenario of adolescence unable to trust. They are also unable to communicate and often do so in indirect and more harmful ways acting out self harming, delinquency, suicide attempts, always of attempting to break the silence. ..... Can we learn how to listen.

The other side of the coin which unfortunately often goes hand in hand with the factors we have already described, is how are adolescents abused and exploited during their adolescence? We have seen how they can be damaged prior to adolescence and as the young person enters the scene of adolescence. But this exploitation continues on a grand scale throughout adolescence. Again wasted resources –

Her are some 'wasted resources' - Gary the son of a teenage mother who was brought up by his grandmother and when she died, became a street child and then attempted to use his meager personal resource to protect his sick mother and younger sisters from an abusive man. He lost his childhood.

John who fled from an abusive mother into the hands of a needy damaged and abusive girlfriend and ended up in prison, taking the blame when she abused their child. Lee who was beaten by his father, led into crime and drug abuse by his brothers and ended up a very angry young man screaming out for someone to listen to him. We need to stop these kids from being trapped in the perpetuating system of abuse.

How else can we waste the resource? By professional abuse. By the care system - in the pregnant schoolgirl survey (The child that rocks the cradle) girls in care had a worse history - higher incidence of abuse, crime, disruptive behaviour and in their pregnancies showed more harmful patterns of repeat pregnancy - their children fare worse at 5 yrs - 10 yrs - 15 yrs follow up. By not allowing adequate funding to break the cycle of waste we are perpetuating the problem from one generation to the other.

Let us look again at exploitation - let me take you briefly through a progression of exploitation. We had a very successful workshop

on exploitation in Atlanta last year in which I concluded that it is very important to regard youth as a resource rather than a commodity, not a commodity we can use but a resource we can value and value together, in so doing we need to encourage youth and not exploit them. However exploited they are, on a number of different levels they are exploited because of their attributes which include youth, vitality, vibrance, sexual energy, a need to be independent, a need to get out there and work and earn a living and a need to experiment and explore their surrounding.

All these attributes are exploited in the work force by being used as cheap labour or by unsafe situations, they are exploited in the fashion market, whether it's in advertising or in purchasing goods ranging from CD's, music, trainers and other more harmful substances such as drugs, alcohol, alco pops, tobacco etc. and they are exploited sexually in pornography, paedophilia, they are exploited by their families, by friends, by other young people and by society and by society at any level.

So what can we do about this? The first things is that we need to stand up and be counted, we need to discuss these issues out in the open and we need to confront the denial surrounding some of these activities. Many of these activities are covert and sometimes as professionals we can collude with the covert nature because we don't want to face some of the wider issue's, but the issue's are wide and world-wide and we need to look at them together. Many of the issue's also involve danger, because in speaking out against pornography and prostitution, we are not only exposing activities but we are challenging and taking away the source of livelihood of those involved in the sex industry, the drugs industry etc. The situation becomes and dangerous game of issues money, finance, power and politics are interwoven in a dangerous web, so we need to stand up and be counted not only in order to expose perpetrators and to expose exploitation of youth but also to allow youth to understand and see that we have a value system, that certain activities are acceptable, concern others and are not acceptable.

As we have seen many of our young people from deprived backgrounds and from abusive backgrounds have grown up without a value system of their own. We do not wish to impose ours, but we do need to show that we have one and they can sample our value system and then decide on their own set of

values. Perhaps if you have a value system they can respect themselves and value themselves enough not to allow others to exploit them. So we need to work on two levels, we need to work on those who would harm and exploit youth, who would waste our resource for the future and we will also need to work on youths themselves to make sure that they value themselves, as an important resource for the future.

And in order to value themselves for the future they need to have a sense of future and a sense of future which is worthwhile, we need to give them a future worth investing in. And perhaps we can do that - here is Beverley - 15 years ago as a pregnant schoolgirl and now a solicitor - We can be encouraged by this and by the positive work done in Jamaica - self esteem boosted - peer counselling; And the Italian earthquake - How many friends in London - and an apt catch phrase - 'Rimarginiamo le ferite ' - 'Lets heal the wounds' Our youth have many wounds - let us help them to heal and conserve their strengths for all of our futures.

Plenary session P5 Mental Health

Chaired by Eric Taylor - Institute of Psychiatry London
and Daniel Hardoff - Tel Aviv Israel

Teenage suicide.

Richard Brown

Good morning. It's really a pleasure to be here and have an opportunity to speak to you about depression and suicide in adolescents. I worked for 30 years in San Francisco since the flower power area, during the Vietnam war and also through different epics and advance in San Francisco and I've been 20 years at San Francisco General Hospital which is an inner city programme with adolescents involved with gangs and marginalised situations, and homeless and runaway youths in central part of the city. So that's the orientation I really bring to talk to you.

Maria was a 16 year old woman who was found in the hallway drunk at Mission High School with a girlfriend and they had drunk a whole pint of brandy. So here they were found in the hallway by the teachers at the high school and hauled over to emergency area for me to see at San Francisco general hospital. She was very inebriated and her girlfriend was similarly. So we had to start an IV, she'd been really quite ill with the amount of alcohol that she's taken. And as she came around she wanted to die, I don't want to leave, I want to die. So it was a befuddlement, why a young woman who was obviously quite suicidal would have done what she did with a girlfriend and then be brought in to the hospital. Very public, very kind of unsuicidal type of behaviour, very disconcerting to us to know what this is all meaning. And without having a guessing game it was all very inexplicable when we found out how the story emerged.

The story was that after her mother came in was that she had lived with her mother alone for some years and about 2 two years previous to this a boyfriend moved in to the home within an angelic beautiful young daughter, a perfect daughter. And Maria was a young Latino wanting to begin to date at Mission High School staying out a little too late at times and in this very traditional family

it was seen as a slut, rejected furiously dealt with by this father who saw her as a very bad girl and he had this beautiful perfect little girl. And as the years went by, these 2 years, she increasingly became rejected, not going to school all the time, and was increasingly isolated. So the issue that Bob Blum spoke about so eloquently about connectedness was destroyed. And she then drank this brandy. Why did she drink the brandy? This father that she was so furious at was a recovered alcoholic, a total teetotaller. He was furious with other people who drank, he could not tolerate anything like this. If there be a way to push the button she knew it. She knew how in this public demonstration to push the button and bring everybody roaring in to the hospital furious, upset, but she was getting attention. Brilliant. Maria knew how to do it and unfortunately I had to face the father. The father had come in and I had to talk to him. And he of course was extremely enraged about what she had done and only validated all the more the obstreperousness of this young woman and her beligerence and what she was doing, but it brought attention to her situation and she got care and she got help and she did do much better I need to say to end the story. This is an introduction to talk a little bit about some psychodynamic issues around suicidal behaviour in adolescents.

A first principle is that there is often a long-term and I have hand-outs for people, I am going to have to ask people to share afterwards, I made a pile of 2 different hand-outs that you can have after my presentation. There is characteristically a long history of suicidal behaviour with adolescents and she had a tenuous long history with just her mother and then this father moving in, so there were a couple of years there where there was a break-down and alienation. And she had really experienced some of the great fears of adolescents. What are the great fears of adolescents?

The worst one of all it’s what Bob spoke about which is isolation and rejection. This is the most profound fear. And for all human beings when I talk about adolescents, I say adolescents are not different than adults in all they are more. Adolescents are just more, you name it they are just more. And there is moreness at back to her situation - she was increasingly isolated, a tremendously fearful thing.

The other fear is loss of control. And indeed increasingly without support, without structure and loving and caring, without limits setting really there was increased loss of control and things were really out of hand.

The other fear is that of hopelessness. One of the tasks of adolescents is to hope for the future and I think we've heard that articulated here over and over again is the sense of what they had in a general affirmation in life is a really important goal. And of course for her it was despair, there was very little prospect of hope for her and helplessness is another great fear.

The fourth great fear is a mutilation, a body alteration and as you all know adolescents are imminently sensitive to their body, every detail, every little things and so when you examine then there is just this one little zit, one breast is a little bigger than the other, one testicle is hanging a little lower than the other and it's bowels zones and it smells and all these things, isn't it? So this body awareness and a fear of any kind of mutilation and that's why with teen pregnancy part of psychodynamic issues of that is a change in a body and often adolescents try to cover themselves up because of the alteration. So body alteration is a great fear. And so Maria really illustrated some of those great fears.

And also adolescents will often demonstrate in public ways and hers was a dramatic public way. Imagine with her peer group in the hallway in the high school, this is an ultimate public demonstration. It is a real cry for help issue with her in that way. And also are ingenious as to how to push a button even though it is results in a very negative response from her family, it brought attention to her despair and her rage and she got help. So those were some of the elements about Maria.

Depression is a basic part of the human condition and a basic part of adolescents. There are normally a wide variety of mood swings through adolescence and they are closely tied with the normative changes that occur. So we all are very experienced with adolescent depression, we just know that that's inevitable. We also know that we work with an adolescent we have to assess the degree of the depression. And sometimes when a young person is in an identity crisis or some personal struggle you can feel the depression just really lift during an interview, they do better and by the end of the interview they are really less depressed. If you do

an interview though and you are depressed at the end of the interview then there is a message there. Then you need to really look at this in detail and always the essence of it is we have to ask questions. There are certain sensitive questions in adolescents that they are not going to bring to us. We have to be there for them and open to them and it's a variety, I'll give you a list of those that we have to speak to them and one of them is the difficult question of do you want to die have you thought, can be direct sometimes, in certain interviewing skills we want to be kind of subtle and all but we have to sometimes really ask this directly.

The other issue about enquiry into suicide behaviour is that this is not a confidential topic. And in the relationship with young people we need to define those things that are confidential and protect them and all and there are some very in our laws are defined and where we live in terms of confidentiality. This is one of a few areas that is not confidential: homicidal behaviour, suicidal behaviour, severe mental illness is not confidential and then abuse, such as sexual abuse and incest and all are really not confidential as far as the young person is concerned. So this is not. And the experience in the literature is that this is never a deterrent to the relationship, I mean young people don't run away. And for the most part there is a real strong cry for help element in a young person who has become suicidal. So we do need to look for evidence of desporia, severe mood swings, we also need to look for a potential severe mental illness. A phenomenon that we see clinically is that first psychotic breakdown right in our clinical setting you probably have experienced this where the young person is basically doing OK and then suddenly they are psychotic and the stresses of adolescence can push a young person over to that.

Just a few weeks ago I had a young Indonesian, a young woman who came in with both of her parents they'd recently come from Indonesia, the mother had died of cancer 2 years previously and the father had found a new lovely Indonesian woman and they had immigrated to San Francisco and the young woman was straight A student and then during the summer she started hearing voices and withdrawing and there were voices for her to jump out of the window. Suddenly in the midst of a very stable family where parent were very concerned, they were very sophisticated and very interested and baffled by these actions. But the stresses upon her which are the loss, the grieving for her mother, the movement to San Francisco, the stress around her school performance and all

and her isolation were those things probably that triggered her towards the first psychotic break. So this is something very important to look towards.

Another element is looking for the interject. Do you know about the interjection? Interjection is a phenomenon in which a person takes hook line and sinker an idea about themselves. So as Diana was speaking out this morning people can get in a vicious abuse cycle in which they take on the identity of bad things that are described upon them from their unsafe environment and they learn then to see that they are bad, they are furious, they feel rejected and they begin to act out and you get an acting out cycle and one of those can be suicidal behaviour. And it is something like, you are just like your father, you are starting to stay out late at night, I know you had alcohol on your breath, he is an alcoholic, you are just like him, must be genetic, I don'' know what to do with you, you are just nothing but trouble, ever since you turned 13 you are just trouble. That young person takes that on often in the lack of resolution of the omnipotence they really take that on as part of their identity and it's a very destructive, negative assumption. It's an interjection, it is taking into themselves an idea and of course one of our tasks clinically is to question that interjection, be able to move out and so better.

There are many factors in the literature which lead to a suicidal behaviour. And my hand-out has some of those, I think in this time I will not go over them you can see them but to go on with the stages of suicidal behaviour that's what I want to complete with. The first one as I said is a long history. So Maria did have the series of years that were difficult for her. The second is a period of escalation that there is, young people begin to have a lot of stress, first signs might be school failure, teen pregnancy and symptoms can develop. And this reflects the issue of how sensitive or how resilient the young person is. Because I've seen young people who have had tremendous escalating type of events in their life but they are not suicidal. And I've seen other young people like a third year student that gets a B and they become suicidal. So there is an issue of a different issues of personality. But there is characteristically an escalating period, it's not really predictive but it's important to define in history. That's stage two.

Stage three is a period of adaptive failure and this is actually the point where the young person is seen in a clinical setting or in the

school counselling setting or in with the social worker, whatever. Things begin to crumble and fall apart. Helplessness begins to take its toll. Coping mechanisms beginning to fail and symptoms develop. Family conflict begins to occur, social isolation begins. And as it goes on becomes more severe, sometimes they are giving away objects, talking about planning to die, talking about running away, actually running away, possibly doing self-destructive acts during this time, becoming accident-prone, increasing use of substances, of alcohol, severe school issues and drop out, anxieties, expressions of sadness, this is really the really breaking down part and it's so important because this is indeed the moment that we might see the young person. And most young people that go on to suicide behaviour actually appear seeking help at this time.

Then the final, the rationalisation is the fourth phase and this is that there is no help in the world that there is nothing that is really going to, there is no consolation, there really is no caring and loving. There is no support, the problems just progressively result in isolation and then something happens. And an illustration of this was at Berkley There was a young man who had killed himself, he was discovered three weeks later in the dorm from the smell in the hallway in the dorm. It illustrates that for three weeks not a soul on this earth thought to inquire or look at this young man, there was a very dramatic illustration of the horrific isolation that can occur leading to this.

I need to conclude. I want to talk a little bit about intervention. And intervention needs to be very immediate and very intense, it often does need to have some psychiatric involvement immediately. For runaway and isolated young people they must have an on-going abiding connection during the time that they have suicidal ideation. Another thing that I want to say that we need to look, gestures and attempts are not good terms for adolescents with this, because many times they can be quite suicidal and they slit their wrists. So it's not a lethal thing but they can be very suicidal. Or they can take a bottle of iron tablets which may have a lethality to it but it was just attention getting. And so we need to look at how public or private the activity is and how lethal it is. So with Maria we can see that it was a very public demonstration, but there're also private ones as well. The young person at home, in the house alone, going downstairs and putting a gun to his head. And maybe leaving a note. This is an illustration of a private act. So we need

to look at the thoughts in terms of how public or private they are. So this is a very major topic but I did want to present it to you from a psychodynamic point of view today illustrating the precursors, the underlying issues, the sequence of events that occur and give some illustrations and some sense of the emotional enormity of what happens with young people who become suicidal. Thank you very much.

Chairman. Differentiation of different tracks into disorder. Now we do have time I think for one or two questions.

Question -perhaps you did not emphasis the fact that mother had suddenly got a man in her house. I can well remember adolescent coming into my large group and lying on the floor mother had remarried it is quite interesting how they need treatment.

Chairman. Thanks very much for that question. It's in some ways more of a comment than a question. We have a question about substance abuse.

Dick Brown. From adolescent medicine view we often look at substance use as self treatment an attempt to deal with emotions. The choice of substances are parallel there, there are also ways of masking other issues such as a psychotic break. I hope to express the enormity of emotion that young people are feeling, substances are often a hint to try to ameliorate or to try to deal with these very severe emotions of loss, grieving, rage, sadness, just the whole spectrum of difficult emotions often experience in this process towards suicide behaviour, so substances are often self-treatment. Or it can be as it was with Maria a way of pushing the button.

Chairman. Thanks very much, if there are no more questions we should thank Richard Brown again. Now Doctor Simon Clarke from Sydney, Australia, he is a paediatrician and adolescent medicine physician, he developed, is running and directing extensive adolescent medicine services in Sydney and he will share with us his experience in attention deficit disorders.

Attention Deficit Disorder

Simon Clarke

Thank you very much. We are, I was going to stick up a formal committee definition of ADHD, all fourteen points and ask you to commit them to memory, I can't spell either. Well, I won't do that, basically these are the main point of symptoms of ADHD and the interesting thing is the contrast between ADHD and ADD where you take away the impulsivity and the hyperactivity and I don't know about other people but we seem to be running into a lot of problems in Sydney where everybody has an adolescent son who doesn't do quite as well as he should at school and has an ADD. I was taught in America in Boston where the belief is that everybody has their learning style and you're entitled to have your own learning style and that within 10 years the diagnosis of ADD won't exist but that is extremist. I think it's an interesting point.

ADHD or the old hyperactive attention deficit disorder has been with us forever, I have not gone to pre-biblical times but certainly there were descriptions from Germany in the 19th century. From England descriptions of people who had most of the symptoms of ADHD following head injuries in the 1st World War, the flu epidemic of 1919 seem to leave a lot of people with a lot of these symptoms, then in 1950 searching for a term, I think a most unfortunate term it was called minimal cerebral dysfunction which possibly described the person doing the description rather more than describe the kid I mean how can you call somebody minimal cerebral dysfunction? You either have it or you don't have it. Then came hyperkinetic or hyperactive and in light of what's coming through now from certain people I am not sure that wasn't a bad description and these were your fidgety boys, you knew how to treat them, you've stuck them on stimulants and they got better and you are happy and they were happy. Subsequently the field has become very confused.

But recently this year an interesting academic Joe Sergeant from Amsterdam feels that in fact the essence of ADHD really is loss of inhibition of motor activity and that the inability to moderate motor activity, to automate responses and to memorise patterns may be in fact what these kids are suffering from so that they continue to make the same mistakes. Again that's an interesting theory. So perhaps the wheel has turned the full cycle.

Where does ADHD actually occur? Well, it occurs in every population so far studied. It's interesting that it occurs in some say 3% some say higher 9%. In other words this is what we are looking at the end of a spectrum: on one end of the spectrum you have your Nintendo playing couch potato to whom physical activity is an anathema and on the other end you have a kid who can't sit still for a second. So it's a spectrum and you should be allowed to have a spectrum. What makes ADHD a problem when fidgety Phil is so disruptive in the classroom with his constantly getting up, talking, fidgeting, etc. And at home that he's driving everybody bananas and that's when you are in trouble and that's where ADHD becomes a problem. So at one end of the spectrum, and we often say this to parents, yeah, your kid has got mild ADHD and they say, What do you recommend, and I say, what about more soccer. In other words get this kid out, have you ever thought of living in a house with a bigger yard. They need more activity and they will do well.

I worked with an Irish psychiatrist once and we were talking about this and she said, ah, now I understand why sister Mary used to send Maureen run around the school twice every quarter of an hour, and sister Mary used to say, Maureen, and Maureen would get up, run around the school twice and sit down again. And that was a very affective cure for ADHD, no riddle in this. So what Maureen's mother and father did I don't know, but in fact one of the funniest people I've ever had was a mother who said, you know I find when my kid walks home from school he is much better, I think that a good 2 to 3 km walk preferably uphill on the way home from school, you don't have to buy your house up the hill but a hill does help.

Males to females: it depends on what population you study. Some people say 3 to 1. If you are talking about ADD it's closer to 3 to 1, if you're talking about ADHD we certainly see far more males than we see females. The females we see seem to have lower self-esteem, have more problems in relationships, seem to be more perhaps more damaged than the males. So it depends. By definition it should have come on about 7, but we see a number of kids who present in adolescence, don't forget it does come and they do come along in adolescence for the first time. Why then, why the circumstances change? For a variety of reasons, but they can present for the first time in adolescence and you need to be aware that they are there.

Now. there's some very interesting stuff coming out now on the aetiology of ADHD. There are some very good twin studies showing a much higher incidence, 60 to 80% in identical twins as opposed to 10 to 20% in non-identical twins, those are American, Swedish, English and American studies. So, it's very good information coming through. Regarding the inheritance of DR for dopamine receptors that's what we are looking at when we are treating people with stimulants and the studies are there but they need to be bigger. There are only 50 patients at the moment. The incidence or coincidence of learning disabilities with ADHD is 40%. There are some good brain studies done by Rappaport and her group which showed 4 areas of the brain are smaller. One area inhibits motor activity, these areas help to automate motor actions. A lot of this is speculation but the fact that these 4 areas are smaller in kids with ADHD seems to point to the basis of a genetic inherited polygenetic, a number of genes.

EEGs, these are the tests we do if we think the kid is fitting and has epilepsy. So any classic EEG, you look at the brain wave, you look for that classic spike and wave. Now, what we did and what Settafield first did in 1973 was to break the wave forms down and what he found was a relatively immature form and that in a way makes sense. Because what you are looking at with ADHD is a relatively immature pattern. In other words this kid's fidgeting, this is 16 year old with a fidgety index of a 12-year old. Or an 8 year old who looks like a 6 year old. And very often you get kids who are developmentally delayed. And the parents come along and they say, he's like a 5 year old, they are so active all the time. This shows that immature patterns in these kids is persistent.

Now literally hot off the press from work we've done looking at Gamma. Now this is a wave form we are measuring with electrodes all over the brain, we are measuring the brain and we are measuring the fastest form, it's been done a number of times before but what happened was we've not only measured the 40 Hertz cycles but then developed a mathematical model to look at how well those cycles co-ordinated in the brain and guess who didn't co-ordinate - the ADHD.

We then go back to the same kids, we had 52 in this sample to look at their Beta, and these are the normal kids Beta and these are ADHD kids Beta with their immature pattern still returning a

high Beta right there over the pre-frontal region and there we looked at their skin conductance levels, in other words looked at their autonomic nervous system and showed that right throughout their thinking pattern these things interfered with their thinking pattern. So that's where our group's going at the moment. I just wanted to show you a brief glimpse of where we are trying to add some science to what is sometimes an area where there is not very much science or the science is confused.

So when you diagnose this a long history is essential, psychometric testing, you must know how intelligent the kid you are calling ADHD is. Look always at school reports, because I am always struck by people who come to see me when they are talking about their kid having ADHD because the next door neighbour's kid has got it, that's generally how it goes, suburb by suburb, and when they come in to talk about ADHD and you go through their school reports and the kid has not changed and the reports are absolutely superbly symmetrical so these kids' performance has always remained as is. What's your differential diagnosis for ADHD? Never forget learning disabilities, because 40% of them have it anyway and if you miss that you are doing the kid a disservice. These are the differential diagnosis but it's also the co-morbidities, in other words the whole lot can exists with ADHD and that's the problem and that' why we are trying to develop an organic brain measure that actually says, well you've got this and yes the kid's oppositional and now his conduct disordered, depressed and angry, abusing cigarettes or marihuana. The parents, every parent has inappropriate expectations. Doctors generally worse than most. And so the kids can actually come in with all of those at the one time and that's sorting that out that's a problem.

How do we manage this? Well, the stimulants in 70 to 90% of kids moderate to severe ADHD the stimulants are still very useful. We use Ritalin, Dexamphetamine, and we find antidepressants particularly Imipramine with your angry adolescent male are effective. I was talking to Gail Slap last night and she also has found that those kids responded to antidepressants. There are some very good programmes and they actually have them in most cities now. In Sydney the parenting behaviour programmes, family therapy programmes, these kids' families often have gone wrong for so long. The school, how do you place this kid at school, how do you alter the work given to him, how do you praise this kid a lot,

how do you get those teachers on side, you must communicate with the school right from the word go. I think the best one was when I put this kid on medication having listened to this tearful mother and the principle rang me 4 days later and said, Doctor, why did you put the nicest kid in school on medication? And I said, I guess you're telling me something, and he said, I am telling you something, so I rang the mother we revised the diagnosis. So it was a learning pattern for me.

You need to see if you can the kid into a group programme for kids where they stop. Look and think, in other words anything to slow down that impulsive process.

Chairman: we can take 2 questions.

Question - How early can add arise?

S.C. The classics are when the mother says to you, you know this kid kicked me to death in the womb and another mother says, this one can't stop swimming, the funniest description that I've heard, the kid's still swimming by the way. Most people say it has to be present, if it is organic problem it must be present by 7, but it's not always and for variety of reasons you need not diagnose till adolescence. And it does not stop at adolescence, it goes right through to adult life in I think probably 60 to 70%. The point is it ameliorates as you get older, so your adolescent will fidget a lot but won't be moving around the classroom, but in your adult life it will still be the few with things right through adult life. Very important to form a good liaison with an adult psychiatrist because the co-morbidities of adolescents become even more marked in adulthood and so you've got to form a liaison with somebody who's going to take this kid over.

Question - what you do with kids who are in a care situation or from a very chaotic background.

S.C. What I do with those kids is try to get them into child and adolescent psychiatric institution near me as soon as possible to stabilise them in some way, just a glimpse of what a kid looks like in a stable situation with the family's needs being met often resolves things. Another situation might be when you take that kid out of family and put that kid into an institution, medicate him and do that way. And you see every other kid in the family becomes

normal. So I've had that happen as well so I mean it's better if you can get somewhere you can just get a look at the kid away from that chaotic family.

Chairman: Thank you very much. It may sound like we are going to the opposite end of the spectrum from talking about hyperactive kids to kids with chronic fatigue. There probably is quite a bit in common, not least that the areas where mental health and physical health need to work together very creatively. They say that people are like their subjects that people study, their subject because they like it, I don't think that's true, I am sure Dr. Clarke is very focused and Dr. Viner is very energetic.

Chronic Fatigue

Russell Viner

Chronic fatigue, it kind of makes you tired to think about it doesn't it. It certainly quite a common response, as Chairman said, I am from a new adolescent health service as we call it which has been set up at University College Hospitals London and Great Ormond Street hospital which is the first time that adolescent medicine has gained some kind of foothold within the hospital secondary tertiary academic side of the health service in this country. An interesting development and one we hope will be followed by developments in many other places.

I am going to be talking today about chronic fatigue, hopefully it will not make you too tired as I said. Chronic fatigue is a particularly topical, a particularly confusing topic or disease for many people, most of my colleagues when they think about chronic fatigue have some kind of flight or fight reaction, either withdrawal, how sympathetic stimulation, or flight sympathetic stimulation. It's something that's very topical in the media, immensely confusing for most, seems a new illness, it's only been around perhaps for last 5 to 8 years, there are others who claim that in fact you can trace it right back to the 19th century as Simon did with ADD. It's interesting that it has been placed in the mental health section of this conference and I think it's reasonable in many ways. I am not one that believes it's purely mental health phenomenon and I think that it's an illness that superbly illustrates the joys and possibilities of adolescent medicine are working in that interface between organic and psychological medicine trying to remove those barriers and divert the sense of the mind-body cosmic continuum.

Whats in a name? Simon pointed out that with ADD there's been a long history of development of names, CFS is a most recent term for this rather vague condition, it's been called many things, I suppose in the 19th century people are suggesting it would have been called neurasthenia, more recently there's been whole lot of things, ME - Myalgic Encephalitis or Catamyelitis or whatever you want to call it is the other most common name, Postviral Fatigue had a brief period of topicality, the Royal Free Disease, I am sure Dora can tell us perhaps more about it at some stage, and many other diseases, I am not sure where Iceland Disease came from but it's certainly up there as well. What's in a name? The answer is

clearly there is this huge number of names tell us that the most prominent things about Chronic Fatigue Syndrome are uncertainty and confusion for us as treating physicians and certainly about it very existence, whether it exists or not, uncertainty about its aetiology, whether it's psychological, whether it's organic, whether it's something else, uncertainty about how we actually diagnose this condition and the literature has been absolutely plagued by differences in diagnosis, it's almost impossible to compare a couple of different studies done in two different places. Concerns about the natural history and a huge complex about the treatments, so uncertainty is what characterises our response to it.

We must remember that while we are very uncertain others are not and the certainty of many people who deal with CFS I find quite scary in many ways. The media, various pressure groups, ME Society and others who are meant to be active and have a lot to give. But as I said their certainty I found often particularly counter-productive. And those of you who have treated this kind of patients know that often they are particularly certain as to what's going on, they might have been through a gamut of medical people, a gamut of psychiatrists, they've been through alternative health practitioners they've been through the lot, and they usually have very clear beliefs about what's going on.

The definitions when one is uncertain, one results in a long list. We find that with ADD as Simon said, and it's certainly true of Chronic fatigue syndrome. The central criteria clinically unexplained relapsing Chronic fatigue for more than 6 month is the centre and core of this condition. These people shouldn't be fatigued since birth or for the last 5 years or so, all fairly new or specific onset. The fatigue needs to be not due to an ongoing exertion, the exertion often makes it worse, and the fatigue needs not to be substantially alleviated by rest, though it can be a little. And the important thing that psychiatric flavour of what makes a disorder is that the fatigue results in substantial reduction in previous levels of functioning, whether they be occupational, psychological, social, educational or whatever. So they are the most central criteria. Also four or more of the following symptoms must be present or concurrent for more than 6 months and there are quite a number there, particularly short-term memory and cognitive functioning is quite a common complaint, sore throat, tender glands, muscle pains, muscle pain in particular very common, multiple joint pains and headaches in particular, I find among most of the young

people we see, headaches, unrefreshing sleep and vague muscle pains. And one of the classic ones is post-exertional malaise lasting more than 24 hours does seem rather unfocused, is it possible to focus it any further, I am not sure.

Exclusionary conditions, to some of us it doesn't seem that anything can be excluded form CFS but I think we need to be certain that they are. Clearly any active or chronic medical condition that explains the chronic fatigue, any past or current major psychiatric illness. Particularly depression, major depression with a psychotic features, also delusional disorders and others. Alcohol and substance abuse, they say within 2 years of onset and also severe obesity with a BMI more than most of us could ever achieve I think. I think there are a number of problems with these criteria in adolescents, children and adolescents. Many people would suggest than one shouldn't diagnose CFS in children and I have a lot of sympathy with that belief, in adolescents I think it is reasonable to make that diagnosis. I think we have to remember that all illness behaviours in young people who are within a family system are strongly influenced by parental expectations, responses and management. It's probably clear that 6 months may well be too long that someone has had Chronic fatigue of some type for more than 2 to 3 months can be called or can be considered as having this entity. And the common symptoms as I said before that we see in our young people are headaches, sleep disturbance, some mild cognitive impairment and major school loss.

There is some recent evidence which may or may not be true that Chronic fatigue is the commonest cause of long-term school loss in this country. Kids with cystic fibrosis, diabetes, they don't miss school any more, we've managed to work that one out. Chronic fatigue - they miss a lot. The prevalence of this illness is unknown. It's likely to be less than the prevalence in adults for which we have better figures and people suggest that up to 1 to 2 % of the adult population, that's probably 2 to 3 people in this room at this moment have Chronic fatigue syndrome, who knows. In children I suspect it's much less than this, there's been quite a variation depending on what study you see, 10 to 30 for a 100,000 adolescents from referral studies to tertiary services and up to almost 500 for a 100,000 from symptoms surveys. It also occurs in epidemics, certainly occurs in epidemics within schools. Otherwise

in the demographic scale that number boys and it seems to have a mean on sex of about 11 to 15 years.

Aetiology, what causes this illness? I don't think we know is a very clear answer, there are those on the right wing that say, it's all psychological. There are those on the left wing that say, it's all medical. There are others who say, perhaps social. Perhaps I'd like to suggest at some stage that it's a syndrome, that we need to have a much more complex context of aetiology in causation of this illness. The evidence biologically the big one was Epstein Barr virus, the mononucleosis or glandular fever virus was the big one that the people sought for particularly as fatigue after viral infection is so common. Only about 6 to 10% of adolescent with chronic fatigue syndrome have a clear evidence of a current or recent glandular fever infection. Other viruses, the enteral viruses in particular but others Herpes viruses have been suggested and people have found DNA and various muscle viruses, etc. But there is no good evidence that these viruses are implicated in more than a tiny proportion. If you ask about symptoms there's certainly a suggestion that viral precipitant may have been around in two thirds of adolescents but then again if you ask most of us had a viral infection in the last month or two so the significance of that is not very clear.

I think it's very clear that the muscle anatomy in these people is absolutely normal, that the fatigue in centrally mediated in some way. Others have suggested that endocrine the hypophyseal pituitary axis may be involved, but there is very little evidence of that. Other people like in ADD have looked at the brain thinking that the fatigue is centrally mediated. Unfortunately there have been a lot of inconsistent findings and it's clear that there are no standard structural MRI findings that are characteristic of CFS. Other people have undertaken scans or functional MRIs and others that show some frontal hyperperfusion but the studies have been poor and they have not separated out those with significant depression from those with just the CFS and these kind of changes can also be seen in depression - some of them show brain stem hyperperfusion. At Great Ormond Street we are trying to do an activated brain study to look at a number of these children to see if we can find changes similar to the changes that Bryan Lask's group have demonstrated using the same technique's in girls with anorexia. Neurotransmitter changes and that's something we are going to be looking at as well. One of the big things

recently has been about neurally mediated hypertension, the fact is that some report that if you tilt these young people on a tilt table they get postural drops in their blood pressure and some of them have been reported to respond to mineral corticoids and excess of extra salt in their diets. Sadly these findings are not replicable.

As I said there are major problems in distinguishing changes in muscle, in the brain, in other systems from those due to rest and we know that even a month of rest in these youth will give you changes in brain profusion and give you changes in muscle and nerve. Others have suggested some unknown model of toxin giving you immune activation resulting in CNS damage may well be operative however they have not produced much evidence for that. The arguments for this to be a psycho-social or psychological illness either lack a physical cause and objective science, the strong co-morbidity is the theme with many of these young people and the fact that they improve with psychological treatment. The theories are that this is a variant of a somatising depression but this is a somatising illness about secondary gain or that it's a social illness or a familial systemic problem in that there is a parental alliance with the child about school and other social problems and this maybe some variant of mood health and reciprocacy. The evidence for this - co-morbidity depression is the one that has been most reported.

Depression in adults is present in 30 to 60%, in adolescents there are variable findings up to a third and some suggest 60 to 80% more recent psychiatric control study suggests about 25% have diagnosable major depression without psychotic symptomatology which would exclude this being CFS. The other interesting finding is that the illness in some senses responds to psychological intervention and drug intervention suggesting a psychological cause. Many of these children have much higher somatisation, adolescents have much higher somatisation scores than controls suggesting again it's a somatising illness and the fact that there is a lot of clustering in families. One's heart drops when one sees the entire family coming in a wheel-chair. And that suggests that this maybe psychological, equally it may suggest that it's infective or biological.

There are many problems with suggesting that it's purely psychological, the consistency of the myalgia, the muscle aches and pains and other symptoms argue against somatisation

because we see many children with somatisation, pain syndromes and all sorts of things but it's a specificity of this that suggests that it isn't just somatisation. The physical signs some of these people certainly do have enlarged lymph nodules and fever. The relationship of fatigue to enjoyable exertion not just the problems that they are trying to avoid, not just the school, and in fact the desire of many of these young people to get back to normal is urgent desire. And also the lack of clear identifiable organic psychological pathology in many as I said, certainly not all of them that have depression.

A synthethis. If I can suggests that we need in a much more complex way using a bio-psycho-social model at what is going on in that illness that there must be some kind I suspect in most of these young people a precipitating illness, whether it's viral or whatever where they learn about fatigue, where they may learn some of the secondary gain of having an illness and fatigue. I suspect that these young people are biologically vulnerable to fatigue, I can't explain exactly where it resides, it maybe in the brain, it maybe in the muscles, but it's about again risk and resilience factors that we often talk about in adolescent medicine. But these people are biologically vulnerable to fatigue, they are likely to get more fatigue with these precipitating illnesses, but then there are social or psychological factors that maintain the illness, whether these be in the parents, and I have a very interesting woman tell me the other day that when her child first got ill she watched her every single minutes of the day and responded absolutely to everything that this young girl did and one can see how that would maintain the illness, maintain the behaviour because of that watchfulness, that surveillance. Again cycles of learnt helplessness and disempowerment, some fatigues causes these people to be treated as fatigued, causes them to lose hope in what they can do and they learn helplessness etc. And I think in many ways we cause chronic or increase the chronicity of fatigue in quite a lot of our patients.

Management. As I said many of my colleagues say to me that their heart sink when they see these patients, they don't know what to do, they have little idea of where they should be going. The principles of management I think are very clear if I can give you what we do and we are just starting off developing our programmes. I think the first thing and the most important thing to do is to dispense with aetiological thinking. If you are going to be

looking for a cause, looking for a psychological cause, looking for an organic cause only, saying to people this is not organic this is psychological, you will probably fail in a great proportion of people. So dispense with aetiological thinking. One certainly must look for a cause, but if one doesn't find one one says, we don't know what's going on, I can't tell you what is the cause of your chronic fatigue but I know how to treat it. And that treatment should be rehabilitative. We often say to our young people who won't accept any psychological parts to their illness we say, you have this chronic fatigue, we don't know what causes it, but the thing that works is to rehabilitate you in the same way as someone with a muscle condition whose cause we don't know. We can't magically cure them but we rehabilitate them and we do the same thing for you. The approach must be psycho-social, it must be multidisciplinary, one cannot do it by oneself and it must be family centred. We try and treat the young person by themselves outside their system - you will fail.

The medical assessment. I probably don't need to go into it hugely, I think it's extremely important to exclude organic pathology. Many of us are adolescent physicians and we must act as physicians not just as counsellors or whatever. And I think it's particularly for those who work in tertiary centres it's important to sign off or draw a line under any further medical investigation. I particularly see numbers of cases who have been to GPs, district paediatricians, city hospital paediatricians and end up at Great Ormond Street, they had this many tests and we are often able to say we'll do this and no more, you do not need any further investigation. They certainly need psychological assessment, there should be individual and family, and some people do depression scales and quality of life scales, I am not sure that they are particularly helpful. We also want to take a physiotherapy and educational assessment, and some people find fatigue scales useful. What's particularly important is that a co-ordinator of a multidisciplinary team, someone to take overall responsibility for this investigation exist and for me it's one of my nursing colleagues Anna, in the audience here.

Treatment. Treatment is biological, psychological and social in our system anyway. Biologically I would give most young people a trial of anti-depressants whether I think they are depressed or not. Many people will disagree with that but I think that many of the new antidepressants have non-specific mood-elevating and

energising effects, it maybe that there's a masked depression there that we are not actually finding out about. Many of these young people have a very significant sleep disturbance, they are awake till 4 and then they sleep till 2 in the afternoon. And the use of melatonin, 3 mg at night about half an hour before they want to go to bed often is particularly useful. Some of these young people have cognitive and attentional problems. We don't have a lot of experience in using attentional agents for these young people and there maybe problems with sleep with using those agents.

Graded exercise, physiotherapy, structured programme is essential. We get one of our physiotherapists to undertake a fitness assessment and then produce a daily graded exercise programme. Getting good balance of rest and exertion is key and for many of these young people it's stopping them doing too much. Many will do no exercise for 2 days, get up, feel well, play a game of football and fall in heap for 3 more days. We have to say no, we have to say you will do 10 minutes walking to the front gate and back, the next day you walk 2 meters further and you gradually increase that. This adds structure and control to the day particularly for the young people who just sleep all day, may not go to school etc. the structure of the day is lost and adding structure back is particularly important. Remember one mother pleading with me saying we need structure. Rest is counter-productive.

Re-schooling is absolutely key. A gradual re-introduction to normal school plus or minus home tutors is important. I don't think that these people shouldn't be going to normal school. Subjects rather than hours at school are important and we like to get our young people back to doing one subject. One of my young men recently has picked geography and he is going back just to do geography which is about 3 hours a week. Then we add another subject. Psycho-social interventions, providing structure for parents and young people is essential. Family therapy is routine in our service. We sell this to those who will not accept psychological aetiological elements in the chronic illness as a way of helping the parents cope and support them. We also try to look at systemic maintenance factors I've talked about. Individual psychotherapy or cognitive behavioural therapy is often useful particularly if the family system will allow, if they will actually buy that there is any psychological element to this.

Prognosis. I think we must remember that the prognosis is generally good in these people. It's easy to be too pessimistic. There is a high probability of return to health up to 2 years. There's been a number of follow-up studies that show about two thirds of them have substantially improved after a year or two. However 12 to 20 % will continue to have long-term problems. Rehabilitation works but we don't have particularly for our services we don't have good evidence for the treatment at the moment. And that's something certainly we need to be going on with.

Conclusion. This is a complex illness, to treat it well we must dispense with aetiological thinking, dismissing chronic fatigue syndrome as purely psychological is simplistic, it is almost negligent and you will anger and cause to leave you a number of your patients and it doesn't help the young people to get better. On the other hand, to ignore psychological element is to ignore treatable illness and extend their illness as well. Rehabilitation is the key, biological, psychological, social, educational physiotherapy and co-ordination and close contact are certainly key and essential as well.

Chairman. Thanks very much for a very balanced and clear account. It's been very enlightening.

Question: how long will you keep them on antidepressants?

R.V. I'll give them a three-month trial, if they don't respond to the first one I will actually give them a second one some kind different balance between serotonin and adrenaline may work for others. I will probably try two antidepressants but it would be in close liaison with the young persons themselves. If it worked I would try it for 6 months and we may a contract to use it for 6 months and then withdraw it and see what happened.

Chairman. Fine if there aren't any more questions it is a tribute to the clarity of the talk. Our next speaker is Doctor Dora Black who is consultant in child and adolescent psychiatry and has established and founded the clinic for traumatic stress and has special interest in treating bereaved children. She will talk about traumatically bereaved adolescents.

Traumatically Bereaved Adolescents

Dora Black

There are two aspects of the talk that I want to emphasise today. One of them is what happens to adolescents who have an acute psychological trauma during adolescence and the other is a group of children who've been traumatised in childhood, how do they present in adolescence. My particular expertise is derived form my interest in bereavement and it's traumatically bereaved adolescents particularly that we are going to focus on. I've been interested in the effect on children of losing a parent by death for many years and as a result of that I've been asked to see more and more difficult cases, it's sort of a phenomenon in medicine that you are all familiar with, you know, can we floor her this way. And gradually we realised that we were seeing a lot of children whose parents have died as a result of one parent killing the other. And we've now seen in our clinic over 400 children whose been traumatised in this way.

This first slide is a picture drawn by a young adult who finally got into therapy in her early twenties following the murder of her mother by her father when she was 4. And I think it's a very dramatic picture of the continuing effect of the trauma on this woman who had really been suffering for over twenty years when she eventually got herself into treatment. And that happens only by accident. By contrast this is a picture that was drawn by a 17 year old girl whose father killed her mother while she was in the house and she and her brother rushed to the bedroom door which was locked and managed to get it open and came in on this scene. It is horrific but it's also very important. It says Mark and me, me is my patient. What is much more difficult to resolve is the fact that this here, in fact I find it difficult to resolve, but this here is the mother whom they found on the floor, this is her head, this is her body, that's her arm, these are her legs. And this here is a cut throat. And all this is the results of the spurting of her arterial blood over the walls. Now, that kind of image which was imprinted on this girl's mind was to lead to an enormous amount of mental ill health in both her and her brother. Her brother actually became psychotic at one stage, she became an alcoholic, because alcohol is one way of blotting out these sorts of traumatic images. And they both require an enormous amount of help and treatment.

Similarly there are other ways of becoming traumatically bereaved. This is the picture that some of you may recognise. It's a picture of the plaque at Dubrovnik and it's a quiet street, rather beautiful, these are the red roofs of all the buildings, as if you are looking on it from above. And this is the way that one young adolescent saw it after it had been shelled by, I always try to remember which way it is around, by the Serbs, that's right, Dubrovnik is Croatia. And this is the way they saw it after it's been bombed. This building here is actually San Franciscan library which had over 2 500 sacred books dating back to the Middle Ages, completely irreplaceable, they were all destroyed. I may be wrong, it may be 25,000 books, but it's an awful lot of books and there is a fire-engine as you can see. This is a very well perceived picture and like the previous pictures done by the 17 year old whose father killed her mother they are absolutely imprinted on the visual memory.

I just want to give you a little background of the study that we did on the first 95 children where one parent killed the other just to set the scene for some things that I want to talk to you about. They are about equal in sex but the majority of children are under the age of 11. Many of them under the age of 5 at the time of the killing. This isn't surprising, young children in themselves are a stress on marriage life as many of you must know and it also a crime of young parents, as you grow older you learn to keep your temper a bit better or that's a theory at any rate. But you can see that there are a substantial number of young adolescent in our group and I want to sort of focus on that group.

The people who are violent to their wives or often violent to their children as well and there is I think there's underestimates amount of previous violence to the child. But you can see that the death of a parent wasn't something that came out of the blue in many cases, it was built on previous domestic violence and it's only in recent years that people have begun to recognise the toll that domestic violence takes on child witnesses. This is the fact that was associated with homicide, jealousy, sometimes more of a jealousy, sometimes jealousy with provocation. The threat to leave was a very important precipitating factor and there is a share of mental illness and alcohol abuse.

Now the child witnessed the killing in approximately half the cases and by witnessing we also include being in the house and hearing the shouts of the mother even if they were actually upstairs in bed

and didn't witness the actual killing and the children often come in on the scene following the incident as my 17 year old girl did. Many of these children develop post traumatic stress disorder, so I want just take a moment to give you the DSM four definition of post traumatic stress disorder I want to pick out the particular features that occur in children and adolescents. There are two groups, there's what I call intrusive symptoms and the avoidance symptoms and the intrusive symptoms are dreams and nightmares, that flashback, suddenly feeling or acting as if the traumatic event were occurring. And the avoidance phenomena which include the diminished interest in one or more significant activities and in adolescents this overwhelmingly is school work.

These young people start to fail at school the brother to the girl that I was telling you about who drew that picture was in the throes of his GCSE exams, he failed everything although he had been seen prior to that to be a student who was likely to gain five or six. The feelings of detachment or estrangement, the constricted affect. Then other symptoms which were not present before the trauma, particularly sleep disturbances, exaggerated startle reaction, guilt, memory impairment or trouble concentrating, of course that affects school work. The general avoidance of activities which bring traumatic reminders and intensification of symptoms by exposure to events that symbolise or resemble the traumatic event.

Now using the definition of witnessing to include being in the house and hearing and coming in on a dead body afterwards, of the children who witnessed the killing nearly all of them developed a post-traumatic stress disorder and of those who didn't witness the killing most of them didn't develop PTSD. A significant number of both groups went against expectation. Children who didn't develop post traumatic stress disorder were children who had by and large an effective intervention. Children who didn't witness but developed it were those who have experienced chronic domestic violence preceding the actual death so they were traumatised by witnessing horrific things happening to their mother, I say mother because 90% of these cases were father killing mother.

In her therapy my 17 year old made use of drawing, she was quite a talented artist in a way, and one of the things she felt that she had to do and I encouraged was to say good-bye to her mother and to tell her the things that she wanted to tell her and hadn't

been able to tell her before she died. But this image of this bloody mother persisted throughout our contact. She saw her anger in her brain as a sort of garage that has got an enormous amount of junk in it, this is all the junk in her mind and each one of these images has a particular resonance for her in relation to her family and her father in particular. You can see that prison wall and the window.

One of the important things in talking about therapeutic work with these adolescents is that they should engage in therapeutic work, one of our findings in our follow-up study of our first 95 children was how few of them actually found their way to therapists. We have seen all 95 of them, they have been referred to us, but very often because we are national clinic we see children from all over the country and although we assessed them in need of therapy they are not able to travel to us to get it. We make enormous efforts to locate and try to find help for them in their locality but very to our disappointment when we did this follow-up study we found that very few of them had actually received any therapy. There are a lot of reasons for it, most important is lack of resources generally in the country but in particular this group of children were not considered to have a very high priority by the clinics that had to prioritise the work that they did and that's because they don't necessarily show symptoms that are disturbing to other people.

They avoid traumatic reminders, they are often somewhat dissociated in order to try and cope with these images, they may present in ways that are not seen as psychiatric problems, they may be delinquent or develop substance abuse, generally adolescents take great care not to alert caretakers to their internal agony and this is partly because they have lost one set of parents and are very afraid of losing second set of parents if he lets them know about how awful he feels. This is sometimes because he feels some guilt over the death of a parent and of course he may in fact have been unwittingly the cause of the death. We've seen many children who told the father about uncle Johnny who stayed the night when you were away working and of course still has the been an affair and has been the sort of cause and effect of father's anger. So many of these children are carrying enormous burdens which they don't let others know about except through ways that are not always recognised as psychiatric distress. One boy witnessed his mother kill his father when he was 6, she was not given a custodial sentence and she continued to care for him.

When he was 15 he was involved in a gang fight at school and he took a knife to that fight as many other young people. Somebody stumbled and fell and was yelled at to stab this boy that was on the ground and he had a flashback to the circumstances of the death of his father when he was 6 years old and I think dissociated, it was a very powerful experience and he dissociated and plunged the knife in to this man, into this boy and killed him. He got a murder rap and I was asked to see him much later on to see whether early experience might have been a mitigating circumstance. These children often present in ways other than the direct way of being affected by the death of a parent or loss a long time ago.

I wanted to talk a little bit about memory. Most of the symptoms of post traumatic stress disorder which is classified as an emotional disorder, most of the symptoms can actually be understood in biological terms and they are related to the what we understand about the neuro-physiology of memory. I don't want to give you a lecture on memory today I want to talk about processing traumatic perceptions because it is something that we need to understand if we are going to treat these children and adolescents. Traumatic experiences becoming coded by the brain differently from non-traumatic events. Only part of the experience is processed and the over-riding need is to diminish emotional flooding. That may lead to focusing attention away from the trauma.

Excessive stress may also directly impair hippocampal functioning which mediates the focal attention needed for what's called explicit or declarative memory. So you have a situation where only part of the scene is actually remembered and which is not properly processed through the normal memory channels which enables us, the explicit memory is memory that we can summon up at will, it's not properly processed and therefore I visualise it as going round and round in a circuit where it can be summoned involuntarily, so what happens is that you are walking along the street and you suddenly see a red wall for example in the case of my patient and you suddenly back in that room trying to comfort your dying mother with all the emotions that were present at that time and you have a most incredible experience of flashback phenomenon and this is related to the way in which the memories are processed. These non-declarative memories are also state dependent so that you can't actually remember them, you can't recall them to memory unless you are actually in the same

emotional state as you were at the time so that you have two things going on, and one of the reasons why some of these children appear to be unaffected by horrific things that they witnessed is because of the fact that they had to process them in a way which does not enable them to come to mind. So they appear to be very calm, very detached, they actually aren't perhaps symptomatic because they actually don't remember what happened.

Now you may think that that's a very good state of mind not to be able to remember these and very often I am told, well, I don't want her to think about it and to remember it, I want her to forget it. That would be fine if she could really forget it, but what happens is that it pops into the mind when you are not in the position to be able to control it and it overwhelms you and this I think is a reason why so many of these young people start to drink, to take drugs, to act out in delinquent way is because they are not coping properly with the memory that has not been properly processed.

Now, the question is, can we do anything about this. We do seem to be able to do something about it and I just want to end by talking to you about treatment. Firstly I think that it is possible to prevent the onset of post traumatic stress disorder. There was a fashion for some time which was called psychological de-briefing which was a single sessions in which you try to get everybody to let things hang out. Now that's been shown not to be effective and indeed follow up showed that children who had less than 3 sessions of any kind of psychotherapeutic help did as badly as those who had none at all. You certainly need to have as minimum 8 to 10 sessions. It is a question of what goes on in those sessions one of the most effective treatments that has been found recently has been called eye movement desensitisation and re-processing - EMDR - this again has got a physiological basis for it and although I am not going to go into detail. The basis of the treatment is the cognitive behavioural one and it has to do with being able to help the individual to summon up parts of the traumatic experience and deal with each part individually and separately so that they are not flooded by images which produce an emotional response which they find dystonic and therefore avoid.

I thought it might be helpful if you had a short reference list which I could take you through which might be helpful. There is a working

party documents which was set up by the government in this country to set up a plan for dealing with disasters, you remember we had rather a lot of them in the 80s and early 90s and this was circulated to all health authorities and directors of social services. Unfortunately the plan wasn't put into action. You know what happens is that you have all these traumas, people get very excited about it, and then we don't have one for a time so it all gets lost, but I recommend that as a very good plan which other people may actually take away with them. I added it to the book with others on psychological trauma developmental approach which takes on further quite a lot of the things that I've been talking about today. Road traffic accidents, I didn't mention today of course it is one of the areas which people are only just beginning to take a research interest in and that's very useful. Goodyear has looked at literature on long-term effects of stressful life events, this is a book on when father kills mother. Judith Herman in the States has written this I think brilliant book called "Trauma and Recovery, the Aftermath of Violence, from Domestic Abuse to Political Terror" and she particularly looks at the way in which rather like our disasters lead to a flurry of interest which then dissipated there's been a flurry of interest in what has been variously called shell-shock or traumatic neurosis and finally PTSD after each war but then people start taking an interest in it after these things fade out, but I just want to remind you about how when we were celebrating the end of the Second World War fiftieth anniversary in 1995 how many people crept out of the woodwork who had been traumatised by their experiences both in the Second World War and the First World War and they were still talking about their nightmares and their post traumatic stress disorder fifty years on or later. So I'll leave it just for a moment and say thank you very much.

Chairman - Thank you for this very difficult and very important lecture. We don't have time for questions and will continue with the last speaker on this session. I am looking forward to hearing this it's a pleasure to introduce Joy Trotter from the University of Teesside, she's been researching in the past into sex abuse of children and her present work is about more general aspects of sexual development of young people, she is talking about a homophobia and mental health in young people.

Young People, Homophobia and Mental Health

Joy Trotter

I was going to be glad to be last was because I was going to be talking actually about mental health that isn't just euphemism, I am interested in how young do stay and maintain healthy mentally particularly of what because of what they experience and what they go through in school is what I am going to talk about I think. The other reason that, well it's surprisingly that I was going to be glad because much of the conference has been very medical model, disease model based and people been looking at symptoms and doom and gloom and awfulness and problems, problems, problems and I was going to talk about some good things really, so hope fully we all get glad by the time I finished. Just to tell you my background, I am a social worker by profession and not a medic so that sort of makes me stand out a bit in this morning session and my background as you said was actually child sexual abuse and mental illness, but now I've been a lecturer and researcher for 11 years I have been working around equal opportunities and more recently sexuality and I think it's been a much nicer job than being a social worker. So I am quite a glad person, usually.

I am only half way through this research but one of the things I started with is what you are supposed to do I think when you do research is read a lot. And as sexuality was a new area to me academically I read all sorts of stuff. And I found all lots of things, and I read philosophy, and sociology, and culture studies but some of things that I think were important are that I found adult sexuality has diversified and relaxed and you find that sort of stuff in the newspapers and on the television that adults can be all sorts of things now and there is new words entered our language that ten years ago we never heard of and we might not know what they are but we are familiar with words like transsexual and those of us who are from England are watching Coronation Street will be following the trails of Haley who is transsexual so we are all familiar with some new words.

However on the whole young people sexuality remains restricted and prescribed and when it is given attention it is usually around prevention and I've certainly heard that over and over again at this conference today, preventing young people getting pregnant, young women getting pregnant, preventing child sexual abuse,

preventing them having sex really, is what I've been hearing. And children's sexuality continues to be denied. Few more themes I found in the literature that in the literature that's specifically about sexuality and there is lots of it, they must sell very well books with sex on the cover, that children don't feature in that hardly at all except as victims or by-standers but they are not sort of participating. And another thing that I found which I thought I heard again at this conference was that people connect, often connect sexual maturity with first heterosexual experience. And some people seem to imagine, or think, or believe, or cling to the idea that children are completely sex-free or sexually innocent until a penis goes into a vagina and then they are sexually mature and then it's sort of very sudden like that. And another thing I found, which I am not going to go into now, there is a lot of confusion who is responsible for all this.

I said that I did do quite a lot of things apart from reading and I'll tell you about what I did do and then skip the results I think. The first thing that I did was some participant observation with a group of young women. The young women were already a group and they were some women who had excluded themselves from school having been bullied. So they were being taught in one of those units for young people that don't go to school and I was called to do something with them. And I wanted to do something about sexuality because that's what I am researching, they didn't want to do that because they we weren't interested in that, they made a rather good video about bullying at schools and it was extremely good and they did really well, but I did learn lots. They knew I was doing that as well about sexuality and about mental health from them while I was doing that, so that was the first thing I did.

The second thing I did was read lots, I got permission to go to two large secondary schools in a poor area near where I live and I read a lot of documents, I interviewed staff, not as many staff as I'd wanted to but I interviewed 11 staff so far. And lurked about in the corridors and things and looked and watched and appeared very suspicious I think. But still again I learnt lots about sexuality and about mental health in the bits I did at school I observed mental health, not mental illness.

I found in the school policies that although the school had recent strategies and policies about racism and sexism, and sexual

harassment, and bullying, very active policies about bullying, which were commonly referred to and available there were no policies about heterosexism or homophobia and sexuality was not an issue requiring attention, I found it mentioned nowhere at all in school policies. In the documentation revealed I looked at the curriculum and found that sexuality was only ever I could only find it in sex education and that was in two sort of forms, either health about sex education and health and that was about preventing AIDS, HIV, preventing pregnancy and preventing abuse, very much like we've heard in the conference today, or the mechanics of sex education, what goes where stuff that I don't know about. But both of those focuses leave the responsibilities firmly with the children, firmly with young people, it was about how they shouldn't get pregnant, how they can protect themselves from strangers and weird people, and it was all about them doing it. In the interviews staff acknowledged ignorance regarding sexuality issues, they were quite up front about that, they didn't know anything they claimed. And most of them acknowledged that homophobia was present in the school very readily told me about things that they heard every day in the corridors, in the classrooms, just in a shot that they knew there was homophobia in the school. But they all had considerable difficulty with language, none of them could say the word "lesbian" to me, one or two attempted the word "homosexual" to me but not all succeeded, but when I pressed them to tell me what it was they were hearing in the corridors and in the back of the classroom and things, I mean they had to pressed to tell me what they heard, they warily looked and sort of said, oh, all sorts of derogatory terms and things, but they managed to pronounce those quite well.

And finally from the staff interviews most interviewees assumed that all the pupils parents and staff were heterosexual, that assumption heretosexualness which is heterosexism. Some of the staff even blamed the young people for homophobia quite blatantly distanced themselves from it and the majority of staff however said the sexuality didn't require attention, that was absolutely opposite of what they were saying, but they didn't need to deal with it in their school.

So my conclusions, quite a lot really and my conclusions come from all the reading as well as from the work with young women in the video group and my lurking around school. That heterosexism and homophobia are present in schools in England, or they are in

the 2 that I went to and that lesbian, gay and by-sexual staff and young people are not visible. Professionals avoid sexuality issues in their work and links between homophobia and mental illness are difficult to demonstrate. That anti-gay harassment and violence is increasing in schools and that heterosexual young people are more likely to be targeted about harassment and violence than lesbian, gay and bisexual young people. That those targeted are significantly more at risk of self-harm and mental illness, however despite all this and despite school indifference to all this or to most of this most of them avoid ill health.

So the last part of my research that I am going to get into very very soon is going to be focusing on that how come there is so much homophobia, so much heterosexism and so little interest and concern from the adults around young people how do they survive, not survive how do they stay mentally healthy. And I think it's going to be these 3 things: conforming, confronting and escaping. Many young people are conforming and they are appearing and that's the important thing heterosexual, heterosexual young people are working at it as hard as lesbian, gay, not yet decided by all people and working at appearing heterosexual because that's how you get through, that's one of the biggest strategies for getting through and staying healthy. Some are confronting, some of them are challenging homophobia and reporting harassment. I don't think they are getting much response from the adults but the confronting is a good way to stay healthy and doing something about it. And unfortunately a few are also surviving by escaping. There is escaping psychologically or actually and the leading schools one was what my young women in my video group had done they were sort of the extremes, but left school or withdrawn from school to avoid it. So I am going to be looking in the future how this resilience manifests itself.

Plenary Session P6 Social and Behavioural Issues

Chaired by Joan-Carles Suris - Barcelona Spain and
David Baum - President Royal College of Paediatrics & Child Health London

The Care System

Keith Drinkwater

The Public Care System for children & young people in this country is in deep Trouble!

This is a gross generalisation and I would not want to ignore the very good work done by the many skilled and committed staff in Social Services Department, nor the many success stories : families happily reunited, new families created and young people who have made a success of their lives.

Nevertheless, for years now we have been subjected to a barrage of news headlines which confirm the truth of my opening statement. Inquiries & investigations into widespread abuse in children's homes in Wales and prosecutions in Cheshire, Liverpool and elsewhere. The report by the Social Services Inspectorate "Someone Else's Child" which included 27 local authorities in England showed that there was not one where all safeguards were being applied. Management was criticised and only 9 out of 27 authorities had plans for all of the children for whom they had responsibility.

A recent report by the British Agency for Fostering & Adoption showed that the problems are not limited to young people. Even very young children often languish in care for several years before they are placed with adoptive families.

SOME FACTS - I in 200 children in this country is "in care" (used to describe both those who are "Looked After" & where there is an order). This is 0.5% of the population of under 18s in this country. Children in Foster Care on average experience 5 moves. We are also becoming more aware of the incidence of abuse in foster care.

Young men in care make up 22% of the prison population.
38% of prisoners under 21 are, or have been, in the Public Care system.
55% of homeless, single people were in care. 1/3 of rough sleepers were in care.
75% leave care without an education qualification, 25% of those aged 14 and over failed to attend school regularly, 80% had no job to go to.
Between 14-25% of young women leaving care have a child or are pregnant. (Only 3% of 20 year olds in this country have children and the average age for a first child is 27).

Many of the young people in the care system have experienced difficult, disturbed and sometimes chaotic life styles. Many will have experienced abuse or have experienced violence in the family. Some will have developed a pattern of running away from home, truancy and delinquent behaviour. This will often have resulted in a "Mind Set" which is characterised by concluding that there is no future – lack of planning – mercy of fate – impulsiveness - with no concept of a career - or stable family life. They are often not easy to help or even relate to. The dice are stacked against the Public Care system succeeding in many respects, but these are all children, unique and of great value.

Many of the provisions for helping and supporting young people in the care system already exist. Representation & Complaints, Independent Visitors, Guardian ad Litem, training in how to relate to children etc. Some solutions rest with Governments, both central & local. The Government has announced a number of measures recently, some directly relating to the care system, others such as provision for young children & the Social Exclusion Unit. Local Authorities are being urged & required to give higher priority to the care of the children and young people for whom it is responsible - eg to end the virtual abandonment of young people on reaching the age of 16 yrs (the power has existed for many years, refocusing away from largely ineffectual obsession with child protection. I hope that these measures are all successful.

There are some very simple things that we can do to improve the situation. We can involve young people and really listen to what they have to say. We can give them some real sense of control over what happens to them. We can offer them opportunities to succeed in something – "Nothing succeeds like success". Certainly

nothing can give a boost to self-esteem, self worth, than being treated as if you are a person of value, listened to and taken seriously and given opportunities to succeed.

A young woman talking about being in care and the stigma attached to it stated: *"That can cause people to run away. It really distresses them. They make us feel like you're an outsider. You don't belong. You're not human just because you're not from a steady background"*

Young people in care who were involved in Running Away responded to Who Cares Magazine and produced the following wish list: Talk to the Kids & listen to them.
Have more experienced staff who've been in care or fostered and who know what they're talking about.
Stop having incident meetings for the whole children's home and just have a meeting with one member of staff and the young person.
Have more meetings for kids to talk about these issues with independent people, such as The Children's Rights Service.
Treat young people as if they were their own children.

Not outrageous are they? Pretty modest really & very sensible/ reasonable. Are they too much to ask for our children & young people in our Public Care system? I think not!

Epilepsy in Adolescence

Frank Besag

Introduction

Although the incidence of epilepsy is high in adolescence and the prevalence of psychiatric disorder is also higher than in childhood or adulthood, specific services for adolescents with epilepsy are rarely provided. This subject also, surprisingly, receives little attention in many books on epilepsy. Adolescence is a time of great change, with growth into adulthood and the issues of preparation for university employment, driving, drinking, social/sexual relationships preparation for marriage /conception and a general increase of responsibility. Epilepsy impinges on all these areas to a significant if not major degree. In addition, adolescents tend to be very body-conscious and do not like to be different from their peer group. The stigmatising effect of a condition which implies loss of control and requires the regular taking of medication is liable to have a very adverse effect on the adolescent unless the situation is managed well. Denial of the epilepsy may lead to risk-taking which may include the refusal to take drugs or to take other precautions.

Management dilemmas

There are some specific management dilemmas in adolescents with epilepsy. Although the focus of both the initial interview and follow-up discussions should be on the adolescent, because the history depends so much on the informant it is necessary to interview the parents. This situation needs to be explained to the adolescent.

Sodium valproate is the drug of choice for a number of the epilepsies of adolescence and is certainly the drug of choice for juvenile myoclonic epilepsy but may be associated with weight gain; this is a particularly unfortunate adverse effect in body-conscious female patients, who may refuse to continue taking the drug.

The dilemma of declaring epilepsy on job/college applications may need to be discussed. Although it is important to be honest with a prospective employer, the applicant will generally not obtain the job if they are not interviewed, and the declaration of epilepsy may prevent short-listing. One option used by some applicants is to leave the appropriate place on the form blank and, after the job

has been offered, to declare the epilepsy in a positive way, explaining how this should not interfere significantly with the ability to carry out the duties required and indicating what measures would need to be taken if a seizure occurred at work.

The broad area of independence versus safety is a difficult one for an individual who is trying to establish independence and a smooth transition to adulthood but may need to rely on others to some extent to maintain safety. The specific issue of drowning in the bath must always be discussed in this context. The issue 'independence versus safety impinges on a number of other areas. Adolescents do not like being told what to do. The doctor should try to avoid "giving advice" but should, instead, encourage questioning and provide information,emphasizing that the individual is in control of his or her own life. The following are suggested rules for the doctor.

1. Always talk to the adolescent first, ignoring the parents initially.
2. Ask the adolescent to introduce the parents to you.
3.Explain to the adolescent what will happen in the appointment
4. View talking to the parents as a "necessary evil" and explain to the adolescent why this is necessary.
5. Write to the adolescent, not the parents.
6. Ask the adolescent's permission to send copies of the letters to the parents.

In addition the following practice points should apply.

1. Check the diagnosis.
2. Characterise the syndrome.
3. Provide accurate prognostic information.
4. Treat with appropriate medication.
5. Provide information on the following. The high risk of the unsupervised bath. The effect of irregular sleep Alcohol Driving Sport Employment Contraception Genetic implications Advantages/ adverse effects of specific antiepileptic drugs
6. Listen, counsel, inform; avoid giving advice.

Diagnosis

There are a number of syndromes which should not be missed. The following may present in adolescence.

Juvenile myoclonic epilepsy
Juvenile absence epilepsy
Epilepsy with grand mal on awakening

Benign partial seizures in adolescence
Photosensitive epilepsy
Reading epilepsy
Subacute sclerosing panencephalitis
Epilepsy from cortical brain tumours
In particular, the important syndrome of juvenile myoclonic epilepsy should not be missed.

Juvenile myoclonic epilepsy - This is an idiopathic generalised epilepsy syndrome with age-related onset, commonly between 12 and 18 years. The sex distribution is equal. Bilateral, single or multiple irregular myoclonic jerks occur mainly in the upper limbs. Most of the patients who present for treatment also have tonic-clonic seizures and many have absence seizures. The seizures predominantly occur soon after awakening. Patients often present with a history of one or more episodes of having a tonic-clonic seizure on awakening. The doctor should always ask specifically about morning myoclonic jerks, slowness or clumsiness. Specific enquiry should also be made about "blank spells". Patients often do not declare the myoclonic jerks or absence seizures. If this information is not available a diagnosis of juvenile myoclonic epilepsy is likely to be missed. It is very important to diagnose this condition because most cases respond very well to sodium valproate but this needs to be continued long-term even if the patient is seizure-free for years the chance of relapse is high if the sodium valproate is stopped. It has been suggested that the new drug, lamotrigine, may be effective in subjects who do not respond adequately to sodium valproate.

Juvenile absence epilepsy -The onset of this syndrome is usually between 10 and 17 years. Males and females appear to be equally affected. The subjects are usually neurologically normal. A family history of epilepsy is common. The photosensitivity rate is high. Over 80% also have generalised tonic-clonic seizures. Absence seizures usually respond very well to treatment with standard anti-absence medication such as sodium valproate or ethosuximide.

Epilepsy with grand mal on awakening -The peak onset is around puberty. The seizures occur exclusively or predominantly soon after awakening from sleep at any time of the day, with a second seizure peak during evening relaxation. Seizures may be precipitated by sleep deficit excessive alcohol or sudden arousal.

Benign partial seizures in adolescence - This syndrome needs to be distinguished from benign partial seizures of childhood. The onset is 10 to 20 years with a peak around 13 to 14 years of age. It is more common in boys. There is usually no family history and no cognitive or neurological impairment. The subject has simple or complex partial seizures, frequently with secondary generalisation. There may be a cluster of two to five seizures in 36 hours. The patient may have only one episode of either a single seizure or a single cluster of seizures. The EEG is typically normal or shows only mild abnormality. There is no typical EEG pattern, in contrast to benign partial seizures in childhood with centro-temporal (rolandic) spikes. Because benign partial seizures in adolescence often present with only one seizure or cluster of seizures treatment should be avoided unless there is a recurrence or unless there are particular reasons for treating.

Photosensitive epilepsies -These are more common in adolescence. They are most often detected around 12 to 14 years, although careful history taking may elicit an earlier onset. Two-thirds of the subjects are female. Photosensitive epilepsies are not a single syndrome. It is always important to define the syndrome in which the photosensitive epilepsy is occurring, such as juvenile myoclonic epilepsy or juvenile absence epilepsy, so that specific information on treatment and prognosis can be given.

Reading epilepsy - This is a rare, benign form of epilepsy with mean onset of 17-18 years. It is more common in males. There is a strong genetic predisposition. The diagnosis is facilitated by the very characteristic motor/sensory aura: after reading for a period, abnormal senations or movements occur in full consciousness, involving the tongue, throat, jaw, lips and face. If the patient does not stop reading, this aura may progress to a tonic-clonic seizure. If the subject stops reading when the aura occurs, tonic-clonic seizures can often be avoided and treatment with antiepileptic drugs may not be necessary. If treatment is given then sodium valproate appears to be the drug of choice. The interictal EEG is usually normal.

Subacute Sclerosing Panencephalitis - This typically follows measles infection very early in life, under two years usually presents in teenage years with relentless deterioration and eventual death. Initially there may be subtle loss of intellectual

ability but myoclonic jerks or more complex abnormal movements soon become evident and the ensuing dementia is all too obvious. The EEG is characteristic, with a discharge in all leads when each jerk occurs. Measles antibody is raised in blood and is high in CSF.

Epilepsy from cortical brain tumours - Although cortical brain tumours can occur at any age, sub-tentorial tumours are more characteristic of childhood and are less likely to present with epilepsy. In adolescence there is a greater risk of cortical tumours. Because of this, serious consideration should be given to investigation with neuro-imaging of adolescents who present with partial seizures. The exception would be those with characteristic benign partial seizures, as described above, with a single seizure or single cluster of seizures and no recurrence of the adverse effects of the epilepsy, even if the seizures themselves are controlled.

Conclusions - Adolescence is an exciting but uncertain period. Epilepsy may present for the first time in adolescence, adding greatly to complexities of this period. Well-established epilepsy may vary over the span of adolescence increasing the uncertainty when so many other changes are taking place. In managing epilepsy in adolescence it is important to consider specific syndromes and causes because these may require very different styles of treatment or management. It is also important to consider impact of epilepsy on the life of the adolescent and to minimise the isolation and stigmatisation the teenager may feel at a time when being part of an approving peer group is so important. These factors plus issues of alcohol, driving, sport, contraception, genetic implications and "safety versus independence", imply that the management of epilepsy in adolescence requires skill and sensitivity.

Working with Young Men in Rural Communities

Simon Blake

I am currently project officer based at FPA London, responsible for a consultancy, training and project based service focusing on the sexual health needs of boys and young men. From 1996 - 1998 I worked in South Wales running a Healthy sexuality in the Community project - targeting boys and young men. The project is still continuing today, and based on its success and a recognised need is now working with younger boys aged 11 - 14. The work that I am going to outline today was with 14 - 20 year old young men. The project tutor team consisted of myself and 10 volunteers who were recruited from the local communities and underwent an extensive training programme.

What I hope to do today is

- outline a rationale for using the volunteer model
- outline the reasons for specifically targeting young men
- share the projects experience and the underlying principles which it has found effective when working with young men
- provide some practical strategies when working **with** young men.

In doing this I will draw upon the findings of the Sex Education Forum's project *'Let's Hear it for the Boys'* of which I was a member of the working group. Before starting I would like to remind you that young men are all shapes and sizes, come from different races, religious and cultural backgrounds, have different abilities and disabilities and different sexualities. Today I will aim to highlight general principles of good practice when working with young men.

So what is currently happening with young men in the UK?

They constitute approximately 3-20% of all Sexual Health service users - and generally do not ask for help at all. The repercussions of this are highlighted by the increasing suicide rates, and the rise in STI's, where HIV infection still remains particularly high amongst young gay and bisexual men.

Girls and young women are overtaking them academically at both G.C.S.E. and A level standards and there are high levels of concern at the social exclusion levels amongst young men. Homophobia is still rife - the recent report by THT Playing It Safe re-emphasised the traumatic experiences many gay men have at school. Prejudice comes from both teachers and peers.

And specifically in sex and relationships education:

Many workers in the field report that they are disinterested, they do not listen and they do little but mess around. The Sex Education Forum's project and the FPA project in Wales show that young men are interested, they do want to talk - **but** about issues that interest them. Young men say that their sex education is 'too little, too late, too biological'. The most common feedback I get from young men when talking about the sex education sessions is -'*it was good because you asked us what we want.'*

The sessions also need to be delivered by somebody that the young men relate to. This is where the benefits of the volunteer model training people from the communities apply. Before becoming a sex educator they undergo the FPA's accredited training programme, and then with ongoing training, support and supervision from myself and peers provide educational opportunities in their communities.

If I can tell you a little bit about Rhondda Cynon Taf and Merthyr Tydfil. They are old mining communities where since the breakdown of the mining industries massive poverty and unemployment has arisen. Some members of the community are resistant to outside 'professionals' preaching about lifestyle change. I was one of those professionals -

'I confidently walked into the centre for the first of a series of sessions. I felt good having just returned from a beautiful holiday - the reception I received was far from empowering, I was hurled racist and homophobic abuse. Racist because I have dark skin and had a sun tan, and homophobic because I dared to try and work with young men around issues of sex and sexuality - I must be gay and a child abuser. I left to find my car trashed - the wing mirror broken and felt silently shattered as I drove the A470 home.

3 months later a male and female volunteer from their community, with the right accent and the right experience delivered a set of 6 very successful and wonderfully evaluated sessions. This really emphasises the point that young men **must** have somebody they can relate to, who they do not find threatening.

This is a crucial learning point when working with any group - since then I am delighted to say I have had no more experiences of this kind - and the sessions run by myself and the volunteers have been very well received. The key learning points from working with the young men over a period of two years have been.

Have a positive starting point - we must move away from the idea that young men are a problem that need to be changed. As a colleague described 'it is about trusting that young men are ok and the more chance they get to explore their sexuality the less likely it is that they will abuse themselves and others'.

Use opportunistic interventions - it will not always be possible to do groupwork immediately. You may need to use television programmes and situations within the setting to just offer a line or two or engage in conversation with young men.

Consult with the boys - do not assume that you know what young men want and need. Consult with them, ask them what they want, where they want it and who with. Sex and relationships education sessions are not likely to be able to compete with certain activities. This also creates an ethos where the young men feel involved in the process and are more likely to participate.

Create a safe environment - talking about sex and relationships amongst young men is often a new experience. They need to feel safe in doing this. It will be easier to do if there is a clear policy and values framework within the whole setting that supports the specific education sessions. Below are some strategies for doing this.

You as the best resource - Young men need the opportunity to engage in a genuine dialogue. To enable them to do this they need to feel confident in the facilitator. Young men have said that it is important not to feel embarrassed, or in particular to be embarrassed by the facilitator. By showing empathy with the

young men's experience and really listening to them you can optimise the time that is spent with the young men.

Use a developmental programme - there is general agreement that active learning methods that involve the young men In their learning work best in sex and relationship education. Involving the young men will also ensure that the sessions are relevant to them. Ask them what they would like to cover. Use trustbuilding games and activities to increase the safety of sessions. Explore the 'safer' topics first, ones which are information based, and as young men become more confident in working in the group move onto exercises that explore attitudes, values and emotions.

Third person techniques - Using role play, drama, case studies that are relevant to young men so they can explore situations without being exposed to peers and vulnerable to bullying.

Single sex groups - these allow the young men to explore issues and concerns that are relevant to them. Girls and boys have different concerns and worries, in single sex groups boys can explore what is relevant to them without being censored and importantly without 'losing face' in front of the girls. It also encourages them to support each other and experience a different way of being together. However some young men have specifically asked to work in mixed sex groups and it is important to respect their wishes.

Male of female tutors - there are often debates about whether male or female facilitators are best. Young men have said it is not that important although they would like a man for some issues. More important than gender however is empathy with their experience. The project in Wales has male and female volunteers and both have been equally successful. We must acknowledge the importance of involving men as educators and encourage and support them in taking on this role. They can provide positive role models, and of course they know what it is like to grow up as a boy and a man.

To conclude, it is important to develop and review policies, explicitly stating how the needs of boys and young men can be met. Consult with them, listen and review

Working with young men is challenging and rewarding, ultimately doing the work has enabled me to learn to like young men more, and understand that the pressures heaped upon them (and myself) to behave in certain ways can make growing up a very painful and isolating experience.

The work has been written up and and published by the FPA in 1998. *STRIDES: a practical guide to sex and relationships education with young men.* Simon Blake and Joanna Laxton. It contains theoretical background, guidance on planning, delivering and evaluating sex and relationship work with young men and practical exercises and ideas. At £15.99 it is an absolute bargain and has been endorsed by the National Youth Agency, with Gill Lenderyou, senior development officer at the Sex education Forum stating, ‘at long last a resource that will really help improve and develop sex and relationships education for boys.

Health Education For Adolescents - Does it Modify Behaviour?

Christine Ferron

I would like to start my presentation by clarifying a point that seems important to me, in order to eliminate the risk of misunderstanding. When I sent my abstract to Youth Support, a few months ago, its title was : "Health education for adolescents : how can we make a difference?" This title was changed to : "Health education for adolescents : does it modify behaviour?". Different cultural sensitivity? Different perception of health? Different perception of education? My first reaction was to ask for a return to my first proposition, then I thought that it might be an interesting point to make in my introduction.

To modify behaviour : is that really, and always, what we want? If yes, is there always a defined direction? Does it mean that we can always relate to consensual norms? Are there recipes to accommodate adolescents' behaviour to our taste? When we have done our educational duty, how can we know whether we actually modified behaviour in our public? How can we be sure that behaviour was changed in the way we wanted? How do we measure behaviour? By asking? "Hey you, did you use condom at last intercourse?" 75% of French adolescents would answer "yes" to this question… And if there is still a probability that we failed in our attempt to change adolescents' behaviour, should we then stop doing health education with adolescents?

Maybe you see where I am getting to. My initial interrogation "How can we make a difference?", was more modest, more realistic, and more methods-oriented than results-oriented. In France, to modify behaviour is certainly not an objective for national prevention programs which are implemented through a large media coverage. Rather, these programs intend to give young people opportunities to think about their health, to clarify their choices, and to make them aware of their responsibilities. Although the possibilities of changing behaviour may be more important in local actions, this objective is not central to prevention programs which are implemented in schools, neighbourhoods or communities either. In this context, to do health education means to increase young people's awareness of their ability to be in charge of their own health and to adopt a healthy behaviour. Depending on the

adolescents' personal situation and social context, behavioural change may or may not occur. It may also take more than one action before a slight change in attitude, a slightly raised consciousness, initiates a process towards a healthier life style. How can we contribute to this evolution , how can we make this difference?

There is a fundamental misunderstanding between young people and health professionals. For the latter, an excessive use of tobacco or alcohol, using drugs, taking risks, getting pregnant, are all problems. For the former, these are answers to their problems. So there must be a misunderstanding on solutions also : trying to modify behaviour on one side, finding a place and a role, a life project, a reason to live, on the other side. Health professionals' attitude often consists in unplugging alarm systems, without knowing why they started to ring in the first place. For health professionals, there are three main traps that should be avoided : rationalisation, an overly medical approach and blaming the victim. Adults' behaviour is not rational : in French, we say that "le cœur a ses raisons que la raison ne connaît pas", which means that you may fall in love with someone who is apparently not the right person for you. In adolescence, determinants of behaviour are usually not more rational than adults', but maybe more specific : search for immediate pleasure, experimentation to test one's limits or to feel more intensively alive, peer pressure, need for recognition and belonging, perception of body and self… See, for example, the reasons for not using a condom with a new partner : rational assessment of risk has usually little to do with these reasons.

An overly medical approach of daily life is another risk. When medical knowledge takes all the available space, popular knowledge is impeached and the transmission of skills within the population is disqualified. For instance, when we talk about nutrition with adolescents - a seemingly neutral subject - we must be very careful not to abate the worth of families' or parents' life style or food habits. Health professionals should be very well aware that their perception of adolescence and health behaviour depends on their own social, cultural and professional background. When we do health education with adolescents, we should acknowledge these personal values in order to leave them aside, for example when we talk about sexual issues with adolescents. There is our opinion, for example about sex out of wedlock, and

there is the adolescents' sexual experience, and the latter should be central to our action.

Blaming the victim is the last trap, and we are very close to it when we focus our intervention on individual behaviour and individual responsibility, without taking into account other influential factors, like environmental ones. Then the risk is to increase a feeling of guilt, and adolescents really do not need that : because of the confused feelings associated with the sexualisation of their body, or with masturbation, guilt and shame are already part of the adolescents' psychological life. Increasing guilt, shame or fear inhibits their ability to take a positive action for themselves. So, what can we do in order to increase our chances of making a difference?

Let's start by relaxing a little bit. Stereotyped health education messages to adolescents usually sound like : "So you like that stuff ? Eating fast food, being drunk, driving fast, listening to loud music, even falling madly in love… Well, it's bad for you". Adolescents are then supposed to give up pleasurable experiences without even trying. Would a child learn how to walk without taking the risk of falling ? Adolescence carries deviance by its very essence. One of adolescents' tasks is to question the norms of their family or of society. Health educators should learn to give up any attempt to control or master adolescents' lives. We should really make a conscious effort to distinguish between risk and experimental behaviour. Risk behaviour is adopted by hopeless adolescents, who place their life at stake. These situations represent social emergencies. Experimental behaviour helps adolescents build their identity and helps them know who they are. Adolescents' normal experimentations will be naturally structured by their self esteem and their psychosocial skills.

How can we try to help adolescents develop their self-esteem and personal skills? First, let's try to talk about health in an educational framework, rather than in an instructional one. In the instructional frame, there is a corpus of knowledge which exists externally to the individuals and to the relationships between people. Relationships are central to the educational process, and knowledge is built inside the relation between health educators and their public, men, women, adolescents considered in all their dimensions (social, psychological, cultural, medical) and their objective living conditions. Health is not an ordinary subject, health

issues are intimate and complex, and health information is never neutral, because it relies on particular perceptions and values. Our responsibility is to help adolescents build their own opinion from their contradictory desires and the contradictory messages they receive, help them find out the determinants of their behaviour, and develop their ability to listen to each other, to express themselves and to deal with their emotions.

Second, health education should be included in adolescents' projects and concerns, because information which is contrary to their beliefs and practices will not be heard. An action focused on a given issue should always start with an exploration of adolescents' knowledge, beliefs, opinions and worries about this issue. Mentioning a virtual risk of getting a disease in a distant future is not efficient in health education with teenagers : their representation of death is different from ours, some of them are more afraid of living than of dying.

Health educators will find support for their action within the reality of adolescents' lives and in their centres of interest : according to a study we conducted on the perceptions of health among adolescents, these centres of interest are :

- relationships to others (misunderstandings, anxiety, self image, depression) and relationships to the surrounding world (television, politics, money, racism, poverty) ;
- interest for body functions (puberty, body image changes, sexual issues) and for the functioning of the universe (information, discovery, progress) ;
- taking care (diseases, allergies, medications, pain) and having fun (temptations, appearance, attraction, fashion, friends) ;

and the main youth issues : on a negative side, internal violence (self-damaging behaviour) and external violence (conflicts, divorce, pollution), and on a positive side, the adolescents' capacity to take some distance (music, humour, and sleep).

A broad vision of health is the key to health intervention with adolescents. Instead of being invited to repeat adults' messages about health, they should be encouraged to express themselves and to say what they already know, what they wish they would know, what bothers them, what makes them unhappy, and to imagine their own solutions. This may occur during debates, role playing and group discussions. The French Committee for Health Education is very much involved in the training of teachers and

school health professionals, because they remain in schools long after health educators - "outsiders" - have left. We believe that it is important for adolescents to have a permanent guidance for their health concerns, in the school they attend.

From the meeting of adolescents' skills and professionals' skills, new skills will emerge, which will increase the autonomy of all the partners of health education. The idea may be more to increase adolescents' ability to intervene, than their ability to get adjusted. Then health education will have a slightly higher chance of making the world a better place…

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Deprived Youth in Russia

Andrei Smirnov

Finding solutions to the problems of adolescent deprivation in our country is one of the most important goals for a wide range of government and non-governmental organisations health service, judicial structures, the social services, education, social and Charity organizations. By deprivation we mean the psychological state which occurs as the result of a life situation where the subject is given no opportunity for satisfying some of his vital psychic requirements to the full extent and over a long period of time. Deprivation is a life style giving no opportunity to satisfy important psychological needs Children experiencing equal degrees of deprivation will behave differently and have different outcomes.

According to data of Russia General Statistic Department by the beginning of 1995 the number of children not in parents' care was 443,000. The majority of absent parents are alive, 113,000 children have been adopted, 201,000 are under somebody's guardianship or trusteeship. 112,000 were living in boarding schools for the mentally and physically disabled children. 70% of them suffer from delayed mental development and behavioral problems.

According to data of the Serbsky Institute of Forensic Psychiatry the following were characteristics in children deprived the parents' care:

Psychic pathology	80%
Mental retardation	33%
Organic CNS damages	39%
Organic disorders	7%
Psychopathic qualities	6%
Oligophrenia	18%
Neurotic disorders	12%
Chronic psychic diseases	6%

One of the main characteristics of recent years in Russia is a return of the problem of homeless children which existed after the Civil war and the Second World War. There are no exact statistics of the number of uncared for children. According to the results of the investigation of two hundred children in one of the Moscow asylums within three years there were 8% of real orphans (the lack of the both parents), 59% of them had one and 42%- both parents alive.

The main reasons for placing a child in the asylum are following: anti-social style of life of the parents, poor hygienic conditions and hunger- 35.5%; losing the child (deliberately or by default) at the railway station, while shopping, while visiting an outpatients' clinics without efforts to search- 26.5%; nomadic lifestyle because of having no parents' care- 14.5%; escape from home after the family conflicts- 8.5%; the death or continuous staying in the hospital (more often in psychiatric or addiction unit) of the single parent - 9%; Lost accommodation as a result of crime - 6%.

Recent years shows a significant increase in the level of adolescent crime (data of the Moscow Serbsky institute).

Trends in Juvenile Crime
Moscow adolescents over a 5 year Period.

Murder	+141%
Grevious bodily harm	+20.2%
Robbery	+122.1%
Fraud	+102.7%
Drug dealing and manufacture	+392.8%
Crimes in alcoholic state	+111.7%
Crimes in drugged state	+140.7%

The same growth in adolescent crime was noted in Russia in the above-described periods of time, characteristic of a high level of homelessness and absent caring for children.

Organisations dealing with the problem. There are some structures dealing with the adolescent deprivation in present day Russia: Social service (called here as the Social defense service)- provides the organization of asylums for adolescents and children where they stay not more than six months and after that have to be placed in an orphanage or to be adopted. Education system- includes some specialized institutions: specialized schools for children needing intensive teaching methods, those with behavioral disorders, for the children who don't want to study, for those escaped from home; schools for mentally disabled children; boarding schools and the orphan houses.

The Home Office structure (called Militia) also contains: special Centers for temporary stay of those escaped from home or who committed crime; labor and tutoring colonies for under aged sentenced by the court The Health service organizations deal with

the problems of adolescent deprivation in the child and adolescent psychiatric services and their main problems are: low levels of therapy with the majority of physicians oriented towards medication.

The main goal of our research is to investigate the typical so called 'closed' institutions which work for the social-psychological rehabilitation and resocialisation of the adolescents. These institutions relate to the three different Departments and they create the deprivation themselves while working with the adolescents.
The subjects of our research are: The Interregional Center for the temporary isolation of adolescents (ICTIA).; Specialized School for the delinquent children. The District Social-rehabilitation Center for the under age children which lost their parents' care and the orphans (The Asylum).

The Interregional Center for the temporary isolation belongs to the Regional Home Office Department and is intended for the boys living on the territory of the Sverdlovsk region, West Siberia and European part of Russia up to the city of Samara. There were 1246 children in a 9 months period last year and for the same period of this year - 1100 children in the Center.

The monthly rates were 138 children last year and 123- this year. There are 30-70 children at any one time. The average repeat stay in the Center is 34.5%. 14.6% of them last year and already 26.8% this year- have committed crime. Others were vagrants who attracted Militia's attention by their behaviour (beggars, prostitutes and other social disorders). While interviewing them the lack of parents' care and permanent place of accommodation becomes clear. Usually these children come to the Center from poor social conditions and they suffer from numerous diseases: 13% of them last year were sick with different infectious diseases, and 10.9% of them had scabies and pediculosis this year already 57.7% of them have scabies; more than 80% of them suffer malnutrition, growth abnormalities and various chronic digestive diseases; all have behavioral disorders and most have psychological problems; All of them are terrible smokers and 70% of them used drugs and alcoholic beverages. 19 tutors, single pediatrician and 3 nurses provide the medical and tutoring activity in the Center. All of them have neither pedagogic no psychological education and there are no psychologist or psychiatrist in the Center.

Specialized School for the Delinquent Children is an educational structure. It deals with the boys committed criminal actions but who haven't reached the age of criminal responsibility. At the moment there are about 120 children at School aged 11-15 years old who were sentenced to stay for a time of 2-3 years. 15% of children are orphans and 52% lack either of their parents. The regime at School is rather strict and meetings with relatives are permitted once a week. Most parents do not visit children or do it episodically, which serves to make the deprivation worse.

Two psychologists and one psychiatrist provide psychological services in school. It is clear to both administration and staff that they lack adequate psychological training, are unqualified in the problems of psychological rehabilitation and in working with the adolescents' families which are usually not ready to receive the child back.

The District Social Rehabilitation Center is part of the administrative structure of one of the city districts of Ekaterinburg. This Center works with the children who have lost their parents because of different reasons: their parents have been deprived parental rights, or they are for along time in prison or in the hospital (more often in psychiatric one), or they are dead, so in the cases when they not provide their parental duties. Its goals are: prophylactic activities aimed at prevention of lack of care and nomad life of the adolescents; temporary residence and welfare for the adolescents in difficult life situations. The final aim of this Center is to get the child back home or to send him to the orphanage or other family.

There are 32 children in the Center today. And the staff of it consists of twenty tutors, two psychologists, eight social workers, three physicians, Five nurses and one speech therapist. Almost all children staying in this Center have behavioral deviations and chronic diseases; 30% of them have mental retardation and 20% have mental development delay. Usually children stay at this Center from 2 months to one year and then they go to the Orphanage or they are adopted by the family.

Summing up all these institutions relating different Departments have the very same problems. And it appeared that: the administration and the staff of all of them are strongly motivated to

improve their professional skills in child and adolescent psychology and social rehabilitation; it is necessary to improve the level of medical and psychological aid to this group of adolescents and their families. Apart from general problems such as finance there is no organising or coordinating structure which works with the families, training of specialists and improving of their qualification (it concerns all related professionals-psychotherapists, psychologists, teachers and social workers). We suggest the elaboration of programs for training and improvement of qualification for the staff of these institutions and also diagnostic and rehabilitation programs for the children.

The main directions of them are the following: assistance for both government and non-government structures in training and increasing the professional qualification of their staff in the field of adolescent and family psychology and psychotherapy; Elaboration and realisation of training programs for the students, physicians, psychologists and social workers.; Organization and providing services for deprived youth and families in the institutions of Health care and Social services; Providing psychoprophylactic activities with the risky families; Introduction of practical and scientific ideas of Russian and foreign specialists; Participation in the accomplishment of international programs.

The Family Therapy Development Fund's activities - coordination of work of the institutes dealing with adolescent problems, regular consulting of the staff and administration of the above Centers in terms of organisation and methodology.; Psychotherapeutic and other medical aid for the families of the delinquent children, families who include sick and invalid people, using the methods of family therapy in both medical as in social-psychological and educational aspects; Attracting sponsors for concrete material assistance to the children from these institutions and high risk families; Providing of scientific activities- research and reports devoted to the problems of children and adolescents and their families. ; Training programs for schoolteachers, social workers and physicians in the subject of adolescent and family psychotherapy.

Objectives of the Fund. - Introduction of psychological training for staff of Center for Temporary Isolation of Adolescents, of the Special School and District Social-rehabilitation Center for Children and Adolescents; Introduction of sexual education of school pupils, based on the results of the psycho-sociological research of adolescents, their parents and schools in schools of Ekaterinburg.; Provision of psychotherapeutic aid to incomplete families; Organization of seminars including scientific and practical issues lectures, supervisions and Balint groups for professionals; Providing joint Russian-British programs and projects on the problems of adolescents' and family therapy; Participation in the international "Youth Support" conference on adolescent health.

Educating the Carers, Caring for the Adolescents.

Helen Russell-Johnson; Rosemary Blunden; Michelle Charles.

For those of you who don't know me, I am not Helen Russell-Johnson, there is actually a team of three of us presenting this paper, my name is Michele Charles and I'd like to introduce my colleagues, Helen Russell-Johnson and Rosemary Blunden. All three of us are senior lecturers at the University of Hertfordshire and we've been involved in the last few years in developing courses for multi-professional groups who are caring for adolescents and so we would like to tell you this morning about our experience in developing those courses and about wider educational opportunities that are available for those caring for adolescents.

We certainly heard much during this conference about the need for education and this became very apparent to us several years ago. We felt there were several reasons for us wishing to see this work in developing courses. First of all we were aware of the need certainly in this country, it's been reiterated on a number of occasions dating right back to 1959 that adolescent would receive some special attention and particularly reports which called for separate facilities for adolescents. This has been reiterated later by the Home Office, by the Department of Health in the 1991 document on Children and Young People in Hospitals, more recently by the National Association for the Welfare of Young Children Hospitals and of course in its new recommendations for sick children. And most recently of all in the 1997 House of Commons Select Committee Report on Children's health called very strongly for better adolescent facilities, particularly adolescent mental health facilities. So we felt there were multiple reasons why we needed to pay particular attention to adolescents.

Our research project has also indicated that nurses felt rather ill-prepared for working with adolescents. Many nurses in fact were working on adult wards working with adolescents and had very little or no educational programmes at all, and even those who are registered sick children's nurses had found that perhaps there wasn't enough about adolescents, many were quite apprehensive still about working with this age group. Certainly looking round there were either no other comparable courses, there were a

number of courses on child and adolescent psychiatry which were excellent in their own right but didn't perhaps fulfil the need of all nurses and of course many nurses couldn't get secondment to those courses. So began to see that there was a particular need, various other research findings by ourselves and others had indicated that nurses were calling for these courses, my colleague Helen Russell-Johnson's experience of setting up very short one-day courses had proved very successful but indicated there was again a much greater need.

We were particularly fortunate in having a group of colleagues both from the service side and multi-professional colleagues too, both in the psychology section, my colleague Rosemary Blunden will tell you more, both in the juvenile crime area, a whole range of people who were willing to help us work on these courses. And within the University if Hertfordshire we were fortunate in having a number of us who had this particular interest, so combined with anecdotal evidence from our colleagues, indication of demands from our service colleagues and the expertise that we felt that we had available we then set about developing these courses so I leave it to my colleagues to tell you a little bit more about this.

Helen Russell-Johnson - Thank you Michele. The first course we developed was called "Caring for the Adolescent". We didn't call it nursing, because we wanted a much broader base, it's open to nurses but also to many other professionals. The only thing we asked specifically is that prospective students are actually working with young people. The reason for this is because we relate the theories to practice the whole way through and without the practice you just can't do it. We also need to ensure they've had a little bit of academic education first.

We have three modules, the first one is based on the tasks of adolescent development. In fact we use the tasks as a framework but we bring in as many theories as available from all sorts of areas so we use all the child development theories, psychological theories, sociological theories. The next module is completely focused on communication. And the third module encourages the students to go somewhere else and compare their practice with their own place. So we are aiming to do is we take people who are already working with adolescents, who feel that they have got some skills and of course they have and we provide theoretical underpinning for those skills. They do increase them and gain in

confidence from them. A lot of this is done by a range of learning methods and together that is the whole group with their very varied backgrounds and all our speakers who are from multi-professional backgrounds they develop constructs on adolescents. And it's a very enriching experience not just for the students, we learnt an awful lot in our first year. We are now in our third year.

We look at as many theories of adolescence as we can, we look at the communicating with adolescents, and we share experience with as broader base as we possibly can. The assessment is related entirely to practice and it has to relate to the young people with whom the students are working. I've never enjoyed marking terribly but these are absolutely fascinating to read and a joy to mark the communication ones especially. Following on from this we've developed a course on adolescent sexuality which is Michele's forte which adds to and complements the basic one. And over to Rosemary now.

Rosemary Blunden As part of our networking procedure because we decided that we couldn't possibly be the only group in the country, I mean a course for the care of adolescents, we've networked mainly with other nursing groups, but when we collected the flyers we've found that many of them have already opened their courses to a multi-disciplinary group. And particularly the NB603 which is child and adolescent psychiatry, these places are operating, Birmingham offers a degree, Bristol and Cambridge offer a diploma in health studies, Hertfordshire, Huddersfield and Ipswich all have this Caring for the Adolescent course which again is multi-disciplinary and in always run by a multi-disciplinary team. The next one. Newcastle I think was the first one to open it to a multi-disciplinary group. And that has been running successfully with a group of professionals as students. This is a year-long course which certainly is practice-based. The Maudsley Hospital has a 603, we are not quite sure of their content. Oxford, somebody earlier was asking for psycho-social training, this is an Oxford-Brooks and this is a course specifically for dealing for those difficult adolescents, that particular group, somebody was talking about this earlier, how do you learn about how to deal with adolescents who are opting out and with difficult behaviour. And Oxford-Brook runs this module. I think it is also a multi-disciplinary recognition because our is not a nursing qualification. Portsmouth, have the child psychiatry, Slough, campus of Thames Valley

University and South Bank University have modules in caring for the adolescents.

We are looking for solutions because there are so few courses. We draw our students from the whole of the south of England, from Birmingham downwards. Every year we've had somebody from the Midlands who travels down to do this course. There is a support group in the West Midlands. We were looking particularly at how we could improve the knowledge of nurses in the care of adolescents. So we look to improve education in the care of adolescents in all pre-registration nursing courses to all nurses across the board. We will in the future have nurse practitioners lecturers who are specialists in this field, and we feel that some of our early students certainly from last year will be amongst that group.

Post-registration skills courses. Again these people who we had last year and who are coming from other places Ipswich and the Huddersfield will be the leaders in this field. We are looking towards specialist practitioner awards in care of the adolescents BSc and ultimately MSc and I think the MSc will be a complete faculty course as opposed to the department course. I think our colleagues from psychology and other disciplines will be very keen to join us in planning this course. Hopefully this will lead on to specialists practitioners providing in terms of hospitals trust via education, both theory and practice based which is absolutely essential. And Helen and I've been delighted to hear people throughout the conference stressing the need, I was so delighted yesterday when I was listening to Helen Fonseca saying that people should have a good knowledge of the task of adolescents, this is our whole purpose of being really, we need people to understand that kids don't just have a problem, but they are adolescents and they have to carry all that with them as well. I was absolutely delighted.

In the meantime because there is such a dearth of courses we are asking nurses to enhance and develop their own practice, to use effective practice specifically if they are working with adolescents to try and enlarge the knowledge, to share their reflections with their colleagues, and to share your knowledge with students from all branches of nursing, well in our case it turns out to be all branches of everything. To form small support groups, and these are happening, they are beginning to form. To form regional

networks and again these are beginning to start within nursing and I am sure from what you were saying you have similar networks in social work and certainly the Association of Child Psychology and Psychiatry have special interest groups.

Formations of educational networks and we have already started on our formations of educational networks, we've been working particularly closely with our colleagues from Huddersfield but we have been able in the course of our network formation to contact all these groups that I told you earlier. And lastly I feel that we should be forming pressure groups to ensure that people with adolescents do have the basic knowledge which so many people have stressed during this conference, we need to work with adolescents. I just feel that everything we learnt over the last 10 years has come to fulfilment by the constant reiteration at this conference of the need for education and we are absolutely delighted. Thank you.

Chair Thank you. Any questions.

Question: I am a social worker working at the youth centre and I would wish to see much more co-operation to be help education of youth workers because they work in difficult setting with young people now I am wondering why we are so rarely talking about youth workers, because nurses or teachers, young people go there because they have to go there, young people go to a youth centre because they want to and I fear that youth workers lack education.

Answer. Yes, I would agree absolutely with that, in fact next year we will be having one certainly, but it needs to be very broadly based and very broadly spread. We tested it out on nurses, all kinds of nurses, and including a midwife and suppose that we know that it works with the broad spectrum of people from a broad spectrum of places. You know the spectrum goes from a specialist adolescent maternity unit to a hospice with adolescents, so and everything in between, so we are now ready to move into social work, we have enough colleagues in order to meet your needs.

Plenary Session P7 - Youth and the Family

Chaired by Gail Slap - Ohio USA
and Neville Butler - Bristol and London UK

Chair person: Welcome everybody, a bit late because the last session ran over some, I am Gail Slap, I am in the Departments of Paediatrics and Internal Medicine in Children's Hospital Medical Centre in Ohio and I am going to ask Dr Butler to introduce himself. I think his name is well-known to many of you for his child health surveys both in Great Britain and many other countries around the world.

Dr Butler: Good evening everybody. I am usually referred to as the late Professor Butler but this time we were all on time so we had to cut corners and what beautiful corners we have we are going to give these sessions and I am going to introduce some people in the end and Gail is going to slap me down if I may say if I do anything right , probably I won't and we leave you to do the introductions, if you will, Gail.

Gail Slap: Our topic this afternoon is using the family as you'll see from the titles that are listed there we're covering it very broadly. Our fist presenter this afternoon is Pamela McNeil who is Director of the Women's Centres of Jamaica Foundation.

Women's Centres of Jamaica Foundation Programmes

Pamela McNeil

We can talk a lot about statistics and figures but it might be better if we remembered that young people we are working for are not statistics, they are people, and if you don't mind, I'll read all the information and show you some slides of the young women who passed through our Women's Centres programme in Jamaica.

I'd like to go back to the year 1977 when in Jamaica we had been watching with dismay the increasing number of births to teen mothers. In that year 31% of the total births were to teenagers and these young mothers were likely of course to follow the usual pattern of repeat pregnancies leading to 3 to 4 children by the time they were 20. Those of us who were teachers can remember the deep distress we felt having to observe the total waste of so many bright girls who dropped out of school due to pregnancy, resigned perhaps to the drudgery of poverty. And they represented a huge loss in national potential. And add to this plight that of their children who in many cases were blamed by their mothers as the cause of all ills besetting them, hence they were very often neglected and sometimes abused. And all this lead to the dream of a day when these young mothers and their children were given the opportunity to achieve their full potential and take their rightful place in the process of national development. The core programme for adolescent mothers was established in January 1978 and we just celebrated our 20th anniversary and it was lovely to have Diana Birch from Youth Support there with us at that celebration a couple of weeks ago. Today we have implemented the programme in 7 main cities across Jamaica.

Right from the start the main objective was to motivate young mothers to choose education instead of continuous motherhood. Only then could we succeed in delaying second pregnancies and raising the employment potential of these young people, a viable alternative to depending on men for support and consequently having more babies. It's never enough to say young mothers put them in home economics or sewing projects. This couldn't be regarded as valid suggestion which could even be considered in the cases where bright, intelligent, promising teenage girls became pregnant before completing their formal education. To obtain

quality results a quality programme had to be implemented. Although academic, skill-training areas were key other components of the programme had to be included in order to deal with the young mother, her baby, her baby's father, her parents in a holistic way. Therefore we had to set up a practical efficient process which would facilitate assessment of each of the participants for academic capability and potential, emotional status, self-worth, economic status or potential, knowledge of sexuality and related issues, nutritional status and acceptability of family planning.

The Women's Centres of Jamaica Foundations Adolescent Mothers Programme addresses all these facets. The academic skill training instruction is geared towards the girls' capability and potential. Extensive individual and group counselling, take care of self respect, emotional problems and the child's grasp of sexual reproductive health and family planning knowledge. You notice I say child because some of our little ones are 12 and 13 years old. All of them are under 16, 16 years and under. Experts from the programme of course are used to deal with the problems which fall outside our usual ambit. Our participants are either pregnant or lactating mothers and we are aware that only a healthy well-nourished mother can produce a healthy child, In the case of the teenage mother we are in fact dealing with 2 growing children. Obviously with these pregnancies there is a risk that neither mother or child will have sufficient nourishment for proper growth and development.

We use the existing facilities in other agencies, whether these be educational or provision of services as it's important not to duplicate any services that are already there. But also as a part of cementing relationship between the agencies.

I'd like to go through the various programmes that we deal with in the Women's Centre Programme. Of course the core programme as I've said is the Adolescent Mothers Programme. The mandate of this is of course to continue the education of young women who get pregnant in school and place them back into the regular school system after the birth of their babies Delaying subsequent pregnancies until the young woman has reached her professional or vocational goal. I'd like to tell you that many many of these young women move easily through secondary school into tertiary institutions eventually serving their nation as teachers, nurses, we

have 4 doctors that have graduated, lawyers, administrators or entrepreneurs.

As well as the 7 main centres we have 5 functioning out-reach stations, the outreach programme provides assistance to those women in deep rural or inner city areas who cannot often get to our main centre. The main centre in Kingston, Jamaica also provides O-level examination courses to facilitate 11th graders, fifth-formers who become pregnant in their crucial examination year. This Kingston centre has been given the status of examination centre by our Ministry of Education, so the students are not only coached towards the exams but can sit the exam at that centre. Dormitory and it's the only residential aspect of the programme, we do not believe in institutionalising our children. But the small dormitory is provided for those fifth-formers from the rural centres who wish to enter O-level classes. Each centre operates a day nursery of course where are babies of the teen mothers are cared for, breast-feeding is facilitated and good parenting habits for both the baby mother and the baby father are encouraged. We've had to expand 2 of these day nurseries in Kingston and Montego Bay to facilitate babies of poor working mothers who can't afford the private nurseries, the costs are very high.

Several counselling strategies are used in the centre but the main thing is the importance placed in ancestry and pride in being a Caribbean woman. The dignity of womanhood is stressed as is human development and its effect on future generations. Pride in our children and careful planning of our families is also given equal importance. The effect of the change in the perception of themselves as individuals is best understood by seeing the vivid contrast between the girls just entering the programme who are quiet, shy, reticent and those leaving who are relaxed, cheerful, outspoken and optimistic. Having discovered a new dignity they hold their heads high and talk easily on all subjects including sexual and reproductive health. They are happy to have their baby but do not want another child until they have established themselves in career or job. It does not require much encouragement on the part of the staff for the young women to accept a method of contraception. Each of the 7 centres, the main centre offer some vocational training as well as academic curricular, for example one centre offers cosmetology, another - home economics, all centres do chicken rearing and some fish-baking, bee-keeping and vegetable growing, the main thing here is

when the girl goes back to school she has another string to her bow, if all else fails she can do something like that to be economically viable. Kingston centre concentrates on drapery, quilting and the production of baby clothes. At all centres counselling and referral service are given to the parents of the teen mothers particularly to her baby father and actually any other woman who happens to see the sign Woman's Centre and wants to walk in gets some help.

To date over 22 thousand young women have been returned to school in the island of Jamaica and 1.4% second pregnancy rate has been maintained throughout the programme. Figures for 1997 show that of the 3,016 births island-wise to mandated age group 16 years and under the programme accommodated 1546 in that year or 51% of these young women and I don't think it's too bad when you can see we only have 1 centre per 2 parishes across the island.

We have another programme for older women skill-training and these pilot projects have been quite successful in the urban areas of Kingston and the rural townships of Morant Bay in St.Thomas and in Clarendon. Over 600 young men and women over 17 years to 25 years have been trained in this particular project to date and most of them are now either employed or self-employed and we are in the process of expanding this programme to other rural centres. We also provide academic instruction and counselling to children aged 9 to 13 years in a well-integrated homework programme. This programme is operated out of the main urban woman's centres and it is an attempt to delay first pregnancies and steer the young towards education rather than early sexual activity.

We have set up a counselling clinic at our Kingston centre and this clinic services children and adolescents of any age with any problem whatsoever. Those children who are already sexually active are assisted in choice and provision of a contraceptive method. We don't have any problem in providing contraceptives to our youngsters who are under the age of consent under 16. And this clinic now has part-time voluntary medical personnel conducts peer-counselling training session for school children during our summer vocation periods and that is where Dr Birch came with us last summer and handled quite a few of those sessions for us. We also run parenting education classes. USAID has given us some

money so we decided to look at the street children and we have quite a few in Jamaica. And out of 5 rural centres for children who have already dropped out of schools or those at risk of dropping out we have what we call an “upliftment programme”. Remedial work is done in those classes but the goal is to keep them at school, return them to school or place them either in training institutions or employment.

We are constantly attempting to develop new methodology in our programmes, we have text-books and teaching aids in abundance but lecturing alone as you know does not work with this generation. The accent is on the visual. The attention span of the young is shorter, they need family life sex education programmes which are compatible with the life-style of the majority of our young in Jamaica. And the background factors of poverty, poor and overcrowded housing, incest, matri-focal households, prostitution and drugs can’t be ignored. The teen mother comes to us at the centres as a product of a negative society and family background. A profile of a typical; student could show a bright 15 year old who comes from a low income housing usually headed by a single parent with additional six children living in a crowed home, she attends a secondary or all-age school, her mother usually was also a teen mother. She enrols through referral from another agency, usually a school or a clinic, or by word of mouth now, and by this time she is in her second trimester. A product of the “it can’t happen to me” syndrome. She may or may not have had much knowledge about her sexual and reproductive rights. Her mother and herself usually agree that the baby will not be given up for adoption and she wants to go back to school. Her baby father would be a young man under 25 and not working. He accepts paternity, is apologetic, knows about family planning, would like the girl to continue her education and he promises to help in any way he can to facilitate her going back to school. He looks forward to having his cut.

One of the most tragic consequences as you know of teen pregnancy is the curtailment of the young woman’s academic education. The practice of throwing the young women out of school is bad enough, but to victimise them further by action or implication in placing them in school training or in essence making her a good house-wife for some lucky man is not worthy of our societies whose representative signs for many international documents dealing with the rights of children and women’s rights

and reproductive rights. The right of a girl to education is not dependant on whether or not she becomes pregnant prior to the completion of her schooling, it is an inalienable right and must be upheld.

A recent tracer study in 1995 showed that the average second pregnancy rate over the years from the programmes inception in 1979 has fluctuated between 1.3 and 1.4%. That the young mothers who have had another child waited an average of 5.5 years before embarking on the second pregnancy. Abortions are nil. Their children, those teen mothers' children are now in school and amongst the girls the children of those children of the teenage mothers who are now teenagers themselves no pregnancies at all have occurred. I think this programme therefore completes that very necessary component of childhood that of academic education ensuring that the young woman grows as she should into a responsible well-educated adult. It breaks the cycle of successive generations of women bearing children in their early teens and it's a prime example of a social programme extending its positive effect to the next generation. And it produces for the nation a cadre of well-adjusted well- educated professional instead of single mothers with many children requiring constant handouts.

If we were to be asked today of real achievements of the Women's Centre we would list the decrease in the destructive negative societal attitudes formerly displayed towards teenage mothers and poor women on the whole by the middle and upper classes in our society. The breakdown of the barriers from the Ministry of Education and the change which we've got working in the education code to allow teen mothers to return to the normal school system. The increasing co-operation and acceptance of the programme by ministries of Government, the private sector, schools and society at large. The many young women who are graduated from our programme, the scholastic achievement of the children of our former teen mother, all of those of school age are now in school.

The results of our appeal, and this is important I think, to the relevant authorities in Jamaica regarding the criminalising effect on our young men of the age of consent law. In the case of consensual sex young baby father below the age of 23 we have got written into the law that judicial discretion be exercised before sentencing. And to have carried this through to the international

stage last year in Ethiopia at the UN expert group meeting I think is a feather in our cap. Because the young men are just is much in need of our help and assurance as the young women. Of course we are presented daily with the abortion problem and surely we think the surge of abortion can only prevented by early access to sex education. and if young people are sexually active to contraceptive techniques and quality service and counselling.

We listen to many of the young women who've been assisted by our Women's Centres and we find common factors running through all of their poignant stories. How casual these boy-girl relationships are, there is no stability at all in this episode, nothing deep-rooted, no thinking through, no positive decision to have children. On the one hand the young women appear to want to continue the relationship, however there is rarely such an implicit response from the young man. And we note their comments some of the young men, if I have to pay out money I will pay her money, but that's all, everything else is with her. To be fair the lack of gainful employment might be the cause of the avoidance of responsibility by the young men, but I think there are other ingrained societal attitudes in play. Another common threat appears to be the apparent relationship between the age of the teen mother and her own mother at first pregnancy. In one case at our Kingston centre we saw both the young mother's mother and her grandmother being first pregnant at 15 whilst other sisters were also pregnant in their teens. We seem to be living with a norm here.

But we wonder if that is the norm, why then throughout the interviews with the young moments we were given the impression that everyone connected with this young woman in the family, at school, in the community and the young woman herself is so disappointed when she becomes pregnant is the pull therefore of historical and cultural tradition so at variance with the hopes and dreams of those involved or does poverty and its attendant social melodies and emotional neglect and ignorance win in the end. What is very clear is that all players involved are convinced that education is the key to upward mobility. Participants who are now at one of our Women's Centres will talk to you of taking my examinations now I still have a chance. Parents clearly come across as being disappointed when their daughter has to leave school and delighted at the prospect of her getting another chance through a Women's Centre. Even her baby father, if they are sorry

about anything at all they are sorry about their girlfriend's having to leave school.

In all the evaluations on our programmes there appears a clear difference between client and control groups. Women's Centres of Jamaica Foundation clients are able to complete their education, are higher achievers, find different career path, find jobs as twice the rate and fetch much higher pay than the control group. Doctor Handa of the University of the West Indies did what we requested him to for many years and that's a cost benefit analysis and I think this should be done much more often with social programmes. Because his cost benefit analysis of Women's Centre Foundation states that the social and private benefits of the back to school programme for the adolescent mother in the year 1993 due solely to increased education was a 136 million Jamaican dollars. There was in that year a reduction of 323 births due to the programme and the implied savings to the health centre was 13 million Jamaican dollars. We are very glad with his analysis because of course it helps us all the time when we are applying to the Government of Jamaica for our budget. But he rounds off his analysis by stating that each dollar invested in the Women's Centre programme results in $7 worth of benefit to the society and that's sort of analysis is very important as I say for social programmes. I think if we really believe that reproductive rights are human rights as women and then we have to recognise the synergy that links reproductive rights and education to the empowerment of young women. And I think it is this that has been demonstrated time and time again in all of these 20 years of the Women's Centre of Jamaica Foundation. Thank you very much.

Gail Slap: We are going to have to hold on questions because of time but I want to say that it was a very moving and beautiful presentation, an example of hands-on strategy that has truly made an enormous difference that varies with the kind of data that we've seen multigenerations coming from other investigators and I think is gone even a step beyond and has given us some cost-effectiveness data which is as you say one of the most powerful pulls we can have as we try to advocate for young people. So congratulations, I thought it was beautiful.

Our next presentation will be given by Fiona Subotsky who is a consultant child and family psychiatrist at King's College in

London. And the title of the presentation is “Working with families where there has been abuse”.

Working With Families Where There Has Been Abuse

Fiona Subotsky

Hello everybody, just a word about myself, I am child psychiatrist working in a general hospital and we see a range of children with different kinds of problems, different ages, it links up with the Maudsley and it's in quite a deprived area in South London. I was going to focus down on one particular aspect of abuse I mean almost one might think the word not should have come in the title it's working with families in whom we didn't realise there was a question of abuse. But the reason I am doing this is that earlier in the year I was asked by the Medical Women's Federation nationally to take an interest in domestic violence. And I said to one of our local public health doctors that I was going to take an interest in this and he said, well what does that have to do with child and adolescent mental health. So I started to think about what does it have to do with child and adolescent mental health and I think this is a process I've begun to think about and I am going to spend most of the time looking at a few cases so I hope there will be time for some feedback discussion.

In a sense partly to link with the issue before I think that the health professions in this country it's just begun to dawn on them perhaps a little bit behind other agencies and other countries of the importance of recognition and awareness of domestic violence, what can doctors do, what can health services do and I think this is stage one. For instance, the Royal College of Obstetricians and Gynaecologists has recently started to take in interest in this and they are becoming aware that pregnancy may either provoke actually the incidence of domestic violence or increase it. And here is a little snap shot from their discussion: there is increased risk to the foetus from miscarriage, premature birth, low birth weight, foetal injury, foetal death. So another reason to take a history in child psychiatry, what was going on in the pregnancy, because there may have been a direct effect on the foetus.

Now domestic violence is an ambiguous term and my looking at the literature shows that there are two schools of thought and they are not backed up by too much evidence either way. One is that it's equal between sexes exchange of fistycuffs as it were and with equal damage appearing in A and B and on the other hand it's

about it being to do with abuse of power and very much male to female. Now I think in these issues which are largely about wife and mother abuse this is what we need to be thinking about, but I think we need to keep an open mind on the directionality.

Various definitions have been used but the incidence has been estimated as being as much as one in four women experiencing abuse from a partner. This likelihood is increased by the presence of children and pregnancy may be a precipitator. It's of interest that 40 to 60 % of separations are estimated to have involved domestic violence. This is not obvious in the later presentation, it's something that's denied and glossed over. What 's also becoming more clear and the NSPCC is taking this up now is that there is a relationship to child abuse which is again not been fully understood before.

In cases of domestic violence in families with children, children witness the abuse in 70% of incidents. I think this is probably in contrast with presentations where certainly our experience is that the mother will say, it didn't affect the children. Take that with pinch of salt. They have been directly physically abused in 40 to 60%, a very high percentage. Sexual and emotional abuse are also increased and conversely in child protection cases it has been found that domestic violence is probably present in about one third. The ranges of figures are rather large but that it's a serious problem is evident. I was looking at a book by Arnon Bentovim called "Trauma Organised Systems", this is not about domestic violence as such, his interest arose initially from child abuse work at Great Ormond Street and then sexual abuse. But what I am going to show I find has got a lot of relevance to work in this field and sheds light on the cases that we are going to look at. These are classic differentials but that does not mean they are not useful. Internalising and externalising, being more characteristic, we don't just have to say it's girls and boys, men and women, because it doesn't always work out like that, but there are correspondences. Internalising you get anxiety and enmeshment, externalising - diversive, dismissive. The attribution and direction of blame, this is very important to listen out for the negative self-representation, the interjective, "It was my fault, I should not have done this, I kept blaming myself" until something finally happens to break the pattern, perhaps the abuse of the child. Externalising, negative to the other perspective, this is part of the pattern of how the cycle of

violence may be produced and we will hear that in some of the examples I've got.

Identification this is a child, are they siding with the victim, the abused, or are they siding with the victimiser, do they become abusing and defiant themselves. And the behavioural responses, the self-destruction, we saw in a workshop this morning, this is very common presentation of young women with self-destructive behaviour, it's common with a lot of young men too, self-mutilation, anorexia, anxiety and depression. Now we are beginning to see the symptoms which we see all the time we would have known in a sense that they derive from stress, but this is more systematic.

On the other hand aggressive, power-asserting conduct disorder, substance misuse. I think we also get substance misused very much this side as well in fact and I think that one of the sad features of our society is that sometimes the aggressors can be highly successful people not presenting as patients or seeking for help in any mode whatsoever, I am sure those of you who work within the courts will have seen for instance all this many times.

I am starting off with what you might call a typical school-phobic. Although she was 11 Mary was in fact pubertal and I think that's important because of the degree of her distress, she was terrified of going to school. She'd only been for 3 half days, many struggles and tantrums with her mother and stepfather. Disliked school and as many of these children do she feared failure and criticism. She worried so much about school, she couldn't sleep, she had anxious dreams and was even sick in the morning under pressure. So we got some somatic symptoms there and certainly her grandmother thought she might have something abdominally wrong. She never liked school and was always clingy, but it got worse at starting at secondary school. That's another fairly classic sort of timing. Friends there, she's worried when she was away from her family, she never liked school. She admitted to worrying about not being at home to look after other members of her family, especially her mother. That's again something one often gets with school phobics, it's not so much the school that they are phobic about although that's an element, it's that when they are at school these young people are anxiously brooding about what will happen to their parents some of which is based on reality. She was also quite clearly depressed, loss of appetite and weight, restless, didn't think life was worth living, loss of interest, not wanting to go

out. Now the history was that there was domestic violence from the pregnancy, I don't have full data of any of these, it's like an incident, but was it important? - yes, it's a kind of organising feature, the pattern of this life. Mother decided to leave father after three months after a violent row and returned to live with her parents. Normal development except some clingyness but she became very insecure when her father reappeared and fought through court for staying access.

When these battles continue through court they are quite damaging for children. Different court systems take very different approaches to access rulings and domestic violence. My understanding is that English courts tend to go more for it's good for children to see their fathers than Scottish courts and Danish courts, it varies in different parts of the world they are sometimes use court battle as a method to control the mother. He continued to appear at the house bang at the door and so forth. He would have not abused the child but all of this had a deal of effect on her and in particular when he suddenly gave up when the money issue came up and said she wasn't his daughter anyway. This was all very much still alive to her and on her mind. However the precipitating incident was that mother had developed cancer and that's what finally tipped her over. But issue about her father was very relevant. So that was an internaliser and a girl. But it's 50:50 with school phobics.

Here is a girl who is an externaliser. Very argumentative, outbursts, exclusions, truancy. She had been rowing with her mother but that had begun to improve. A very lovely girl extremely tall conspicuous and I think when she squared up to her teachers they found it rather alarming. Indeed they burst into tears. Now, where was this coming from, the only thing we essentially got out of it was the background for domestic violence which was the reason the parents have broken up and one felt as one often does that the child blamed the mother and was angry and to some extent it was coming out at home in terms of rows with authoritative figures at school.

Little boy we saw recently lacking in self-confidence, maybe aggressive, very poor history. School failure. The oldest of four children often very helpful. Suggestion that he is becoming the father and indeed he sort of sat in the father's chair in the assessment, we don't have a specific father's chair but if we did he

was sitting in it. Stormy relationship with frequent violence, mother had certainly gone for father with the knife and recounted this with great enthusiasm. On the other hand the children were certainly involved and it was frightening for them, they had been the ones who'd had to call the police on several occasions. A disconcerting thing Terry remarked that his mother's sister is now pregnant by his father, this was disgusting to have a cousin who is also a half brother and how could we help - kill my aunt. Well, in terms of problem solving solutions this doesn't go well for his future relationships.

The most frightening one in some ways was the story of least violence and think this is why individual cases are so important to look at. Ryan was brought by his mum and said if it's anything stupid I am walking out, that's threatening us, I am happy. Mother downplayed everything, we want to communicate better, she was upset, Ryan had got physical with her. She was blamed by an older sister and Ryan blamed her. So they were blaming and victimising the mother. Ryan is an able boy despite dyslexia, he was communicative, mature bossy. What was going on here. Mother had had three major partners: the father of the oldest girl who had died and I think that's very important, her next partner who was the father of the next two, they had a baby who had died so we had two deaths. He used to drink, freak out and smash the place up, but he wasn't violent. This is the account from the daughter, it may or may not have been true and it was interesting that it came from the daughter, the mother didn't dare say anything so direct. They were supposed to be on friendly terms, he remains unwell, that means alcohol. The more recent relationship with the partner had broken up because the daughter said, he wanted things to be clean and tidy, i.e. mother wasn't getting them clean and tidy and that again was blaming the mother, sort of abusive control. We are worried about this boy, he does not see that as a problem and the mother is finding it's difficult to control. Many other cases suddenly come to light when you wonder about domestic violence and it isn't just direct child abuse but involves children in abusive family system.

Gail Slap: Thank you. Our third speaker is Aggrey Burke who is a consulting psychiatrist with St. George's Hospital and Medical Centre is London, The title of the presentation is "Youth and the Family with Respect to Deprivation and Cultural Issues".

Youth and the Family with Respect to Deprivation and Cultural Issues

Aggrey Burke

I am Jamaican by background and I wanted to look today at an area of interest and aspects of work that I am researching in and working actively clinically as well which concerns black people in Britain. I am kind of worried that in America, in France, in Holland, in Britain, in Germany - in the Western world the real problems about deprivation and disadvantage and these are often shelved within the context of findings among more privileged persons in these societies. But there are some generalised findings and they are relevant to all groups. Parental acceptance and rejection. There was some work done in which they tried to look at what happens to children who are rejected, self-esteem is very much affected in that population and how such individuals have a hostility and feelings of aggression. And indeed here in London for those of you who don't come from here or here in Britain if you have an ethnic minority population living in a town and you go to any locked facilties, locked facilities for the mentally handicapped, locked facilities for disturbed adolescents, locked facilities for children who children who are out of control, locked facilities for mental patients, you find about 70% of black meaning people like me persons even though we make up only about 5 or 6% of the population. So it's round about always 10 times. And one wonders, is it the society which is leading to greater rejection or is it simply parental rejection or acceptance.

Now I want to look today at the whole business of a sample of adolescent mothers who became pregnant for the first time when they were under 18 and want to reflect a little bit on what sort of interaction might there be between the mother and the child and is age a factor in that. Well in fact the critical thing which might affect mother/child interaction might be disadvantage, that they are the group of mothers who live on welfare are really up against it. And here in Britain is the same thing. Now, we should wish to reflect on the fact that even in 1982 in America there were black excesses for children in institutions, that makes sense with their high levels of black poverty there, the same is true here and we suspect in Holland and in France we suspect the same is true that we don't only have children in institutions but young people who get arrested by the police and are locked up are going to be more

often black. So we want to know whether this issue is simply an issue which will go away or an issues which we need to reflect on a bit more.

Now Charleston and others looked at about a thousand children who are placed between 1980 and 1984 and the followed up. And they looked at mixed race groups and white groups and black groups and what they found was that a tendency to placement breakdown seemed to be greater among children placed transracially. You know there is a debate here about this transracial placement, the black workers like myself believe that transracial placements should not happen. The government thinks that it should happen. So there we are. And the reasons for the two sides are worthy of debate but we don't have time today. Now Ravinda Barn looked at a number of children in one borough and found that the black cases in care came from families where their mothers had mental health problem, whereas white cases came into care more frequently because the children were disturbed. Now that's interesting from many points of view because the mother's mental health is something that we often subsume under the categories schizophrenia and voices coming through light, whereas mental health has something to do with self-esteem, feeling good about oneself and all those kinds of things.

I am doing a large sample of consecutive cases of mothers referred to me because of family proceedings here in Britain and I am an adult psychiatrist that sees myself as a psychotherapist as well. And this is a sample from this large sample and these are 58 mothers born here in Britain, the reasons that one is taking the ones born in Britain is that one finds that those who come here when they are children are very very different from those who are born here. And those who come here as adults whether from Africa or wherever are very very different from those who come here as migrants as children. So there are 3 very very different groups. Now this sample of mothers is youngsters who are 17 years old or less at the time of birth of the first child. OK, there are lots of individual issues about this sample but the group issues are much more commanding in terms of interest. The great majority of them came from a background of disadvantage and many times very profound disadvantage, and one has a sense that this teenage group can be distinguished from the other bit of the sample that 18 years old at the time of the first pregnancy. What kind of home did they come from and is it really important to be

able to look at the background of these people in terms of their homes.

We divided the sample, into 3 groups: those who have 2 parents who are black, those who have 1 parent who is black and 1 parent who is white and that's called a mixed race parental sample and those who have 2 parents who are white. And so you have these 3 groups and one would want to know are there differences in the backgrounds of these groups of adolescents, mothers at the time of the birth of the first child. Well, mental illness is equally distributed among the 3 groups in terms of mental illness in a parent. And 55% of these youngsters came from households in which their parents committed violence against each other usually the man against the woman, the father against the mother, but sometimes the other way around as well, women are not taking it any more in the same way. And that seems to be true for white mothers, mixed-race mothers and black mothers, they seem to be muscling up and saying, We are not going to take it any more.

Now, the youngsters, these mothers came from abusive backgrounds, 60% complained of physical abuse when they were growing up, 60% complained of sexual abuse and a lot of them it was the same person getting these two things and more than that complained of rejection and emotional abuse. So just to picture this, the youngsters who had children before 18 and come to the courts here in Britain under the Children Act come from very abusive backgrounds. 55% domestic violence, 60% - physical abuse and 50% - sexual abuse, it's a big tragedy. To begin to estimate the extent of a tragedy is to be working with these youngster and the previous speaker was very helpful in looking at couple of cases. Now, surprisingly parental alcoholism seems to be the stronghold of the mixed race and white mothers, so people who come from white homes, usually a mother white seem to booze much more. And the black mothers in this sample have a lower rate. Now I was very impressed with that because there are sort of reasons to believe that this kind of thing among deprived groups might not be that different.

In terms of disturbance, what kind of youngsters were they? Three fifths of these youngster mothers suffered conduct disorder in childhood and upbringing, so they were disturbed people. And a half of them were aggressive people. So we are looking at not an easy population, it's a population that somehow had a lot of

difficulties. The non-white mothers, the mixed race and the black ones were more likely to be expelled from school. Now we know in Britain that there is a selective factor at how people are locked up and how people are dealt with, we don't know the extent of a selective factor but here we have some little bit of evidence that in terms of what was happening to these youngsters earlier in life they were having the same amount of abuse but they were more likely to be expelled from school if they were black. And you can imagine what happens to these mixed race group, they are growing up in a white household and then they notice that the teachers are doing the same to them as the black children, can you imagine? The non-white mothers were more likely to be locked up in secure facilities, in special homes, in prisons, they were more likely to be locked up than the white ones. So we are beginning to sort of see the social workers, people like myself psychiatrists and all that and not all that fair sometimes.

A worry in this sample is that half of the adolescent mothers have spent time in care so they have been already put into the care system and they were coming back to the family proceedings courts with a kind of statement, hey, I've been there, I've come back with my child, and you say to yourself, what's that about? Is it a cycle of abuse, is it a cycle of care, is it a make belief care system, what is it about? Well, almost all of the mothers in this sample admitted to feeling angry, depressed and confused from early adolescence, you could say, not surprising, and you could say, well, is it a statement, getting pregnant before they are 18 s statement of their anger with the world or it is a statement of seeking another home? These are very powerful issues and one would certainly wish to be able to work with it. And of course we all worked with it and one want to know these feelings of anger and depression and confusion, what are they about?

Now, I started off by talking about disadvantaged and one of the really bad things about modern urban life is the council house, the local authority residence in a society where to own your house makes sense. And 90% the sample of people coming from the family proceedings court come from the deprived, they come from housing estates, social workers strive on rescuing children in housing estates, I don't know if there are any children to be rescued in other estates but they strive on housing estate. And it's important to know because it's a law, the Children Act which is almost entirely designed to deal with the disadvantaged though it

was not written in that way. And they are on housing estates, they are on income support, they are on the welfare that we were talking of before. Black mothers were less like likely to be married than mixed race and white mothers. That's an incidental finding, there are lots of ways you can look at it but there we are. When I examined these cases I had some surprising findings: 40% were suffering from a diagnosable condition in which they are abusing some illicit substance, so I wasn't examining them when they got their first baby I examined them later on sometimes, sometimes when they got their first baby. And when I examined them 40% were abusing in a diagnosable way addiction way for many of them some illicit substance, crack cocaine, heroin, marihuana in vast amounts is also alcohol. Almost all of them were suffering from personality disorders.

So in a way they were coming to because they were messed up people and you see here low self-esteem, messed up feeling, impulsive behaviour and fears of abandonment that makes them the way they are and really any programme of retrieval or treatment which ever you want to seek, you have to dwell on the problem that they were messed up people, I am not saying everybody who gets a child before they are 18 I am talking about those who were coming for family proceedings courts. And that's very important to kind of distinguish them from the main body of the population.

Parasuicide was something that black mothers did less. In fact three times less. The mixed race and the white mothers three quarters of them were involved in cutting or overdosing or something, but the black mothers is was about a quarter. And you wonder well, is pregnancy part of this sort of impulsive behaviour for some of them and what is it about, because many of them of course go on to have many more children. Now, there is some lot of business, little things which might be important in explaining some of these findings. One of them is a stepfather. A stepfather has all kinds of implications in a disadvantaged group and one wonders here whether the stepfather might have been important in the mixed race and white group. It was more prevalent than in the black group. And then the business of race and what are we. Do we want to be all white in this society and are we proud to be black or proud to be Asian or Turkish or something. Racial identity confusion was found to have been present in upbringing in three quarters of the mixed race mothers, three quarters, three out of

four are those mothers who came to the family proceedings courts were brought up mainly by white mothers were messed up in terms of who am I, in terms of race. It's very powerful I think. Because I would not for a moment want to pass comments on the generalisable, how much this can be generalised I think white mothers and people being brought up by white mothers it's fine. A quarter of black mothers, remember a lot of them were brought up in care by white children's home's people you know, a quarter of the black mothers here were also racially confused. So it's not just a mixed race thing, it's a black thing. As they grow through and become adults about half of them started to say, hey, I am black, I am OK, I accept that. But about a half of those who were confused in growing up remain confused in adulthood. You can imagine what that can give rise to.

Something interesting is how we start to think about working with this population, can we really say it doesn't matter who is working with what. Racial experience of mixed race and black mothers may be important factors in placement decisions and in management. In a place like London more than half the children in care may be black, so we would want to have a sense of a how we go about it.

In terms of making sense of deprivation one would wish to reflect a little on what happens to children in single parent households. These households tend to be more deprived, there is a higher rate of accidents, there are higher rates of illnesses and abusive violence to children. What I want to say today and to leave you with is, is there a violence as well coming from how we in society and that's professionals are dishing out knowledge and does the violence leave this very very vulnerable group of youngsters on the rocks for life or do we have a way to start reallocating resources, start rethinking the model so that we don't leave them on the rock. My work with this population is problematic. No less so than your work. I thought the material might have been useful today in terms of offering a possibility of thinking through something that may be almost impossible. The background factors of the black mothers in this sample were somewhat different from the background factors of the mixed race and white. But the reaction to the background factors of the mixed race mothers was like the black. That's something we've got to bear in mind.

When the going gets tough

Sharon Pettle

I am going to ask you to change lenses, to change focus for the next 15 to 20 minutes from the level of programmes from the level of the families that have been abused and away perhaps for a moment from cultural issues into micro moments of us working with adolescents and their families. Many people who are at this conference have been drawn to work with young people because of how rewarding this can be. So there is an abundance of energy to harness, people are young enough to change perhaps more quickly than adults who have years of habits to overcome, they have more cognitive capacity to grapple with complex issues and a multitude of feelings of younger children and sometimes a real personal motivation to sort out their difficulties.

These are the easy ones. The ones we like to work with, the teenagers who help each of us feel good about the work that we do and whose occasional non-attendance brings on disappointment rather than relief. But what of the others? The ones who sit silently, barely making eye contact in a session accompanied by one or more parents or worse those who come alone to a session in which a therapists feels more akin to a dentist pulling teeth than a sensitive person who has created a safe and secure environment in which troubles and worries can be expressed. Silence can indeed be tough. I spent a number of years working in in-patient settings with disturbed adolescents and learnt something very simple but very important earlier on: working at the sharp end with the young people often with extensive professional network surrounding them can be daunting for everyone not least the young person. It was not uncommon for myself and colleagues to go to a consultation meeting where they would be 7 or 8 professionals, 1 or 2 parents and an adolescent.

Facing entry to a psychiatric unit for a teenager is pretty massive. Let us not kid ourselves, this is how teenagers see it. It only happens when things are pretty bad and people can’t cope with what you are doing. When meeting these families for the first time a colleague suggested that a formal handshake with everyone was appropriate. I am not sure how you greet your clients. I am not sure what I did before that comment or how formal I was but the comment certainly made me think about the important communications that take place in those first few seconds. How

did I convey respect, what did I do that gave a message that I was interested in everyone's view point and particularly in the eyes of the adolescents gave a message that I have not already ganged up against them like everyone else. In this culture there are few conventional ways to greet people. We don't bow, too much physical contact is inappropriate and a hand shake at least fits common practice even if in this day and age it's a little antiquated and conventional. As professional we may greet new colleagues in this way and I certainly saw earlier this morning colleagues meeting for the first time here and shaking hands so when I went on a consultation that was very often the way that I introduced myself and greeted new colleagues. So greeting colleagues in this way surely it carries the message to parents that they are no less important. And there by implication was the need to include the young person. Young people may respond limply, it's true, but in my experience they rarely fail to extend a hand and my offering mine subtly conveys a message which does not place them apart. My colleague further suggested the importance of eye contact, sounds incredibly basic but it was very important which if the atmosphere feels appropriate I'll sometimes say lightly, you can do better than that when a well-built teenager offered a soft limp sort of hand. A brief glance might follow, we might smile and at the very least something is gleaned by me in the exchange often in the waiting area about family relations, the young person's state and the difficulties or not that there may be to engage them.

Imagine this scenario: into the consulting room walk 2 parents and a sullen looking teenager. The therapists makes initial contact with the parents who explain in detail what it is that their child is doing or not doing. The therapist aware the teenager is not contributing to the conversation invites him to join in, maybe to comment on his parents' description. He remains silent and looks at the floor. Further attempts to include him meet with resounding failure and the session continues as an interview with disgruntled parents who feel that their son showed himself to be as difficult as they believe he is exemplified to his non-responsiveness to the occasionally proffered question. This may sound familiar. The therapists has a range of feelings, anxiety and impotence to name just the two, trying harder and harder to make the adolescents speak, doing more of the same simply compounds these feelings. Re-framing or positively connoting the silence can be useful in redefining the behaviour as helpful in some way. It may be worth trying some of the following: I have sometimes said, I've met many adolescents

who wouldn't let anyone to get a word in edgeways, I am impressed by your ability to give other people the space to talk, or you seem to be very good at listening, I suspect that you are doing a lot of thinking about what your are saying, I'll be interested to hear your view when you feel ready to speak, or even I think you are wise to wait until you are sure that you can trust me in this context before speaking about the situation at home.

When the silence is accepted and valued as the young person's contribution it makes it more possible to invite other family members to give opinions from different perspectives. Circular questioning - a technique from systemic therapy involves the silent member in a different way, for example I might say to a sibling, you sister was asked what are the things that make her so angry what do you think she would say. This may bring forth interesting and important information and the silent teenager may not or shake vehemently their head or angrily deny what has been offered. At the very least more information has come out. Alternatively I might ask if someone else in he family was going to speak for you. Who would be the person you would most want me to ask questions of? If they don't want to use their voice try ask the adolescent to point to point to someone or use some of the non-verbal signals that you have noticed by asking, I see you look at your older sister a lot, would she be able to give me an idea of what you think. Prescribing the problem is another of acknowledging the silence. This sort of comment also conveys understanding that coming into a therapeutic counselling context is not always an easy step and trust has to be developed. I have often said I really think it is important that you don't speak for a while, maybe until the next session even. It's very important that you think carefully about what you say and make sure that you are ready to join the discussion.

Some of the strategies might succeed, when they do not it's hard for a therapist to avoid the temptation to repeat attempts trying harder and harder to gain control. The risk of the unhelpful asymmetrical escalation grows. A strategy that did not work the first time is unlikely to succeed if used again. I feel pleased when I manage to try something different or not to be further organised by the silence. In my experience trust is more likely to be built up and silence less ominous if the scenario I mentioned just before can be avoided. If the holy problem orientated diatribe can be curtailed before it becomes overwhelming a connection with the young

person is more likely. Engagement is a very important part of beginning sessions and often receives little attention in training. Those first few minutes can be crucial. Like many people I often try to ask about strength and what is going well in the life of teenagers and their families. Brief and solution-focused therapists and those interested in narrative approaches like have encouraged us all to explore the non-problem areas of the lives of the people that we meet. What do they like about each other, what was it like when things were better, what would they would like things to be like in the future - these may all be useful questions and may present new information that makes the difference to how people see themselves, see each other and to how they relate. At the very least they give us a wider picture of families' lives and may give clues that may help in the pursuit of change.

Some therapist favour ending session in a way which conveys a message to the family and may suggest a therapeutic task for them to undertake before the next session. Validation g all the member of the family, addressing comments to each individually even somebody who has been silent throughout contributes to the individual sense of having been heard and respected. Task do not have to clever and in early sessions noticing or recording task that involve everyone in a less blaming way can be suggested as helpful to you in understanding more. They may even help the family have some new thoughts. Using the language that they have used is likely to connect you more strongly with them and is a very powerful message about your attention having been focused on them. I might say directly to the adolescent, I know your parents have probably experienced your silences as frustrating but I see it differently.

At least when they are in the family in the room there is somebody else with whom you can converse. When a silent teenager sits before you alone the onus is very much on you to find a way to help them connect. Obvious comments about how difficult it must be to be in the room, to face feelings and problems and saying how courageous they've been in keeping their appointment are important but may not start a dialogue. Some people can use this extended silence and I am sure that some young people find the space to reflect a very helpful experience. More often I have the sense that the young person is willing me find a key to help them pour out their words or at least start to put outside of themselves some of the turmoil they are experiencing. It's the put out side that

has left me to use techniques born from the creative therapies that are often used in group work in the individual context. These are in particular life-lines and feeling maps. If family issues are to the fore drawing family tree together or using simple outline cut out with bluetack like this I have a huge box of them all in different shapes and sizes attach on to a huge white board may create energy and be a vehicle for important discussion. I am not going to go into the details of this but this in this family little Terry struggled to make sense of his large and complex family and we used these sorts of figures in a sessions with his parents and their respective partners those his father and his current wife and his mother and her current co-habitee to help him think through some of these relationships and begin to make sense of it.

I'd like to share a case example with you. 14 year old Katy was referred by the education social worker who accompanied her and father to the first session. Katy had been refusing to go to school for 2 months, there was no domestic violence, except very early on in her childhood. Her school refusal appeared to be linked to an emotional outburst precipitated by a lesson about parenting. Her father who had resumed care at the time of her mother's death a year earlier was at the end of his tether. He was very critical of Katy contrasted with the glowing description he gave of her younger sister. The social worker labelled Katy as disruptive in class but until this meeting had not even known that her mother had died. Katy was silent avoided eye contact and sat further down in the chair as the session progressed. My early attempts to engage her met with stony silence. Her father commented on this that it was proof that she was totally impossible. I reframed her as the careful listener and someone who is doing a lot of thinking as she emerged I complemented her on waiting to feel sure that she could trust the situation. Although she did not speak very much she did begin to look at me and agreed to meet with me on her own. At the appointed hour she arrived clearly nervous and apprehensive. She had a fixed expression and tightly closed mouth. I was already aware of her parents' separation, mother's cancer and subsequent death but it did not look like words would come easily. She said she did not know where to start, sighed deeply and said, there are so many things and tailed off into defeated silence. After a short while I suggested the idea of a life line to place event in their chronological order. She took the following 2 minutes to make a sketch which looked something like this. She indicated the tension and fight in her parents' marriage,

her father's departure, her mother's drinking, her prolonged cancer treatment, her mother's return to alcohol abuse during a remission phase and her movement to her father's during the terminal phase of her mother's illness. The life line presented a vehicle to talk about some of these events in more detail in later sessions. At the end of therapy she reflected on how important it had been to place it all before her without somehow giving one event priority. A similar technique is to suggest drawing feelings. Once provided with a sheet of paper and a range of pens young people often create an image which conveys and communicates very effectively what they feel and what they can talk about articulately, interesting if you ask them tell me what you are feeling, you get nothing. Some use stick people and events, other use colour and shapes of symbol, there is no right way. An adopted teenage boy recently taken into temporary care by social services at request of his adopted parents crumpled up his sheet into a tiny ball and threw it in the bin. I thought it was an eloquent metaphor of how he felt he'd been treated.

Humour is a very important tool with young people diffusing some of the tensions between them and their parents making it more possible to talk. Cartoons can be a helpful therapeutic aid. This one speaks to the universality of teenagers flouting their parents' ideas about how to present themselves to the world. 'Come on Ilea, don't hog the bathroom, we'll all be late for the Earth-Ship reception. - OK mother, I am just coming. -We want to give them a good impression to go back to Earth with, don't we dear. Mother sees her coming out of the bathroom and says, You cant's go looking like that, you look like something from another planet.

Some of you who've been to the States may be familiar with Kathy. Kathy cartoons very often speak powerfully of issues of strength of connectedness and the struggle for independence in young people and young adults. Mother's on the phone saying, Oh sweaty, phew, I spent the morning grinding cranberries by hand for thanksgiving dinner. Kathy says, Mum I'm having thanksgiving dinner with some friends this year, remember? Mum, says, I drove to the next country to find a nice fat pumpkin for your pie. Lots of people spend thanksgiving with friends and then see their parents for the real holidays. I got your grandma's best linens out and then starching and ironing them. - It isn't that I don't love my family. - The butcher is picking up a special little drumstick for your puppy Electra. Kathy says, It's just that my friends are my sort of second

family. Mum says, I bought containers that match your kitchen so you can take home lots of leftovers. - I need this time with my friends, mum. - Dinner is at 4Thursday, if you don't show up your father will croak. 4 o'clock fine, says Kathy. Dad says, That wasn't really necessary, dear. Mum says, I know, sometimes I even impress myself.

To contrast that, because it's often very helpful to communicate to parents that they need to think about change as much as their kids do. I am fond of Kathy. Kathy is going home Christmas and she is standing at the end of the garden gate.The second I walk through that door I am going to turn into a 5 year old, my mother will treat me like a 5 year old, feed me like a horse and then tell me my pants are too tight, my hair too long, my nails are too short, my apartment is too small, my skin's a mess and then she'll say, I am perfect. Then my mother would say I am so perfect that no man in the world is good enough for me and then she'll ask me why I am not dating anyone. I know I'll feel picked over, grilled, I know I am marching into the arms with one person who can make me grow berserk with one tincy glance. How ironic I am facing this great challenge there is only one thing I can say runs, - Mummy! - into her mother's arms.

What is helpful depends on what the therapist is trying to achieve and on the relationships in the room. I wouldn't suggest offering cartoon without some thought. Sometimes can ask as a prompt to raising difficult issues and lead to lively exchanges. In the wrong context I think they are patronising, insulting and will not go down very well. Young people perhaps more than any other client group challenge us to be flexible and creative at the same time as providing a safe container for their anxieties and pain. Having more ideas up our sleeve can only help us face the challenge. Thank you.

Dr. Butler: Thank you Sharon, I think one of the most important factors is personality of therapist and we of course will be lining up after this to ask Sharon to give us some help in all the things we do. Now I think we'll go straight on if we may. Go to the last contribution which is Kathy McAuley from the Thomas Coram Centre and she is going to tell us about of the family in leaving care.

The Importance of Family in Leaving Care

Kathy McAuley.

I usually in situations like this speak too fast and I know we are all flagging a bit at this point in the afternoon but I think it will probably be better if I pace myself. My name is Kathy McAuley and I actually work with Coram Leaving Care Services which is part of the Thomas Coram Foundation for Children and this part of Coram provides supported accommodation for 16 to 18 year olds and we prepare them for leaving care and moving into the community. We also provide an intensive move on and aftercare service until the young people reach the age of about 25 and thereafter as they need it. We also periodically run group work programmes and we've just completed group work programme for young women in foster care and young mothers in care in the London borough of Brent. We've also most recently set up an education support service which provides one to one literacy and numeracy teaching for young people leaving the care system who like many of them have missed out on a lot of their education.

The original title that was given to me for this session was "When the family is the care system", which I didn't really want to focus on and my title was "The Importance of the Family to Young People in Leaving Care". When I got about the fourth sample of the programme it has come back to first one so I am actually covering both. First of all I want to actually start with welcoming the new Government initiate, yet one more but an important one which is called "Quality Protects" which it's hoped will go a considerable way to improving services for looked after children and young people leaving the care system. This "Quality Protects" programme will require local authorities to approach services for children as the corporate parent. And that won't just mean social services, that actually for the first time makes elective counsellors, health, education leisure as well as social services responsible as the corporate parent. So they all have joint responsibility for the children in their area and we are all hoping that this is an opportunity for the corporate parent to take its role seriously and to provide children in need, children who are looked after by the care system and also those leaving it with a varied range of high quality services which could meet their and their families' needs.

To move to the first part of this paper is "How does the care system operate as the family", this is the one I have difficulty with

because I don't believe that the care system can really be the family for most young people looked after by local authorities. The majority of looked after children and young people still want to belong to their own families and to maintain contact with them. This is quite often despite quite serious neglect, abuse or rejection. In the words of one young person I worked with who actually opted for residential care, not foster care, he said, "I don't want someone else's family, I've got one of my own, thank you very much". And it didn't matter to him that there's been all sorts of problems, it's still his family. In my view the care system therefore should not try to replace the family but should create the conditions whereby the highest quality care is provided in partnership with parents or extended family whichever is appropriate. Unfortunately as a society we've not provided the type of quality care for looked after children which we would expect to provide to our own children.

According to the Department of health in 1991, it is salutary to reflect that far from remedying existing deficiencies research is showing that periods in public care have further impaired the life chances of some children and young people, because of poor educational achievement, uncorrected health problems and maladjustment. Pretty damning really, and this statements begs the question in some ways, then why take them into care in the first place. But obviously the situation is not that simple. Some children need protecting from their families or time away from them, but it would seem that some also need protecting form the care system. Unfortunately despite a number of enquires and recommendations Warner in 1992 for example, on training for staff working with children, it remains the case that most disturbed and needy young people are cared for by the people with the poorest pay and the least training. It's not surprising therefore that so many looked after children fail to achieve their educational potential. And this is confirmed by the SSI and the OFSTED report in '95 when they said, the care and education systems in general are failing to remote the educational achievements of looked after children.

Many carers particularly within the residential setting don't carry out or don't have an opportunity or not encouraged to carry out what any good parent should do, for example, they won't go on school trips or go to open evenings, help with home work, liaise with teachers and equally importantly they rarely actually involve the natural parents or other family members to support their own child's education while they are still in care. The Children Act 1999

was hailed as an opportunity to improve the quality of care for looked after children. Two of its central principles are listening to the needs and wishes of the young people and the continuation of parental responsibility whilst children are being looked after. Despite these principles it is still very difficult for parents to continue to carry on their role once their children have been taken into care. They don't know quite what to do.

Carers and social workers have to give more priority and commitment to identifying ways of facilitating and supporting these relationships no matter how difficult. At Coram Leaving Care we've encountered many parents who've talked about their distress, their guilt, their sense of powerlessness when their children have been taken into care. And they've often attributed their subsequent lack of contact with their children to their feelings of failure and also to their assumption that their children will be better off without them. The children in fact usually don't agree with that. Other parents fortunately have managed to overcome these feelings and have struggled throughout chaotic lifestyles and lots of bureaucratic procedures to maintain contact with their children. In our experience on-going contact with the family can reduce the understandable feelings of rejection, isolation, confusion and anger often experienced by children being looked after away from their families. Fanshell in the 1982 US study of children in care refers to the profound insult experienced by a child whose parents seem to care so little for him that they didn't visit to see how he was fairing. Giving children and young people the opportunity to see and talk to their family about their past can also help them to understand the situation better and to hold a more a realistic view of their parents in general.

Those young people who've lost contact with their families or have not received any counselling on family issues whilst being in care often construct an unrealistic and distorted view of their parents and the reasons why the y themselves were taken into care. These young people often have the greatest difficulty in forming trusting relationships in adult life. It is central therefore that social workers and carers encourage and support contact and mediate between children and their families in order to insure that the children can continue to be part of the family network. And I know this is viewed with great difficulty because of the range of reasons why children are taken into care. But there are a lot of members in the family that can still be involved.

To move actually to the importance of young people leaving care of the family we at Coram Leaving Care support and encourage the 16 to 25 year olds that we work with to re-establish or extend contacts with their parents, brothers, sisters or other extended family when they move into our supported accommodation but also when they leave and move on into their own flats. This approach was confirmed by the Children Act in 1991 when it came into force but more importantly was influenced by the expressed wishes of the young people themselves to renew family contact. Consequently young people need sensitive and careful support in working through the process of renewing contact which in times be painful, traumatic and for some ultimately disappointing. One young woman to whom I will refer as D spent several months to track her father down with the help of support work group of the project. She eventually managed to achieve this and he was some where in the Midlands and she re-established contact and then spent several weekends with him which were very positive and enjoyable over a period of about 6 months,. She then suddenly discovered that he'd moved away and had left no contact details for her. This was as you can imagine devastating for her and brought back all of the pain, and hurt and rejection which she'd felt when he first left. However despite all of this she is determined to track him down again because he is so important to her sense of identity and her need to belong.

Another young woman referred to a S has renewed contact with mother since moving into supported accommodation. Unfortunately S. is being constantly let down by her mother and whatever she does is never good enough. She herself is disappointed by her mother because she is never motherly towards her, she behaves more like a sister and also leans on S. herself for support and research shows that this is quite common for women whose daughters have been taken into care over a long period. The staff of the project experience quite a lot of difficulty at times in supporting young people in pursuing what can sometimes be obviously disruptive and unproductive relationships with family members. We therefore have to work on building up the young people's sense of self-esteem as resilient survivors which most of them are who have ambitions and goals for themselves not just for other people. And it's also very important to look with young people at how families function, how difficult it is to be a good enough parent, how parenting has to be learnt for some people

and the benefits to he gained from good role models when you are a parent. And also how some people just can't fulfil the enormous requirements of the parenting role. This sort of discussions help the young people gain a better understanding and also enables them to think about what they would like in terms of a parent and also how they would like to be a parent themselves. If positive family contact is re-established family members can be encouraged by the project to provide support to the young people to make the most of the placement in the supported accommodation or when they move on or out when they move on into their flat. And we found that such input from family members can actually give them a renewed sense of responsibility for their son or daughter which they lost when the young people were in care And can also obviously give the young person an extended network which they will need when they move on into their flats in the community. This input from parents has also sometimes given then an opportunity to actually acknowledge their mistakes to their children which clearly lays a good basis for future relationship developing in a more positive way.

As born out by research by B. Helen Wade on care leavers in '95, young people we work with often want to live near their families so that they can share their social network and just pop in to see them, they also value having a home base if they are in crisis or feeling lonely. Most young people do not actually want to live with their parents and the truth is that most parents don't actually offer this although one recent case resulted in a young man returning to his mother's home at the age of 18 on clear adult terms and it's actually working out very well for them. The level of contact young people have with their families whilst they are in care is a good indicator of whether family contact and support will be provided to them after leaving care. For some young people no family contact is re-established and they are dependant on professional support which is often very limited so young people have to rely on their own personal resources and build up their own network which is quite a daunting prospect for 18 year old who may lack self-esteem and confidence and find it hard to motivate themselves.

Whilst there have been some positive developments in the area of aftercare support to care-leavers services vary enormously and are often too short-term to really give the young people what they need. The provision of intensive and on-going aftercare support to young people until they no longer need it is a hard concept for

social services to accept, it's crucial for all care leavers but particularly for those who have no family support networks to fall back on. There is clearly need for a great deal of improvement in provision of support to children looked after to maintain a sustained relationships with families both during and after periods spent in the care system.

Under "Quality Protects" local authorities have now got to produce action plans by January 1999 in terms of what they are going to provide for services for children, the actual quality for those services. I'd like to make a few recommendations that social services prioritise support and encouragement to looked after children and young people leaving care to maintain contact with their immediate or extended families. That they devise flexible ways of supporting parents to retain contact with their children who are being looked after or leaving care. They should provide mediate and counselling re family and personal relationships for children looked after and who are moving on from care and recognise the centrality of these relationships to young people's sense of identity and security and for longer term informal support.They should also provide on-going aftercare support which is flexible and allows for periods when young people may need respite from full independent living. We all know it's too young to move on to your own flat to be an independent person between 16 and 18, so the level of support needs to increase rather than decrease for those young people. We hope that under the "Quality Protects" programme local authorities address these needs in partnership, in true co-operation and partnership with families and extended family members. Thank you.

Dr. Butler: Thank you very much for a very human approach to a problem which is universal and arrangements differ tremendously in every authority don't they. There should be a guideline as to what ought to be done, not what's being done and said.

Gail Slap: Thank you to our speakers, we have questions, I am sure, on just about every presenter, I might suggest our speakers are here, please stop them, speak to them, give them some feed back. It's been a long afternoon, so thank you for remaining.

Plenary Session P8 - Abuse and Self Harm

Chaired by Robert Blum - Minnesota USA
and Ann Sutton - Glasgow - Scotland

Chair - Rod McClymont is at the Department of Adolescent Medicine, Westmead Hospital and New Children's Hospital, Sydney, Australia where he has conducted the following work with his colleagues Simon Clarke, Gail Anderson, J. Benson & M. Kohn

Transitional Care in Adolescents with Eating Disorders.

Rod McClymont

Eating disorders are chronic illnesses which disable adolescents over many years. The features and management of the 11-12 year old adolescent with anorexia nervosa is usually very different to that of the 17-18 year old. Many units try to manage patients with a wide age range in the same program. We describe a program in which four units with different types of services offer a logical transition from pre-puberty to adulthood with overlap of professionals involved and cohesive comprehensive management of patients.

Services managing young patients with eating disorders need to be aware of the issues of transition from child-centred to adult-centred care if patients are not to be lost to follow-up with subsequent increased morbidity, mortality and costs. Adolescents are vulnerable if there is no continuity of staff and resent having to divulge their secrets yet again. As eating disorders may take 6 to 9 years to resolve, care should include continuity of the relationship with at least some staff over the duration of this time.

Although high numbers have been lost to follow up, in general what we could say about figures could be said to be true there are between 0.2 to 1% of adolescents had anorexia nervosa fulfilling the criteria and at least 90% 0f these are girls, very few boys. In bulimia nervosa its' more common, 1 to 5 % and there are more boys here, they represent 20 to 25%. Overall the rate appears also

to be increasing. Mortality seems to have declined over the last 2 to 3 decades from an average of 10% to 5%. But the duration of the illness is static, the average duration of anorexia nervosa is around 5 to 7 years, it's the average. The 50% go beyond that. With an average age of onset of around age 14 most of these adolescents will be affected well into their early 20s. Some 50 to 70% will make a good recovery in physiological terms. Menstruation, weight gain, but at least half will have on-going significant psycho-social problems in particular difficulties with long-term with relationships, depression and anxiety. In adolescents the course of eating disorders is further complicated by their developmental changes.

This just briefly shows how developmental stage which I loosely relate to chronological age and where the person is in the course of that 5 - 6 - 7 - 8 year illness can interact in a very complex way. In our experience the early or developmentally immature adolescents the ones who often present dehydrated as well as having significant food restriction, they often need resuscitation with nose-gastric feeds, they are very concrete in their thinking and they respond well to a very structured programme.

Those between ages 14 to 16 are of the very variable maturity, some 16 year olds behave more like 12 year olds and respond very well to strict guidelines, whereas some 14 year olds are very mature, they abstract thought processes and they do very well in a flexible programme. The later adolescent who has achieved abstract thought responds well to a programme that is flexible and allows their input in negotiation. Those who are more disturbed at this stage may need more intensive psychiatric care. Westmead Hospital and a New Children's Hospital in Sydney, like many other institutions has developed a model for transition. In our case it centred around the Department of Adolescent Medicine which spans both hospitals. This model has been applied to other chronic illnesses but only recently to eating disorders. Interestingly the report from which this picture comes is illustrated with photograph of a young anorexic girl from our ward but at the time no thought was given to them as being part of the process.

We feel that transition is particularly significant for eating disorders as these patients and their family often resent to have to re-establish trust with new therapists and our experience is that transfer without transition frequently result in drop out from care or

a loss of earlier gains. We've been able to initiate a transition process which started informally and is being facilitated by close physical proximity and co-appointed staff in New Children's Hospital and adult's hospital. A Child and Adolescent Psychiatry Department is also available for those who are more disturbed and there is easy transition on to an adult service which is a psychiatric run service. The children's hospital normally looks after adolescents with eating disorders from age 11 to 14. We in the Adolescent Department of the adult's hospital from 14 to 18 years old and those from 18 on - in the adult department. The transition is initiated based on the developmental stage of the adolescent from the more structured child hospital unit to a more open adult unit as required. 11 patients have been transitioned so far, 6 of these have gone from the children's hospital to the adult hospital's adolescent unit, 3 from the adult hospital's adolescent unit to the adult ward there and 2 have transitioned right through from the Children's Hospital to our adolescent unit and through on to the adult ward. This photo was taken with me at the adolescent ward 14th birthday party, Simon Clarke, the tall one at the back, the unit director is always on the lookout for funding and publicity opportunities managed to rope in the Director General of the Department of Health to officiate the occasion, I think we got some funding there. The young lady on the right, though undoubtedly she does have an eating disorder was actually in with asthma at the time and all the other young people there are girls who are in our in-patient anorexia or bulimia nervosa programme, 3 of them you can see have nasal gastric tubes. The girl who is second from the left Melanie is now 17 and a half, she was one of the first to be transitioned. She has a 2 or 3 year history of both bulimia and restricting, very difficult to engage, hated the very structured environment down at children's hospital, had a brief admissions for hypo-bulimia. Came up to us, again very requiring her initial carer to be to maintain contact with her, took months before she even spoke to me apart from 2 words which I won't repeat. And has now further transitioned on to the adult service, she's finished school, she is starting to work. And again I remain very much involved and there's what kept things working with this girl has been having that continuity.

The girl on the far left very similar, bulimia, not too much of a problem from a weight point of view, but again didn't respond well at children's hospital, it was too restrictive for her and has done well with a more open programme, both as an in-patient and out-

patient and is now transitioning to the adult programme. The girl close from the left is very interesting, she is quite tall, looks quite mature, but at this stage she has only just turned 14 I think, but she was with her thinking also quite mature, was not getting anywhere in the kid's hospital system, she was very resentful of a strict ward and managed to do very well in our ward but again the consistent thing was having the same family therapist, the same individual therapist through that process.

Overall the process has been a positive one from the young people involved and the staff. They see progress and they see a willingness to respond to their needs. Problems that have arisen are similar to other programmes, other transitional programmes that is, specifically difficulties in ensuring timely and reliable access to background notes, difficulties with predicting staff availability as they are responsible to more than one department and inflexible hospital administrative procedures. We are pleased with this apparent success that the next step is to implement objective procedures to evaluate this progress. Outcome studies in eating disorders have had many methodological problems, transitional programme outcome studies are few, very few control ones.

Treatment of eating disorders is expensive in terms of hospital beds and staff input. We do not develop objective methods to evaluate our progress and potential new methods of treatment, those who provide the funding, whether they are governments or whether they are insurance companies will demand it of us.

In 1993 the following methodological changes were proposed to improve research, the importance of clear definitions of who you are talking about, do they definitely have anorexia, why are you defining it as anorexia. Clear definitions about the patients, their weights, how long they've had the illness for, what their lowest weight was, many of these things are missing from studies. You need to have multiple outcome parameters, not just how they are doing from the point of view of their bones or their bodies but very closely looking at how they are functioning psychologically and with other people. The data that you collect needs to be reliable and objective, bringing up people who have had anorexia nervosa and saying, have you put on weight, is not a reliable way to get data but it's commonly used. Co-operation by asking a partner, a parent can help you. Allocation of time is important as the longer

you go obviously if there is improvement there will be less and less patience there. A clear and detailed description of your treatment is important, otherwise you can't compare between studies and to account for those who have lost a follow up so we have some idea of the potential biases involved.

So in summary anorexia and bulimia are both chronic illnesses in adolescents which follow prolonged course, they are associated with significant morbidity. Mortality has improved, but morbidity in time terms remains the same. Loss to follow up is all too common in our experience and is part of the illness, these kids will readily take advantage of any gaps in the service. We must take the next step of development and application of effective and objective evaluation procedures because those who hold the purse strings will do it for us otherwise. Thank you.

Chairman: I think we can have one or two questions. The question that was raised for those who didn't hear it is that at a recent meeting the Director of the National Institute of Mental Health in the US indicated that he didn't see a lot of new treatments for anorexia nervosa in process or even on the horizon. And the question was, from your perspective is that true?

R.M. Very simply, yes, I agree with that statement. There is a lot written but the use of word promising at the moment - no, in terms of changing outcomes medically - no.

Chairman: Thank you very much. Our next speaker is Professor Ueli Buhlmann. Ueli is Chief of Paediatrics of Triemli Medical Centre in Zurich in Switzerland and is an international expert in areas of chronic illness particularly in cystic fibrosis and eating disorders and is a very dear close personal friend.

Admission and Initial Therapy of Severely Ill Anorexics

Ueli Buhlmann

I will not present any really new statements, more a summary than anything else, so I will certainly agree with what's been mentioned that it has been a battle and it will probably continue to be a battle. What I am talking about today is not just anorexia nervosa in general but I would like to share with you what we do in a rather small setting in a hospital on a combined paediatric and adolescent medicine ward when we have to deal with severely ill adolescents with eating disorder.

I am going to focus on severely ill adolescents. I must tell you that in Switzerland we still see a lot of kids that are severely ill. What Do I mean by severely ill? We see a lot of adolescents that come in early adolescence somewhere between 12 and 14 years of age of a body mass that is below 14 or with a pulse rate which is extremely low and really is of concern with very low temperature, all things that you find in the literature but you think we should no longer be in a position where we can wait as long as that before the kid will get treatment.

So what do we do when these kids come to our place. Usually they would have had some kind of contact with the medical system. They either have been followed by their paediatrician or by their family doctor having sort of managed for a long time to cover up a very low weight they reached. So patient of course will be in the centre of our work that we do. But we only work with the patients if the family is willing to participate in our programme as well. So these are key players that we are working with. And who is we? We move in with whole group of therapists, physician on one side, psychologist and family therapist, and we move in with nurses, physios and occupational therapists. And of course going from all those no care or just a standard follow up by a family doctor such a multi-disciplinary group is quite a shock and so before the meaning the patient we see the family in a first session when there are two goals: number one we as a treating team want to hear more about the history and not only know that from the parents but we also include the siblings and of course we want to hear if that's possible if the patient actually speak up about their disease from their perspective.

In the second part of this first family session we show them how we work, what will happen, if the adolescent was to be admitted on our ward. From other side in terms of participating it's the entire family who is invited to come. We really put this up as an indication to everybody because that's very interesting to see who is showing up. Sometimes it's just mum and the kids, sometimes really the family is showing up as an entire. From our side it's usually one of our physicians the family therapist and the nurse who will be the one person who follows all the way through the hospital stay. The family after this first session goes home. Unless there is really an emergency or something comes up in a brief exam of a patient that would preclude us allowing her home overnight, if at all possible we send the family home so that then they can debate about what they heard usually it's a very tense period because it's the last opportunity for the patient to influence the parents once again its very hard on the parents but we actually encourage that process because we have to have this parents support otherwise our programme is more likely not to work.

We then admit the patient and in the first week we'll do all the medical work-up meaning that we do really a lot of exams. We only recently have changed our approach to looking more closely into the details of the medicals, of the somatic conditions. And it's just of the same purpose that's been mentioned in the talk before, I think that we need data bases, as a basis for evaluation and when you are looking into the literature about anorexia nervosa there's been a whole lot about the psychological, psychiatric issues, there's a lot more and it's not until a few years back that we learnt about the somatic problems that will probably last for a long time. One of the point being the bone mineral density, if these girls are really deficient in their nutrient intake for a long period of time they'll be at risk for a low mineral density by the end of their adolescence.

We watch closer into gynaecological problems including the adolescent gynaecologist having a close look at what is going on doing like abdominal ultra-sound but also with of lab work. There is always the question about the CD scan or MRI of the brain, we not always do that is there's a classical history in a girl with all the signs of an anorexia we probably will not do an MRI of the brain, we'll do it certainly on the boys and in the cases where there is any doubt of the diagnosis. Then doing any of the lab work and the

second goal of the first week is to introduce the patient to the details of our treatment plan. So what's the plan. We work with contracts to all the different peers during that through all the phases of the treatment. And we divide the treatment in 3 parts. When I talk about severely ill kids most of them will come by a BMI the low 14 and a half or 14 and in our hospital this means that we need re-feeding through nasal gastric tubes. The longest period of time is what we would call control re-feeding. It's a phase where we carefully monitor the kids while they are eating. And in the last phase we'll work with them to finish the hospital stay, it's a time where they go to their homes live with the family step by step progressing out again with their schools or with the work or slowly move out of the hospital when they finally reach their weight that we set as a goal.

The average calorie intake for the kids is around 2000 calories per day and we set as a goal a weight gain of 500 grams - half a kilo per week. When you calculate that kids come in in a really starving condition then this will end up with a first hospital stay anywhere between 3 - 4 months as average. So we really talking about a long hospital treatment. I would like to show you how we set the goal and how we work with the patients. This12 year old was admitted to hospital at 28.2 kg. It's a BMI of 13. So this kid was severely ill. We calculate the BMI percentage, we set the goal and ask the patient that the weight that we measure on an irregular basis remains within +/- 500 grams between the initial weight and the goal weight. Initially with naso-gastric tube we didn't have any problems, then she started to eat quite well and then lost quite a lot of weight. So first time she was below that lowest limit we added calories, added calories the second time until she was back in her channel. Patients have the same diagram so that they can follow their weight and what they are supposed to do by themselves.

Just a few words because it's quite controversial about use of naso-gastric tube feeding. In children with very low weight we start with a low calorie amount of 800 then we'll add 200 kcal per day to reach the goal of 2000 calories per day as average afterwards. We want to carefully monitor what's going on in terms of balance, in terms of serum electrolytes and we also check the urine to be sure that kids are not just drinking water to gain weight. I have said a lot about somatic part of the treatment, in parallel the kids are carefully followed on a psychological treatment plan level. They

have three session of individual therapy. In psychotherapy with these kids anything depending on the developmental stage of the adolescent can be anything from creative work to really speaking with the patient. I use a variety of technique. The family comes in once every two weeks and we have group session.

Once the patients reach the level when they eat by themselves they will have in addition physiotherapy and see the occupational therapist. In summary what we do in a rather classical setting on the combined paediatric and adolescent medicine ward for a long duration of first hospital stay we work with the family form the beginning, we have a multi-disciplinary approach that works very well, the team meets twice a week all the people involved really have a very clear line of where the patient is and what we want to do. We work with contracts sometimes difficult with the smaller children, we re-phrase our contract when we first start work with 11 year olds then probably have to adapt the language that used with this age group, but even with the smaller ones contracts work well.

We have a strong emphasis now on somatic development because we realised that there is a great risk if the patient's average length of disease is for many years that is a high risk for a problem later in their lives and that's all I wanted talk to you, thank you very much.

Chairman: We can open out briefly for comments and questions.

Question: If sexual abuse is part of the background of your patients who do you deal with that, do you deal with that within your programme or you go outside for it?

U.B. This would be one of the issues that I would expect to come up in the individual therapy sessions and so far we had very few cases where it's been open. In these cases we dealt with it in our own programme so we didn't go anywhere else.

Chairman: Thank you. This is again I think a very good way into our next paper, Elaine Yordan is a Professor of Clinical Paediatrics at the University of Connecticut in the United States, is a clinician and works in the areas of sexual abuse and will be talking on the topic of sexually abused adolescents with the history of prior victimisation.

Sexually Abused Adolescents with the History of Prior Victimisation

Elaine Yordan

Good afternoon. I wanted to show you here my setting the State of Connecticut, it's very small and this I consider my home away from home (don't tell my husband and son). Previous sexual victimisation is a risk factor for subsequent sexual assault. Those of us who counsel and treat adolescents who are victims of sexual abuse must keep in mind that a past history of sexual abuse places these teenagers at greater risk for sexual abuse, for sexual assault in the future.

Why do clinicians need to know if their patients have been a victim of forced sexual experience? In addition to obvious reason of needing to provide medical care and making sure the abuse is reported to child protection services healthcare clinicians need to make sure that the psycho-social sequelae of sexual abuse are recognised and dealt with appropriately before the adolescent begins to engage in risk-taking behaviours with potentially devastating outcomes such as unprotected sexual contact with multiple partners, substance abuse, delinquency, run away, school failure, drop out, pregnancy or suicide.

Adolescents sexual abuse whether current or in the past includes dating violence, permeates all aspects of modern society and every clinician who provides care for adolescent patients needs to know how to screen for the problem. When obtaining a psycho-social history or sexual history from an adolescents patients questions regarding past victimisation can be easily included as part of the routine screening. Getting a history of sexual abuse is not always easy and certainly we personally need to feel comfortable with this. We've been taught to incorporate questions about domestic, physical violence in our history-taking on the whole. We must also learn to include questions about sexual abuse, sexual assault, date rape as it is called in the United States. However simply asking the question, Have you ever been sexually abused? Often would not reveal the true history.

Many teens are unprepared to answer this question or they may not want to believe that they may have been abused. Questioning should be preceded by the explanation of the need to ask certain

questions that may be very difficult but are necessary to understand their need. Questions should be formed around the types of behaviour rather than the term sexual abuse. Example include, have you ever been touched in the way that makes you feel uncomfortable and hurt? Have you ever been forced to perform sexual act that you didn't want to? Were ever told to keep a secret or threatened if you did not? As a child were ever made to touch another person's genitals or watch sexual activity of others? As a child were you given pornographic pictures, magazines or videos? If the psycho-social history reveals problems with family conflict, school failure or truancy, depression, suicide ideation or substance abuse the possibility of undisclosed past sexual abuse should be seriously entertained.

The sexually abused either a child or adolescent may have vague abdominal pain, pelvic pain very commonly seen by the gynaecologist, school phobias, advanced sexual talk, sexualised behaviour, secondary enuresis, secondary encopresis, defiance, panic attacks or passive behaviour. And with that in mind it's also possible to realise that ironically some adolescents some may not show signs of immediate distress or dysfunction in relationship to sexual abuse.

It is very possible that symptoms may not become manifest until late adolescence or even adulthood. Statistically the reality is that only 30% of victims experience a single abuse episode. In one study adolescent female victims aged 12 to 18 years the abuse on average began when the girls were 10 years old and continued for more than 3 and a half years. More than 80% of the abuse was perpetrated by the father or a male dominant figure in the home. Numerous studies confirm the high frequency of multiple abuse. The relationship between prior and subsequent victimisation often coexists with other risk factor.

A very important risk factor is the absence of adequate guardianship. The situation leaves the adolescent with compromised defences against victimisation. Defencelessness make a young adolescent a more attractive target to a predator. Clearly children and adolescents who are well less supervised by parents because of impaired relationships are more vulnerable to multiple victimisations. In addition sexual abuse by a family member, often an adult male might create alienation from other family members who could serve as guardians against intrafamilial

and extrafamilial sexual abuse. In betrayal a child comes to understand that someone who she trusted and upon whom she depended manipulated and hurt her deliberately. Further more another trusted person disbelieved was unable or even worse she was unwilling to protect her from harm. The worst circumstance for what I see clinically is the mother that does not believe the adolescent female when she discloses sexual abuse. Just splits them in their relationship.

If the abuse becomes more and more sexually intrusive, more coercion and threatening may be become necessary. The victim may feel as if she is responsible because she didn't or felt she could not tell her mother or someone else immediately. Also she is prone to feel guilty because any physical or emotional pleasure she may have experienced as a result of this sexual abuse. If she is able to tell her mother and the mother disbelieves her the adolescent will feel further abandoned, unprotected and at the mercy of the predator's sexual desires. Sexualisation of the adult-child relationship often takes place gradually over a period of time during which the offender rationalises his behaviour, for example by redefining the sexual abuse. I've heard this in my clinical practice.

The predator maintains the victim's co-operation by a variety of coercive means that play upon naiveté, dependence, love and loyalty. These means include seductive pressure to establish guilt, verbal and physical threats, physical abuse, outright bribery and exploitation of the perceived reaction of others: should they be told, your mother's never going to believe you. Several factor contribute to perpetuating the abusive situation: secrecy, helplessness, entrapment and finally accommodation, the means by which the victim emotionally tolerates the situation in which sexual abuse is followed by further sexual abuse. Symptoms resulting from betrayal include extreme dependence or clingyness in relationships because of the need to establish a trusting relationship. Sexual assault by a family member creates impaired attachments. The victim may show poor judgement about the trustworthiness of others because she has no model to appropriately establish trusting relationships. An adolescent and an adult survivor of sexual abuse is particularly vulnerable to later victimisation and may become involved in relationships that involve physical, emotional or sexual abuse of herself or her children.

Again I am sure all of you if you deal with adolescents who've been sexually abused in your practices also hear from the mother or the family member that they themselves have been sexually abused and sometimes you get a history that it is multiple generations. She may also have absolute distrust for all male-female relationships perhaps resulting in deficient heterosexual relationships in the future. Survivors of sexual victimisation need to be aware understanding of the effect of these past experiences on their current behaviour they are at risk for being victimised again.

In the process of examining past practices it is often not surprising that women with patterns of frequent sexual activity may appear to themselves or others as could be called over-sexed. Their sexuality may however be of a function of not knowing how to select partners who desire a non-sexual relationship. Given that they may have been survivors of child sexual abuse they may need to re-learn strategies for expressing their need in relationships and for selecting partners with whom they can share sexual decision-making. In these instances learning how to perceive themselves as sexual beings and not sexual objects to communicate their sexual needs, to anticipate when contraceptive use is needed and to negotiate with partners about the type and frequency of behaviours in which to participate may be central to their effort to prevent re-victimisation.

Another risk factor is to the extent in which sexualisation follows sexual abuse may prompt sexualised behaviour. As a result of traumatic sexualisation the child receives emotional or tangible reward for behaviour that is not developmentally appropriate. For example, father-daughter incest may not be negative. She may be convinced that she has a special close relationship with her father, she may feel that she has power over her siblings and she may have privileges, the given privileges that they do not have. She may crave the attention that she is getting from this man whom she is every reason to trust, She may receive special gifts, she may enjoy feeling like an adult. She may conclude that the sexual behaviours are appropriate for children. This traumatic sexualisation results in a child's sexuality being dysfunctional and inappropriately shaped. The sexualisation and stimulation that is experienced becomes a matter that may obsess the child and prevent psychological development in other areas.

Another factor that should be considered is proximity to high crime areas. One plausible explanation of the connection between prior and subsequent assault is due to proximity to crime that people who live in dangerous communities are exposed to more predatory individuals and suffer more victimisation. Rape is only one of the many forms of sexual abuse perpetrated against girls. Unlawful sexual intercourse by force against an adolescent's will is one of the most damaging.

Another risk factor for adolescent sexual abuse is the victimisation of another family member. This phenomenon has been termed "indirect victimisation". The victimisation of the child's family member is associated with increased risk for sexual abuse for that other child. Fearfulness engendered by exposure to victimised family member may result in characteristics that may make a child a more attractive target. Another plausible hypothesis for the existence of this phenomenon is that indirect victimisation may have a corrosive psychological impact on the child and her ability to protect herself. For example since people tend to view their own vulnerability as similar to those close to them exposure to a victimised family member might increase a child' feeling of vulnerability and weaken their assumption that the world in a safe controllable place. Because feeling vulnerable or powerless has been suggested as a risk factor for child sexual abuse victimisation of a family member may in this way put a child at risk for sexual abuse.

Child prostitution and sex rings are additional situations in which adolescents are repetitively abused by adults. There are 3 types of sex rings: the solo, the transition ring and a syndicated ring. In the solo ring there is one offender and several victims. The perpetrator usually has a legitimate access to the victims. In transition rings there are several predators. The victims are usually adolescents. In the syndicated ring there is a highly organised system that may extend over geographic areas, across countries, across continents. In these situations children usually are abused in a group or at least aware of other children involved. The children may be manipulated to become competitive for the adults favour and special attention by receiving rewards for their various behaviours. As a child becomes older she may be used to obtain other children to bring them in to the ring. The children develop strong bonds with one another and their abusers. It is their family so to speak. As such they are unlikely to disclose their abuse to

anyone. Children and adolescents in these situations may be prostituted or may participate in group sex with adult and peers, pornography may be developed from their activities.

The general public must be made aware that child sexual abuse like all forms of maltreatment is everyone's responsibility, everyone's problem. Beyond increasing the public's recognition of the problem we must change the social environment that allows child sexual abuse to flourish. The goal is to create a culture that eliminates any tolerance for child sexual abuse. Eliminates the confusion over what society condones as appropriate interactions between adults and children. All parents need to be educated not only about sexual abuse but also a child's normal sexual development. We must encourage broader parenting responsibilities beginning with early attachment and bonding between the parent and child. Parent education programmes should emphasise communication skill to create a contact in which secret or manipulation by another adult becomes difficult and not tolerated. Thank you.

Chairman: Thank you very much. I think in interests of the time we'll hold questions to the end if we may. Our next speaker is Robyn Rosina who is going to talk on youth suicide and self harm. Robyn is with the adolescent service Royal Prince Alfred Hospital in Camperdown Sydney Australia and she has prepared her paper in conjunction with her colleague Gail Anderson of the adolescent medicine department Westmead hospital Sydney.

Youth Suicide Prevention - An Australian Hospital Nursing Perspective

Robyn Rosina

Youth suicide and self harm are major public health problems reaching epidemic proportions in Australia. Suicide and deliberate self harm arouses the most poignant feelings in any health worker but particularly when it is a young person. This paper will assert that hospital nurses with their ongoing contact and caring relationship with young people are in pivotal positions to ensure care is best practice and evidence based.

The rarity of adolescent units has lead to nurses caring for young people in a variety of settings with varying nursing skills. Nurses appropriately prepared in youth suicide prevention can provide effective interventions within a critical pathway of response. Hospital nurses and nursing can take a leading role in youth suicide prevention with and within integrated approaches to care in general hospitals. Nurses within the hierarchy of hospital systems can deliver an effective acute care response to the epidemic of young people presenting to hospitals after a self harm attempt.

Youth suicide is currently the second leading cause of death of young people in Australia. In some studies Australia unfortunately has the highest rate of youth suicide in the world. In a survey of 14 industrialised nations, 16.4 in every 100,00 young Australians took their own life a rate of approximately one a day between 1987 and 1990. The social and financial costs of youth suicide to our community are huge. The financial burden to Australia of youth suicide exceeds $100 million each year.

The increase youth suicide in Australia is only the tip of the iceberg of the psychological distress and disturbance among young people. The disorder is apparent in nearly all developed countries and rising since World War II. The disorder includes drug abuse, depression, suicidal behaviour and suicide. Depression and drug use are common denominators in suicidal behaviour but when combined with a self, family or peer history of suicide there is higher risk of self harm. Social factors are also associated with youth self harm and suicide. Youth and/or family unemployment, family breakdown and the availability of a fatal means of self harm often correlate with youth suicide. The link between drug use,

depression, at risk behaviours, previous attempts and suicide has been well described in the literature. Drug use is associated with 81% of hospitalised cases of intentional injury. Unintentional injuries account for over 1600 deaths each year and 60,000 young male admissions to Australian Hospitals for injuries each year clearly linked with alcohol and drug use (Australian Institute of Health & Welfare, 1998). There are links between depression, at risk behaviours, drug and alcohol use and deliberate self harm. The same factors can be associated with unintentional injuries. One may suspect that some unintentional injuries may be suicide attempts and these young people may benefit from risk assessment and suicide prevention interventions. A false positive diagnosis of suicidal risk is better than missing a young person at risk of further attempts and completed suicide.

One of the strongest predictors of suicide is a previous attempt. Currently in Australia attempted suicide is most frequent in young people with a female to male ratio of 3:1. Female overrepresentation is diminishing due to a rise in young male suicide attempts associated with drug use. Suicide attempts or parasuicides are a strong predictor of completed suicides with a risk of around 13% will complete the act - 60% of young people who kill themselves have made a previous attempt and many present to hospitals for treatment.

Young people present to hospitals in vast numbers increasing each year in Australia with intentional and unintentional injuries. In 1995 434 young people aged 15-24 died by suicide and for every suicide 10 young people are admitted to hospitals with intentional injuries (Australian Institute of Health & Welfare, 1998). The problem is that many young people who present to hospitals with unintentional and intentional injuries can present with a myriad of diagnoses. The concern is that the presenting diagnosis may mask the predictors of suicide illness or injury and not be addressed by the medical model of care in hospital nursing.

Clearly, the hospital admission provides a unique opportunity for nurses to intervene in the plight of these young people regardless of diagnosis. Interventions can include comprehensive psychosocial assessment and astute suicidal risk detection within a critical pathway of response. Psychosocial and suicide assessment are not routine nursing practice in the care of young people in hospital. The information elicited from these

assessments can ensure interventions and discharge planning is effective in meeting the community health care critical pathway. The underlying problems that often result in the presenting problem can be addressed. For example depression and substance abuse in a young person admitted with injuries following a motor vehicle accident. The young man in this example would have an orthopaedic diagnosis. Utilising astute assessment skills the underlying issues could be detected, and the opportunities of interventions attainable.

Strong predictors of suicidality are high risk taking behaviours that can be masked by a medical diagnosis of young people accessing health care for chronic illness. These conditions can include somatism, illness behaviour, trauma, substance abuse, motor vehicle accidents, accident recidivism, chronic illness, conduct disorders, delinquency, general acting out and aggression adding to the difficulty of detecting suicidal risk. The key is to be alert and recognise risk factors masked by other diagnoses such as chronic illness, depression, mental illness, aggression and risk taking behaviours in all young people in hospital. Assessment and interventions need to target all young people accessing health care rather than concentrating on those with a self harm diagnosis. Suicide prevention targeting identified suicidal people will miss most of those who have a different diagnosis with suicide risk factors and higher risk of completed suicide.

The biomedical model is predominantly the driving paradigm of hospital nursing care of young people who self harm. However it limits nursing to the medical phase of healing ignoring underlying causes of the presenting problem. The pitfall of the biomedical paradigm is that it focuses on technology, technique, single causes and cures within an acute care model. Nursing becomes a technical aid to the medical phase of healing which is when young people decide to leave the hospital. The narrow focus of the medical model impedes the holism of nursing theory and practice, comprehensive risk assessment and differential diagnosis. The delay in suicide risk assessment prevents effective supervision of the young person creating legal vulnerability's for nurses. Young people often leave hospitals when medically well with a medical follow appointment completely overlooking the underlying issues associated with the self harm attempt.

Young people in many cases do not wait for psychiatric or psychosocial assessment currently performed by other psychiatric services and leave the hospital when medical treatment for self harm is complete. At Royal Prince Alfred Hospital the most common time for presentation of young people who self harm is 11.00 PM on a Sunday night impeding the psychiatric services' response. Nurses trained in suicide prevention strategies can provide interventions improving the success of a critical pathway response to self harm attempts at whatever hour of presentation or discharge. Given that a previous attempt is the strongest predictor of further suicidal behaviour, it is crucial that a psychosocial and suicide risk assessments are done early in order to facilitate appropriate supervision and referral.

Young people find compliance with follow up care particularly difficult. Whether the venue or the time is inappropriate, failures in rapport with the new practitioner or it may be that a depressed person is not easily motivated to attend appointments. 75% of a large study sample did not receive a referral or did not comply with follow up arrangements after a self harm event. Considering the significance of a previous suicidal attempt as a major risk factor of suicidal behaviour, preventing subsequent self harm should be a major focus of discharge planning when hospital staff organise the appointment the rate of compliance by the young person is higher.

Discharge planning for young people could include the following:-

1. Details of previously discussed appointments and options if the appointment is not successful. The arranged appointment details can be faxed to the community service provider to enable the service to follow up the young person if they fail to attend.
2. A list phone numbers to call to seek another appointment, service enquires or further 24 hour assistance for the young person, family or peers to access in times of crisis.
3. Information about medicare and accessing health care services.
4. Details of relevant psychoeducation and self help seeking strategies.
5. The young person could be assisted to make their own appointment prior to discharge and a community outreach visit could be arranged.

In summary, the hospital admission is a unique time for nurses to offer young people appropriate interventions 24 hours a day within

a critical pathway of response. An effective nursing response as asserted by this paper can improve the continuity of care between hospital and community services. Nursing care in order to be best practice and evidence based needs to focus on five key areas of practice. These keys areas include early and ongoing psychosocial and suicide risk assessment within a critical pathway response, a safe level of supervision with ongoing risk assessment, the development of a therapeutic relationship with the young person, their peers and family, thorough defensible documentation and effective discharge planning.

Nurses and nursing need to be involved in policy development and the decision making in all of the five practice areas highlighted by this paper. Active involvement by nurses and nursing can ensure some control over their practice, expand nursing practice beyond the medical model, protect nurses from legal liability, ensure the integrity of the profession and most importantly contribute to national and international efforts in youth suicide prevention.

Chair person: Our next speaker is Pat Cox. Pat is currently a lecturer in social work specialising in child protection. She has worked with children and families for approximately 13 years and she now is engaged in research about child protection and particularly child sexual abuse and Pat is going to address the theme “sexual abuse - protecting young men and women from abuse”. Thank you.

Sexual Abuse - Protecting Young Men And Women From Abuse

Pat Cox

I am going to be talking today about protecting young women and men from sexual abuse, I am going to be talking about how we use knowledge and understanding to protect young women and men from abuse and I am going to be talking about how I believe knowledge comes in waves, I am going to be using the metaphor ebbing and flowing rather a lot. I am going to talk about where we are now and what I think we can do about that. Inevitably I am also talking about a very complex nature of knowledge, I am actually talking about that by default, I am talking about what we know, what we let ourselves know, what we allow ourselves to know and I am talking indirectly about how many forms of knowledge are privileged over other forms. For example, knowledge that is written down or printed is privileged over the knowledge which is spoken. Men's knowledge is often privileged over women's knowledge, that of white people is usually privileged over that of black people, that of able-bodied people is privileged over that of people with disabilities and last but not least adult's knowledge is usually privileged over that of children. What I am going to be talking about today is mainly backed up by existing studies and research. This is a different sort of presentation, as I said my background is social work. It's very much about thought piece, it's about where I am, what I am thinking about, what I am writing about.

I think in audience like this I don't really need to go into the history of child sexual assaults. We understand that it's going on across cultures, across centuries. We can go back as far as Ancient Greece, we can go back into the legends and stories of the Eastern world, we can come forward in time to medieval folk songs, we know that historical accounts have been recently reclaimed, we know it's gone on and it's gone on everywhere in fact thank Professor Yordan for this for leading me in that it's still going on everywhere. What is important I think is that knowledge and understanding about child's sexual assaults is moving constantly in waves and if we take any historical perspective we are looking at a wave coming up, we are looking at understanding developing and this is repeated circuiting, repeated kind of driving up into public awareness and professional consciousness and

then there is a negative reaction, and a wave ebbs off again down the shore.

I think that in the 1990s we are in great danger of not building on where we know now, I think we are actually almost at a peak kind of in knowledge and understanding. What my concerns are that we are not building on that, we are not using knowledge effectively, we are not publicising knowledge effectively and I am very worried that if we don't build, we won't stand still we'll actually start to lose what we've got and we'll end up with strategies for protecting children that are at the very best apolitical and quite adult-centred and at the worst much much worse than that, certainly not child-centred.

I'd characterise, a quick flick through history here, I apologise reading stories in the audience, I'd characterise the period of the 1970s and the 1980s as a great period in public and professional awareness. We know that the credit for raising consciousness about child sexual assaults in these years goes to many unknown black and white women working in women's refuges and rape crisis centres, this knowledge was picked up in varying place in varying times by social workers psychologists, youth workers, paediatricians and we are now at a point where a great many of us recognise child sexual assault as a root of a great deal of childhood disturbance and at the root of a lot of adult pain. The 1970s and 80s are characterised by individual survivors speaking out, by research, by the developments here in England for example of child line, the help line for children, various films, soap operas running story lines about child sexual assaults and a message reaching a much wider public than previously.

I'd say that in the 90s we are lazing a bit. I think that the pronouncements of for example Peter Lilly and John Redwood when the last government was in power about the abuse on single parents' of the Child Support Act for example shows that they have no idea that someone would choose to live singly with their children rather than living in a two-parent household with an abuser, I felt it was deeply significant that the media treatment of the Department of Health messages from research in the media the response focused much more on what was being said about social work practice than on what's being said about abuse Reports that came out in '95, feasibility study about ascertaining the prevalence about child sexual assaults in this country did not

get any news coverage whatsoever, that to me says what's happening to that knowledge.

I want to talk about very broadly it will have to be and I apologise for that I want to talk about studies and research. Studies have been going on for a long time now, 70s and 80s were kind of peak time for this, and all the studies and all the research tend to use different definitions of what child sexual assault is or isn't, tend to use different audiences, tend grade the data differently and so on, you know all this, I don't need to go through all this in too great a detail. But what is interesting is when you start to look at these studies en mass and when you start to look at study of studies what we see is commentator saying things like, and this is back in 1990 now this isn't a recent comment, "there is been enough research to show that the sexual abuse of children is not a negligible issues or a question of public hysteria but a serious social problem, even the lowest estimate of its prevalence indicates the large number of children are involved". That was an English commentator in 1990 and more recent commentators have said things like, "a huge fundamental question of policy, practice and prevention". These studies and research, this is if you like in a category of official knowledge, it's written down, we can access it. There is also I think a lot of unofficial knowledge and I think that perhaps we may, we cannot say in confidence, but we know the true numbers and young women and young men who are sexually assaulted and we may never know that.

Commentators had indicated how it is for young black women and young black men to speak about sexual assaults because it may mean an involvement of the police and as we know policing in this country is very heavy-handed and often very racists. Young lesbian women and young gay men find it difficult to speak out about being sexually assaulted because of the heterosexism, homophobic oppression that they daily experience and we talked about it this morning. Young women and young men who are disabled very often can't communicate directly, you may not have the power of speech, the language that they use to communicate may not have the terms for sexual assault.

In relation to understanding about sex rings and understanding about international sex tourism and our understanding about abuse generally we are at the bottom of a very steep learning curve, we just don't know enough about all this yet. Pornography,

that was another thing, this is the extent and state of pornography and involvement of children in that who have been abused, we are learning but we don't know, so it is difficult to say exactly what we are talking about. What we are clearly talking about are huge numbers and when we're ask about the fact that we know that people who commit sex offences very rarely will own up to all the offences they've committed, we've got another figure, another hint figure. And the fact that survivors don't know to talk about everything that they've suffered and sometimes they can't because they are into forgetting as a defence mechanism.

So we've got a lot of information, a lot of it official, we've got a lot of information that we recognise but we can't get at right now and yet it's still very difficult to get policy - makers to kind of take on board the issues of child sexual assault. I think there are two things around it, I think that there is prevalence that I just talked about, I think it's very hard for all of us, people in this audience than let alone the wider public to get our heard around something so wide-spread, so wide-scaled and something that's gone on for so long. I think that it's also and this is again difficult but all the studies that have looked at the issue of gender, and again Professor Yordan led the way for me on this all the studies that looked at the issue of gender show that overwhelmingly that it's men and it is men in families who are committing, who are perpetrating these offences. It's difficult for all of us. It's difficult for women to take this on board, it's difficult for men, whatever our sexual orientation, whatever our relationships with our own sex or the opposite sex, it is very difficult to get to grips with it this gender nature.

We are into the politics of gender, we are into the politics of heterosexism and we are into the large large debate for the full picture and I think that it does make it difficult for all of us. I think that it's easy therefore for a lot of us to express our discomfort with all of this in challenging studies or disagreeing with studies or saying, you know, this doesn't really exist, we know everything there is to know, we've got it all under control, various responses. We've all heard them sometimes, we may be guilty of making them. I think there is resistance to knowledge. I think that we are talking, I don't really like the description which is used by an anthropologist, he talks about public secrets: we know this and we don't know this, and we sort of don't know ourselves into denial. There is resistance, there is avoidance of these public secrets.

What we have to do particularly those of us who have access to both the official or privileged knowledge and the non-privileged knowledge which is a lot of us in this room is we need to be talking more widely about this, we need to be saying, this is a major issues, this is a major social problem, we need to be talking, I mean talk to anyone and listen, you know, I mean, talk to, a lot of people want to know more and don't know what to ask, if you kind of let on that you know a bit you will get asked questions. I think that it's important as well that we correct misapprehensions in the media, I think for example the way the media is treating in this country the enquiry into abuse in children's homes in Wales it's very much re-enforcing this notion of individual men who are abusing and I out this in inverted commas I am not happy with this word, individual paedophiles, dreadful men, you know a long way removed from normal people, normal men. And we need to start correcting this, we need to start saying, hey you know, we are not talking about individuals, we are talking about large numbers of abusers.

In this we can be helped, people like David Finklehorn have led the way saying we must rebuff, we must refute, we must engage with the audience, we must get people on our side. There's recently been stuff written by two practitioners who work with sex defenders and they've got a lot of practical advice to offer the rest of us about getting journalists on our side and getting our information into the public arena. To get to grips with it we have with the prevalence, we have to get to grips with the gender politics, because I think if we don't I think it will all disappear again, it's already, I don't hear these debates very much anymore, I do hear them , but I don't hear them as much as I did. And I think that I will wholeheartedly agree with Professor Yordan and as you see I do about the widespread nature of child sexual assault. I think that we can accept that it is widespread but we don't have to accept that it is the way that it is always going to be, that it is inevitable. Thank you.

Ann Sutton: I understand that Doctor Vivien Norris and she can't co-present. Michael Maher is going to present Self-harming behaviours and group processes in adolescents residential settings. Michael was formerly deputy director of Peper Harrow, a residential therapeutic adolescent community, where he worked for 6 years until 1992 and is now a group analyst with a continued

interest in residential care and treatment for adolescents. Thank you.

Self-harming Behaviours And Group Processes In Adolescents Residential Settings

Michael Maher

There have been a number of very deep and very intense presentations on some difficult subjects I just want to pick up on the last talk though in terms of turning away from knowledge some thing I agree with very much and from a different perspective because I amore concerned with the treatment the care and treatment needs of adolescents who have been sexually abused to abused in other ways as well. Personally coming from a therapeutic community background working with such adolescents who have extreme conduct disorders and many types and you are all going to hear and presume people will understand the type of kids I am talking about to be working in that situation and then for that institution to close is a very personal reaction I have to what felt at the time like a deliberate turning away, because not only it is about public awareness about the extent of this, there is also a very very big question what do you do with these kids? Where is the treatment resource?

And it's not just these kids it's also these adults, these adults who then grow, these men particularly who grow into the adult personality disorders issues of violence that go along with that which could be addressed at an early stage and which have not been. And I think particularly the things that have gone hand in hand in the last 10 - 20 years in terms of things that go wrong in attempts to treat kids particularly in residential institutions like in North Wales have been used as an excuse to close down hell of a lot of places that are trying to do things. And there are some places where things did not go wrong and I'd like to talk a bit about it now.

My colleague Vivien and I both worked at Peper Harrow until it closed about 6 years ago now. Vivien's gone on to train as a clinical psychologist since then and I've trained as a group analyst and this is an attempt to integrate two perspectives on a type of self-harming behaviour and I am limiting myself to cutting, OK. Vivien's done a piece of research with young people mainly girls and the vast majority of young people who self-harm in this way

are girls, and she did a piece of research in 3 places: therapeutic community, a community home and an in-patient adolescent unit.

Cutting often starts in adolescence and in in-patient unit this is very prevalent up to around 40% is suggested. When I am talking about cutting I am talking about the type of cutting which is distinguishing suicidal behaviour. I am talking about are repetitive and of low lethality unlike severe self-laceration which can be associated with psychosis. There is growing consensus that this type of cutting can be distinguished from suicidal behaviour so in this I am departing from the approach that you took looking at a more broader aspect. And many adolescent will start cutting while in in-patient settings. In her research which came in 3 main areas Vivien looked at explanations of cutting, the impact of cutting on others, some of it I am going to miss that bit out, and responses to cutting and how they are experienced by young people. And she came up with a model which I will go through, and then I want to say something myself which is my perspective in response to the work that Vivien did and this is going to be again a brief summation of that.

The explanations that come from talking to the young people and the people who are attempting to care for the young people were divided into these categories: that they were survivor strategies, as a way of avoiding suicide, general coping strategies that came under a number of headings that I don't have time to go through, behaviours which were orientated towards calming and agitated state, release of tension or distraction from very painful feelings, issues which she grouped under terms of self-hate, punishment and internal anger attacking self in a very visible way about feelings of worthlessness, feelings of responsibility, feelings of guilt and a very common one about making concrete bad things from the inside to the outside, so I look normal on the outside, but I feel anything but normal, if I do this to myself and often people will know my arms that take the brunt of this behaviour then I can show that I am not, how I look corresponds more to the sense how I feel, I am not normal.

Now those were intrapersonal explanations and just the some kind of knowledge of value over others, some kinds of modes of being of value I mean where we find ourselves now, the individual and the intrapersonal is valued above the interpersonal, I think that's a universal phenomenon. Those interpersonal explanations which

were offered came around things, issues like communicating distress, punishing others and attention and status. Interestingly no person who cut themselves ever attributed interpersonal motives for the reason. So no kid that Viv ever talked to as part of this study said, I do this as a way of communicating to other people. All the explanations were all intrapersonal, all about personal feelings, very vehement about it not being about communication.

What of the staff reactions. What you have over a period of time is the member of staff who has attempted the rescue which is failed over the period of time. What the would habitually do is start to defend themselves against that experience. The member of staff would stop entering in to have their hopes dashed. And they'll stop attempting themselves, and they'll start becoming more cut off from the kids, more distanced, more arms-length. That will be about being angry, about being you know these kids are not getting well, there is no gratitude, it's being thrown back in their face, all this work I've been putting in and look what they do, you know, well, thanks a lot. And I'd certainly felt like this myself and I've seen that many times, oh, you've cut yourself again, and a lot of people in here when the kids you know either go to A&E, the things that they hear is why don't you do it properly, they get stitched up without anaesthetics, they've got a lot of rough handling, let's encourage them you know out of this cutting behaviour, very very terrible set of feelings, very similar to things about suicide, you know, we are here to help people, we are not here to be messed about by people. So you have anger, you have a cut off response, withdrawal, rejection and anger and that's a very powerful and self-feeding cycle.

What Vivien and I suggest is a answer to that is the need for a physician which falls into neither of those loops, sides of the loop. But if you go for a heroic rescue attempt you are bound to fail and you'll fail the child. If you cut yourself off from the painfulness of the feelings then that's kind of professional rationalisation of having come to work every day who will have the same effect, it's a feeding cycle either way. What we are aiming for in our advice to staff who find themselves in this very difficult situation is to find a place of being suspended in the middle, aware on the pulls on you to react one way or another, to go into either of these fairly comfortable positions but to actually stay in the middle of the dynamic forces, such a place referred to as negative capability

when writing in a different context is about being able to bear unresolvable tensions. This is not possible to resolve this, not in action.

I'll give you a quick story and I'll stop. In action what would might this look like being neither controlled by either impulse. One night I was a senior member of staff working that night at the Harrow and it's been a fairly OK night in my terms and kids have gone to bed at a reasonable time or it seemed like they had and I'd gone home maybe even before midnight which was great and then I got called back in, the phone went and my heart sank and I am running back in and I lived close by and I got back, I got in there and there was a scene of mayhem and there is this girl who I'll call Katy who had a history of self-harming, cutting herself and what she used to do over repetitive times, she'd been in the community quite a long time, she'd been there about 3 years and she'd made a lot of progress but she had this pattern, she would get out, she'd drink until she was very drunk and she cut herself and then she'd talk. The rest of the time she was a very silent character, very difficult to know, non forth coming, sexually abused as a child and very very difficult to cope or deal with through words any of the residue of that that she's been left with. So I came in, Katy was drunk, drank very large amount, had cut herself really really badly, very deep in the arms and there was a lot of blood and she gone up on the garage roof and then she's fallen off. So she bashed herself on the side of the head with all her arms in a really terrible state and all the kids were up then and there was high drama and you know I was called in and everyone was looking at me, what are you going to do?

And the other thing was that she was refusing to go to hospital, I won't go, she said. She was losing a lot of blood and the kids panicking, and the staff panicking and I am panicking, you know and so we got to work. Some of the staff were trying to contain the anxieties of other kids and some of the staff were so involved, they were trying to talk to Katy and say, you've got to go to hospital. Eventually, over a period of time and sustained pressure, she said, OK, I'll go to hospital, but I'll only go to hospital in Kevin takes me. Kevin's a member of staff, he was on that evening, he was there available, she had a special relationship with Kevin, it's mostly good but there is something about it which is difficult too. And that part is the unspeakable part, OK. That part of her in which she is attracted to Kevin and also in which Kevin reminds her of the man

who abused her. Now I felt very strongly on an intuitive level at that time that she must not go to hospital with Kevin. I thought there was something about her re-unitement back illusion with the parents, the kind of system that gets set up in the abuse in the first place in which you find it nearly impossible to do anything else. And I though I was in a position where it's nearly impossible to say no to this because we have chaos, we have high drama, we have blood and violence and all this kind of stuff and here is an answer.

So I took a deep breath and said, no, you can't and then suffered the anger of everybody, all the kids and the staff as well. And eventually it's kind of grounded out in which Heather took her, Heather was another member with whom she didn't have particularly special relationship, but it was OK. And eventually we got to that point and eventually she went to hospital and she patched up. Now I think what I was doing then was not being pulled in, not allowing myself or my staff to be pulled in to either of these cycles. I wasn't rejecting her, I was not giving the slap response, I wasn't manhandling her, or calling the police or getting her sectioned or something like that, that would have been one way, I guess, you know, the kind of a hard way, the hard-edged way of dealing with that situation. I wasn't doing that, neither was I taking the easy way, neither was I going in to the pathology of the situation and reinforcing something. And that's a very small example, but I do think that kind of being able to stay in a very difficult place to be not pulled into either of those directions by the need of a young person or by the needs of the group is the way which I would say you have to work if you are going to have any success with this type of young person. Thank you.

Poster Presentations and Free Papers

Renal Function in Adolescents with Eating Disorders

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Abstract: Renal dysfunction, both transient and permanent, is a recognised complication of eating disorders. Permanent dysfunction has mostly been described in adult patients, usually with a chronic history over many years of hypokalaemia secondary to bulimia / laxative abuse or of extreme low weight. Other studies, in small numbers of adult and adolescent patients, have shown renal dysfunction that resolves quickly with weight gain.
Renal function was studied in all patients admitted to an adolescent eating disorders unit over an eighteen-month period. Creatinine clearance was reduced in the majority of patients. In most, this corrected with weight gain. On follow-up, renal function of a number of patients remained compromised. In one patient, there was the unexpected development of permanent renal pathology. This study emphasises the importance of considering the possibility of both transient and permanent renal dysfunction in adolescent patients with severe eating disorders.

Teenage Pregnancy as a Motivator for Positive Change

Marcia Nogueira and Chiyo Maniwa

Teenage pregnancy is usually viewed as a detrimental occurrence in the life of the average adolescent, given its tendency to isolate the individual from peers and invoke premature responsibility for infant care. Project NATEEN, part of the division of Adolescent Medicine at Children's Hospital Los Angeles, was established in 1985 with a vision of using the crisis of pregnancy as a positive change force in an adolescent's life. Staffed by a program manager. 3 co-ordinators and 18 case managers, over 650 young people receive services at any one time. To be eligible, participants must be pregnant or parenting and must be under 20 years of age. The population served is predominately female and primarily Hispanic (76%) and African American (16%). Many are gang involved, not attending school and using alcohol and/or drugs. A comprehensive evaluation and needs assessment directs the attention of both the case manager and the young person to develop solution focused interventions, Deficits are reframed as opportunities for personal growth. Common areas of need include parenting and play skills, accessing prenatal and child care, ongoing health and medical care for self and baby, maintaining up to date immunisations and managing the maze of the welfare office and Children's Protective Services. Emphasis is placed on infant and child development, school re-entry, vocational training resources and employment opportunities. School attendance and progress is closely monitored. A philosophy of competence and self-efficacy is promoted in all contacts. Counselling referrals are provided for those whose progress is hindered by psychosocial challenges. To counter the sense of isolation so familiar to teen parents, social networks are encouraged and child-parent bonding experiences are facilitated ("Mommy and Me"). Assertiveness training integrating HIV education and protection skills is provided through a "Young Women With Voices" program. Outreach support groups are held in four local high schools and other agencies in the community. Quantitative and qualitative evaluation has shown that NATEEN participants acquire enhanced awareness and skills for self-advocacy both within the social service system and in their relationships with professionals, peers, and partners. Parenting skills are improved. Academic performance is also improved within

6 months of intake into the program. The NATEEN program utilises the case manager/client partnership to empower parenting adolescents to make positive life decisions for themselves and their children.

The development of a rating scale to assess general practitioners communication skills with children & adolescents.

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Objective: To develop a rating scale to be used as a formative tool, which will assess a general practitioner's skills in consultations with children or adolescents when a parent is also present (triadic consultations).
Method: Existing instruments used in both formative and summative assessment to assess General Practitioners' consultation skills (Leicester Assessment Package (1994), Pendleton et al (1993), West of Scotland Summative Assessment scale (1993), MRCGP videotape assessment scales (1996)) were scrutinised to consider if they were applicable in a consultation where a child was the subject and both the parent and dependant child were present. None of the instruments considered were satisfactory, as significant aspects of the skills applicable were not measured. To develop a new scale we used Neighbour's 'Five Checkpoints in the Consultation' (1987) for the main headings. The skills to be identified within each heading were derived from the existing rating scales used for analysis of consultations with adults and our knowledge of children's difficulties and how these may be assessed in general practice. 44 videotaped triadic consultations involving children or adolescents were collected from 6 General Practitioners. The scale was piloted against the taped consultations and was modified until the final version was produced. Four raters, two general practitioners and two child psychiatrists, independently rated the initial 44 and a subsequent set of 30 triadic consultations.
Results: The final version of the scale contains four headings: Interview and history taking, Examination, Problem solving and management and Safety netting. Under each heading is a division

into General skills and Specific 'Triadic' skills, which are listed. In each section a doctor's skills can be identified using a Likert scale with four defined points. A workbook is included outlining the skills to be assessed and the criteria for allocating points on the Likert scale. A high level of agreement was reached between the four raters when a summary score was given for each section of the scale, after viewing 6 of a doctor's triadic consultations.
Conclusion: A valid and reliable scale has been developed which can be used as a formative tool in the teaching of the skills required by general practitioners in triadic consultations. This has wide applicability in teaching General Practitioners, Paediatricians and Accident and Emergency physicians skills required to allow children and adolescents to contribute appropriately in consultations where their parents are also present.

Physical Abuse of Adolescents in Chile - Does a Problem Exist?

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The battered child and adolescent syndrome has been increasingly drawing the attention of health care professionals and of the population as well. In Chile, however, both the frequency and the characteristics are unknown, since the subject is still a matter of secrecy. The objectives of this study were to investigate the prevalence and characteristics of physical abuse and the association with family types during the adolescence period in university students. This group was selected thinking that it was easier to report an event that has occurred in the past. The population size was 1,062; with an expected frequency of 50%, worst acceptable value of 55 % at a confidence level of 95 % a sample size of 282 was calculated, In order to assure the sample size an excess of 10% was considered and 302 students participated in the study A questionnaire was answered containing relevant information of the history of physical abuse in the adolescence period (12 to 21 years of age). The sample was

composed of 165 male and 137 females (the distribution by sex reflecting the composition of the population), with a mean age of 22.7 years.

Results: 53 % of the respondents confessed having been physically abused by one or more family members (54.6% among males and 51.1 % among females). Mother and father are most frequently the batterers. Among 156 physically abused students, a total of 444 episodes were recorded and the mother is responsible of 259, the father of 152, grandparents of 15, uncles/aunts of 12 and step-parents of 7 episodes. A total of 577 motives causing the abuse were recorded, most of them associated to behaviours: being disrespectful 14.7%; not obeying 13.7%; lying 6.1%; being late 5.7%; poor grades at school %;, alcohol and drug use 3.1%; sexual activity 0.35% and stealing 1.21%. In 76% of the episodes other members of the family were present, (siblings or other parent). 37% of those people did not intervene and only 21.3% tried to stop the Situation, although 21.3% supported the victim afterwards. 23.6% of the victims reacted with crying, 21.4 faced the abuser, 17.8 run away, 18.8% got paralysed. 2% asked for help to neighbours or other family members and only 1.6% went to the police. The association with family type was studied, Family type was classified as biparental (nuclear or extended); monoparental (single parent, nuclear or extended) and remarried, A ratio of battered I not battered was calculated for each type of family being 1.04 and 1.2 for biparental families, 2 for extended monoparental families and 2.5 for families with remarried parent, showing these two as families at risk. An association was found when comparing both extended monoparental and remarried against the other three with a p-value = 0,06 and a RR = 1.33. Also an association was found between being a family with remarried parent and the risk of physical abuse with RR 1.36 p=0. 17). On the other hand, an association was found between being a biparental family and a lower risk of physical abuse with a RR 0.87, p=0.26.

These results from a prevalence study and an initial study of association stress the need for further analytical studies in Chile.

Adolescence: - Myth or Reality for Pacific Youth? A Samoan women's Perspective.

Author/presenter. Anne-Marie Tupuola
New Zealand born Samoan at the final stages of doctoral studies at Victoria University of Wellington, New Zealand, My thesis critically examines the notion of adolescence and two processes commonly associated with adolescent development - personal and ethnic identity formation within Samoan contexts.

The concept of adolescence is debatable in different cultural contexts. Is adolescent development a universal stage of human development?

This paper will critically analyse some of the common assumptions made of adolescent processes within diverse Samoan contexts. What does adolescence mean for young Samoan women of the age group commonly referred to as adolescence? Can the concept of adolescence' as defined by several western adolescent theorists, be used to define and describe the experiences of Samoan youth?

The findings from both my Masters and Doctoral studies will be discussed to illustrate some of the limitations of some western adolescent theories in Samoan societies The experiences of 53 women aged between 14 and 29 years of age, most of them of Samoan descent in New Zealand, are discussed to highlight some of the problems of confining their human development processes within rigid stages and boundaries

The implications of both studies will also be outlined with some recommendations made to youth workers and adolescent practitioners working with youth of cross-cultural and/or Pacific backgrounds.

Adolescent Sexual Problems and Education

The Status of Adolescents' Sexual Behaviour in schools. Experience of using a questionnaire in Ekaterinburg, Russia.

Natalia Smirnova

Research into adolescents' sexual behaviour is quite common in western countries. As regards Russia this subject has been studied little. The work described below is the first stage of a large sociological research based on the results of the questionnaire for the pupils (14-15-16-17 years old) of the senior forms (9-10-11-th forms) of several secondary schools in Ekaterinburg. The research was made in 1998 January-May and included 306 pupils of different schools. The main goal of this work- is to get acquainted with the problem, it's reality.

There were no so called "difficult adolescents" (here it means the adolescents with evident behavioural, learning, family and other problems) among the interrogated pupils. Nevertheless the level of conflict with family members is rather high:- 79% among the pupils of 14-15 year olds and 56% among 16-17 year olds. At the same time there is a tendency to close interfamily relations:- 72% among the pupils of 14-15 and 69% among them of 16-17 years.

The attempts to leave home for a time of one to three days were noted in:

	Boys	Girls
14-15 yrs.	10%	4%
16-17 yrs.	16%	12%

Desire to leave home was noted in:

	Boys	Girls
14-15 yrs	33%	39%
16-17 yrs	25%	22%

By the age of seventeen 89% of boys and 52% of girls tried to smoke, among them 40% of boys and 30% of girls smoke constantly. At seventeen 95% of boys and 84% of girls had drunk alcohol, 28% of these boys and 40% of girls drink alcohol from time to time.
As regards drugs at least once they tasted in:

	Boys	Girls
14-15 y.o.	13%	7%
16-17 y.o.	17%	12%

Among them began to use drugs in:

	Boys	Girls
14-15 y.o.	33%	29%
16-17 y.o.	64.7%	0

By age 14-15yrs 40% of boys had the first sexual intercourse and 36% of them have it regularly. Among girls there were 25% who had their first sexual intercourse by the age of 14-15 and 8% have regular sex. As regards the adolescents' opinion about at what age is it possible for beginning sexual life they answer: "at the age of sixteen" (a year ago it was the age of getting passport in Russia). And 19% of boys and 32% of girls think this age to be 18 yrs (the age of official majority in Russia).
The moral (or mental) readiness for beginning sexual life was marked in:

	Boys	Girls
14-15 yrs	87%	25%
16-17 yrs	84%	40%

The initiative of a first sexual intercourse among the boys belonged in 61% to them and in 33% to their partner. Among girls- in 27% the decision was theirs and in 39% their partners. In 7% adolescents answered that the partner forced them and in cases with girls of 14-15 years they have been resisting till the end of the sexual intercourse in 38%. About 85% of pupils have an opinion that it's possible to begin sexual life before the marriage.
The pupils' attitude to abortion is the following:

	Boys		Girls	
	14-15 yrs	16-17 yrs	14-15 yrs	16-17 yrs
Approve	21%	9%	10%	20%
Disapprove	33%	36%	45%	34%
Don't know	46%	55%	45%	46%

The main sources of sexual information for the pupils are: - books, - friends, - erotic magazines and films, - in 33% among the girls- their own parents. Nowadays the scope of sexual education of the school pupils in the Russian educational system is not considerable. Only 17% of pupils said that they got such information from school teachers or psychologists. And 23% of them answered that they never got any information from anywhere. And the relation to the necessity of establishing a new subject devoted to the sexual education at school is the following:

	Boys		Girls	
	14-15 yrs	16-17 yrs.	14-15 yrs	16-17 yrs
Strongly against	9%	11%	2%	7%
More for than against	19%	25%	23%	22%
More against than for	4%	0	4%	6%
Firmly agree	52%	56%	56%	57%
Don't know	16%	8%	15%	8%

So the first stage of research shows: - the reality and actuality of the problem of adolescents' sexual behaviour and education, - the necessity of extending and continuing of the research with additions or changing of the questionnaire, - the necessity of co-operation with sociologists and teachers in solving the problem and perhaps in establishing a new subject for school pupils.

Adolescent Health in Urban India; A Study of Mumbai

K. Anil Kumar

Paper prepared by K. Anil Kumar, Usha S. Nayar, and P. M. sandhya Rani of the Unit for Child and Youth research, Tata Institute of Social Sciences, Sion- Trombay Road, Deonar, Mumbai 400 088 India - The research on which this paper is based was funded by the Ford Foundation through its grant to the Centre for Health Studies at the Tata Institute of Social Sciences. Mumbai, India

Introduction Recognition of adolescents as a population subgroup with unique needs came late in India. Popularisation of reproduction health concept, increasing number of AIDS cases among young people, and prevalence of early marriages were important factors for the recent attention on adolescent health from policy planners and researchers.

Research studies on specific facets of adolescent health exist in India in abundance. Such studies mainly focus on risk-taking behaviour especially among students the implications of social cultural differences for health promotion, gynaecological problems related to early pregnancy and child birth and adolescent sexual behaviour. Those attempts which dealt with adolescent health in a comprehensive way, examining its different facets in a single study were mainly based on secondary data and could not look into the less obvious problems of socio-economic inequalities. The present paper, based on a study among Mumbai adolescents aged 15 to 17 attempts to understand their health using both subjective and objective health indicators, and examines the relationship of health status with socio-economic situation and health related attitudes and behaviours.

Data and Method Conducted in 1994-95 in suburban Mumbai, the study covered 311adolescents from various socio-economic backgrounds respondents were selected from slum areas as well as from posh localities. Two other concerns in sample selection were gender and school going status. Strong son preference traditionally prevailing in India necessitates consideration of sex differences in heath situation of adolescents. A considerable proportion of Indian adolescents are out of formal education dropping out at various stages for various reasons. Exposure to

health risks, and health status differ between these two groups.

Because the sample size is not large, results are to be treated as indicative rather than conclusive. That the study covers adolescents from different social and economic background and views health in a broader perspective makes it an exploratory attempt towards understanding the health of adolescents. Students of two schools which admit those from middle and upper class families, and adolescents from two slum areas were selected for the study. Adolescents from slum families were interviewed individually by trained researchers. Students of XI and XII classes of the selected schools filled in the interview schedule themselves with research staff explaining each question initially to the entire class and then attending to the individual clarifications. In addition to the interviews anthropometric measurements were also taken.

The study gathered information on household socio-economic status, eating habits of adolescents, perceived health, perceived adequacy of nutrition, nutritional deficiency diseases, illness during the 15 days prior to the interview, disability, risk taking behaviours, exposure to mass media, health services utilisation, their concept of health, and mental health status. For the purpose of this paper, perceived health, ailments during the 15 days prior to the interview, height, weight, and mental health score are used as health indicators. The variations in these indicators are viewed as functions of socio-economic status, eating habits, nutritional adequacy, prevalence of nutritional deficiency diseases, exposure to media, and attitude towards risk taking behaviour. For analysing the effect of independent variables on perceived health and reported morbidity, logistic regression analysis is used. To examine the changes in height, weight, and mental health score, multiple classification analysis was employed. In the bivariate case, differences across population groups in health indicators is examined using x^2 test and one way analysis of variance.

Results The number of boys (139) in the sample was lower than that of girls (172). Of the 311 respondents, 57.6 per cent were school going and the rest were dropouts. The distribution of respondents according to subjective health indicators by selected socio-economic and other health related characteristics was recorded. Keeping in mind the importance of sex and school going status, we consider these two also as dependent variables. Age-sex distribution shows significant age differences between males

and female adolescents in the sample; the mean age of males being higher (16.2 years) compared to females (15.8 years). Sex difference in school going status is also significant (I% level) with more females dropping out of the school system. This observation is consistent with the situation prevailing in India at large. Sex distribution by religion is not significant whereas that by caste is significant at 5% level. One indicator related to housing - whether the household has a separate kitchen served as a proxy to other housing related variables. The distribution according to this variable is not found different between males and females.

A household socio-economic status index shows that the level of living of the selected male and female adolescents differ considerably (probability of I%) The rest of the variables are some of the intermediate variables which have a more direct bearing on health status and behaviour. Of these six variables, the sex differences in perceived nutritional adequacy, nutritional deficiency diseases, and per capita daily energy intake are significant. The distribution of adolescents by socio-economic and other characteristics according to whether they attend school or not show significant differences between these two groups. Further, the health related behaviours and attitudes as well as indicators related to nutritional adequacy show significant difference between these two groups.

Distribution of adolescents by background characteristics when two subjective indicators of health are considered. The first of these indicators is obtained as the response to an item to rate their own health status in a four point scale: excellent, good, fair, and bad. The second is reported acute illnesses during the 15 days prior to the interview. The term 'illness' is perceived differently by different people and can be thought of as subjective. The results show that, of the seven socio-economic and demographic indicators considered, three of them show significant influence on perceived health. Of the six health related indicators, only one shows significant effect. When ailments during the 15 days prior to the interview is considered, of these 13 indicators, only one - the number of meals per day - shows any significant impact.

Objective indicators of health considered by socio-economic characteristics and health related indicators are presented. For most of the independent variables, the mean height, weight and mental health score differ significantly across various categories.

In the case of height, seven out of the thirteen indicators, in the case of body weight ten out of thirteen, and in the case of mental health score eight out of the thirteen show significant differences across the categories. Anthropometric measurements show that, body weight rather than height exhibits a larger variation across the categories of different indicators. Mean height is significantly different across sex, age, school going or not, caste, having separate kitchen, perceived nutritional adequacy, and energy intake. Body weight differs significantly for these variables as well as for standard of living index, exposure to media and religion. Mean mental health score varies according to sex, school going status, religion, caste, whether the household has separate kitchen or not, standard of living index, nutritional deficiency diseases and exposure to media.

The first set of multivariate analysis used logistic regression analysis with perceived health status and acute illness as dependent variables. Many of the selected variables are not significant in explaining the differences in perceived health status. Of the thirteen selected variables, age, separate kitchen or not, and nutritional deficiency diseases are the three factors that have a significant influence on the perceived health status. At the same time, only two variables -separate kitchen and number of meals per day are significant predictors of ailments reported. When variables other than demographic and socio-economic are entered, the variable number of meals per day in the case of perceived health and nutritional deficiency diseases in the case of ailments become important predictors. When demographic and socio-economic variables are used as independent variables, only age and separate kitchen in the case of perceived health and separate kitchen in the case of ailments show statistical significance. When age, sex and school going status are the only independent variables, age and school going status become important in predicting perceived health whereas none of the three variables is significant for ailments.

Finally meals per day, perceived nutritional adequacy, nutritional deficiency diseases, exposure to media, attitude towards risk behaviour, and energy intake were analysed to see the influence of demographic and socio-economic variables. Surprisingly, in only two regressions - for media and energy did any of the independent variables show significance. Religion and school going status are significant predictors of exposure to media and age is related to

the energy intake per day.

Anthropometric measurements and mental health score were treated as dependent variables. Multiple classification analysis (MCA) was utilised for analysis and since no more than ten factor variables can be entered in a single command, the variables energy, number of meals per day and standard of living index were not recorded and were introduced as covariates. The same analysis was repeated for each of the three objective indicators initially for the entire sample and later for each sex and for school going and non-school going adolescents. The grand mean of height, weight and mental health score were respectively 163.1cms, 42.9kg. and 9.2 The gross religious differences in height of adolescents is 6.44cms and the net difference is 2.81cms. Among Hindus, the height tends to be higher than the grand mean by 0.85 cms, among Buddhists it tends to be higher by 0.97 cms and among other religious groups (taken together), the average mean is lower by 4.63 cms. This pattern of variation changes considerably when the effect of other variables are controlled. When adjusted for such effects, the net religious differences in mean height increases from 2.81 to 3.91 indicating that the effect of other variables tend to hide the independent effect of religion on height. The deviation from grand mean for each religion also undergo considerable change. when control led for the effect of other variables, the effect of religion increases considerably; the variation explained increases to 4.84 per cent the greatest effect on height is of sex followed closely by caste. The effect of sex on height is considerable 9.61 per cent of variation in height can be explained by sex differences alone. Caste explains 9 per cent of the variation in the height of adolescents in Mumbai city.

It is possible to interpret the results in a similar way for the other two dependent variables also. The unadjusted and adjusted deviation from grand mean body weight is most affected by caste and sex, as observed in the case of height. The effect of independent variables and covariates on mental health score decreases once the intercorrelation of independent variables and covariates are controlled. The most important of the explanatory variables are nutritional deficiency disease and whether the household has separate kitchen.

The differences in the effect of independent variables on height,

weight, and mental health score were analysed also for each sex and separately for school going and non-school going adolescents. For males and school going adolescents, the influence of these variables are considerably higher compared to females and non-school going adolescents

Discussion - Four-fifth of the selected adolescents reported their health as excellent or good underlining the feeling of general invulnerability prevalent among youth. Forty two respondents (13.5 per cent) reported to have suffered from acute ailments during the I5 days prior to the date of interview. If we compute a rough estimate of the prevalence of acute illness, it would be higher among Mumbai adolescents compared to the national situation and that observed in some Indian states. In spite of the socio-economic differences, Mumbai adolescents both males and females - tend to think that their health status is good.

An interesting related result of the study is the perception of health by adolescents. The respondents reported that they are in general healthy, but they could be healthier. In order to become healthier, most of the adolescents thought that they need to eat more food, eat food, with nutritional value, and exercise regularly. They were asked whether they knew anyone who can be regarded as healthy. Those who responded 'yes' to this were further asked why they regard this person as healthy. The responses centred around 'because he/she is physically fit', or 'he/she doesn't suffer from any disease' indicating that mental or social health are not thought by adolescents as facets of health.

We found that the variation in subjective health indicators across socio-economic categories is not marked, the bivariate analysis of objective indicators of anthropometric measurements and mental health score showed significant variations with social, economic and demographic factors. Similarly, while in the case of perceived health the intermediate variables rarely showed significance, objective health indicators showed statistically significant influence.

Whereas for subjective health indicators, sex-wise analysis and separate analysis of school going and non-school going adolescents did not provide any important deviation from the overall scenario, the objective indicators present a different situation. The influence of the independent variables vary

considerably between sexes and between school going and non-school going categories. The differences in the influence of various factors between objective and subjective may be due to the lack of association between these types of indicators.

The relationship between objective and subjective indicators of quality of life is often weak. Of eight possible relationships only two between perceived health and ailments, and between ailments and mental health score are statistically significant.

Promoting Adolescent Health on an Adolescent Ward

G.Anderson, S. Clarke, R. McClymont

Health promotion is an important aspect of primary health care for young people. This presentation will describe the Health Promotion Program currently offered at Westmead Hospital Adolescent Unit, Sydney

The aim of the program is to provide relevant health educational activities for hospitalised adolescents based upon needs assessments and involvement of young people in the planning, implementation and evaluation stages. The program is designed to extend young people's knowledge of and sense of responsibility towards, a range of issues affecting health and well being.

Adolescents are more eager to participate, learn and adopt positive changes when they play a role in determining their own health educational needs. In this program, adolescents positively contribute to the process of identifying and prioritising their own health educational needs. As a result of being involved in the planning, implementation and evaluation of the program, young people feel a sense of ownership and enthusiasm about the learning process. These learning experiences promote positive health related behaviours in physical, emotional, social and value orientated aspects of health and well being. A few examples of requested topics include: Feeling good about yourself Managing on a budget; Getting on with parents; What happens when you have an anaesthetic; The effects of drugs and alcohol; Healthy eating; Skin care and pimples; Sexuality and contraception; How to get the job you want.

The use of small group work and peer support stimulates thought, critical thinking and opinion. It also fosters a non-threatening milieu of interactive, yet relaxed sessions which maximise learning experiences. Evaluation by young people is a crucial part of this program. This presentation will describe planning and functional aspects of the Adolescent Health Promotion Program.

Reducing Teenage Pregnancy: An Interagency Discussion Document

Helen King
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Womens Health Directorate Sheffield NHS Trust

Sheffield has a Sexual Health Strategy, which was launched in January,1995. A multi-agency Implementation Group was formed in 1996 to monitor and review progress towards achieving the Strategy's objectives. The group determined priorities for action, one of which was the need to reduce unintended teenage pregnancies A small working group whose brief was to focus on inter-agency strategies for reducing unintended teenage pregnancies was established in January 1997.

This group, which consisted of representatives from Sheffield Health (Health Promotion and the Centre for HIV and Sexual Health), Community Health Sheffield NHS Trust and Sheffield City Council Youth Service, agreed that it would aim to produce a short working document by June,1997.

An initial extensive literature review drew attention to the over-riding importance of the cultural, social and economic context, including sex education, in occurrence rates of teenage pregnancy. It became clear early in the process, that the group could not presume to write a strategy that would seek to change areas of work over which it had no direct influence. However it would be able to produce a consultation document relevant to Sheffield presenting national and Sheffield perspective highlighting key areas for action.

This poster chronicles the process of developing the discussion document, which took 6 months longer than anticipated - the final version, appeared in January1998 - and subsequent multi-agency workshops were set up to pull together ideas and opinions from a large group of professionals in order to take work forward.

Mortality from Violent Causes in Adolescents and Young People: A Challenge for the Region of the Americas.

Tamara Zubarew[1], Joao Yunes[2]

Director, Adolescent Health Programme, Catholic University. Santiago, Chile.
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This paper summarises findings from analysis of mortality trends in homicides,suicide, traffic accidents, and all external causes in adolescents and young people from 16 countries in the Region of the Americas. Information compiled by the Pan American Health Organisation Data Bank between 19S0 and 1994 was utilised. A description of different subgroups of adolescents and young people, by age and sex, is provided Results indicate that in the majority of the countries (Canada, USA, Ecuador, Mexico Chile) Costa Rica, Trinidad & Tobago, and El Salvador) mortality trends due to external causes have been decreasing in adolescents and young people. Colombia and Brazil are the only countries analysed demonstrating increasing mortality rates in their populations. The countries with the highest mortality rates due to external causes in adolescents and young people, in decreasing order, are: Colombia, El Salvador, Venezuela, Brazil and Puerto Rico. The primary external cause of death in adolescents and young people are traffic accidents. However, in almost all the countries analysed, the death rates are decreasing. Ten of the countries analysed revealed a progressive increase in homicides in all of the age groups studied (Colombia, Puerto Rico, Trinidad & Tobago, Argentina, Uruguay, Panama, USA. Venezuela, Ecuador and Brazil). The countries with the highest homicide rates among adolescents ages 15 to 19 years, in decreasing order, are: Colombia, El Salvador, Puerto Rico. Venezuela, and Brazil. Young men, ages 20 to 24, were the sub group with the highest homicide rate. In the United States and Brazil there is an alarming increase in the homicide rate of boys between 15 and 19 years of age. Suicide is a growing problem in adolescents and' young people in Cuba, Canada, USA, Trinidad & Tobago, Argentina, and El Salvador. Increasing mortality rates due to homicide reflect the dire need for more epidemiological surveillance and violence prevention programs directed towards adolescents and young people in the Region of the Americas.

The Development of a Concept of Family therapy.

Sergei Sannikov

A short literary review

Family therapy as a branch of psychotherapy dealing with the issues of family relationships, means of affecting change aimed at both prevention and treatment as well as psychological and social adaptation was reflected in the parallel works of a number of psychotherapists from different schools and methodologies in the fifties and sixties.

Levi describes the observations of a number of experienced clinicians, who came to the conclusion that "functioning of the individual could be better understood and changed in the frames of his family": The following factors are relevant here - patients staying in the hospital feel worse after the visits of their family members, - in cases where the patients' health improves the same clinical symptoms may be noticed in the other family members, who was previously considered to be healthy, - psychoanalysts who deal with children having behavioural deviations noticed that their parents often resisted positive change in their children, trying sometimes to prevent further treatment. After these observations they began searching for causes of changes in the interpersonal relationship and the peculiarities of interfamily communications.

A. Zakharov described the influence of the family relationship on the development of illness in children (relations between the parents, between parents and grandparents between other family members). S Minuchin proved that the conditions of the family boundaries and it's subsystems, may influence disease and social and psychological maladaptation. Quite the reverse occurs when adequate valid assistance of psychotherapist is provided the inner family relationships lead to it's healing. Menegetti notices that very often a family member which is considered to be healthy becomes the inductor of the interfamily psychological tension but not the real symptom carrier. One of the basic terms of Sallyvan's theory - is the image "of the nuclear family" taking place from very early childhood and based on present family relations and which has a strong influence on the forming of relations between the individual and environment.

Rollo May states that the basis of the personality of an individual develops from early childhood and depends on his role in the family. Further the character develops depending on how the individual realises the primary model. The main goal of psychotherapy in his opinion is to help the patient, paying attention to the significance of childhood, to understand step by step how to use the influence of today's environment for successful correction of the individual's model. Virginia Satir who worked successfully in family therapy considers that creative potential and successful functioning of the individual may be only increased with the changing of the conditions of other family members and acquiring new aspects of their relationship. She considered that family therapy means the mandatory participation of all family members in the work. J. Bell as the first steps of therapy deals only with the parents and than added the "child's problem" to the work. In Bowen's opinion it is possible to work even with the one family member for changing the whole family. Famous family therapist R. Stewart deals only with married couples. The Milan school uses the whole team of psychotherapists working with every family while others (including V. Satir) prefer that the family as a whole and each family member deals with the same psychotherapist. So there is no common idea of a family therapy.

The Kocharyans describe their view on the problem. According to their opinion the term "family therapy" is polysemantic and carries different meanings. That is because of the fact that the base for highlighting of the family therapy may be such opposite sides of the psychotherapeutic process as the OBJECT. In the first case we deal with the psychotherapy of a family as a system, and in the second- with the psychotherapy by the family (means using the united family effect for treatment of the patient).

They divide the three main models of the family therapy:

- An Energetic model, which is based on the idea of energetic homeostasis. The therapy preferably is directed on decreasing of the emotional tension.
- Symptomatic model. It is based on the correction of a psychological incompatibility. They use the method of informing the partners in their individual peculiarities and searching for the proper ways of their co-operation. First of all, the symptomatic model appeals to the role and behavioural structures for reaching the cross-matching of the role waiting and role behaviour.

- The semantic model. In the frames of this model the individual structure and it's actual features are seen as the secondary defensive features when the individual's structure is modified with the "psychological defence". The conflict is explained not by the personal "defects" but quite the reverse the conflict itself provides the formation of some personal peculiarities. The idea of multidimensional individual structure, of the primary, secondary and tertiary individual peculiarities lies in the base of this model.

Own experience

I Practice - The years of experience of working with the patients having neurotic, psychotic and psychosomatic diseases show the insufficiency of the level of medical aid without using direct or indirect family therapy, especially in children and adolescents. In these cases we saw very often the inefficiency of treatment and early recidivism. In the case of repeated hospitalisations and visit to the physician the relationship between the interfamily co-operation and the deterioration of the patient's status was underlined. The addition of family therapy to the individual and collective therapy leads to quick healing, increasing the quality and the continuance of the remission, to the increasing of the other family members' health and psychological conditions. The higher was the grade of the participating of the family members in the treatment the better were the results.

We used different schemes of the work: sometimes it was possible to make the whole family take part in the process using individual psychotherapy and other kinds of medical aid for the family members. In other cases- it was a work with the family members who "were interested in" the changes. Not uncommonly it was possible to improve the child's condition by changing the accent of the work to the psychological assistant for his mother and harmonising of the "wife-and-husband" relations. We used both the work of one psychotherapist and the two of them.

2 Dealing with the problems of healthy people.

In recent years we have notes a changing emphais in our work from treatment of really ill people to the ones who were previously considered to be healthy. In some cases it was enough to use individual and collective therapy, in other cases an adequate aid was impossible without using family therapy. We mean in that cases not the "therapy by the family", but the "therapy of the

family", in which case the family is seen as a multilevel system with numerous self-depending and self-developing structures.

3 Dealing with groups of people and collectives.
The practice of family therapy used similar methods to the business consulting of groups of people for developing the optimal relationship, searching for the new resources and underlining the most fruitful development strategies.

4 Education of the specialists.
In recent years interest in family therapy among physicians, psychologists, teachers and social workers has significantly increased. More and more time and skills of the family psychotherapists is required to be allocated to the education of these specialists. Nowadays we have in Ekaterinburg very few psychotherapists having adequate skills and knowledge in family psychotherapy.

Ill Preliminary conclusions
The influence of a family on the process of establishing a human being in childhood, on the self-realising of adult, on the conditions of an old person is self evident. And it is also evident the influence of the family on the development of harmonic adaptation or maladaptation. The improvement in the quality of life (it may be healing after some disease or the person feeling better) which reflects the individual's relationship with the world and his formation as a more successful professional are impossible without changing the interfamily relations. Taking into account today's situation it is possible to confirm the need of further development of the theory and practice of family therapy.

IY Means of development of family therapy.
1 Foundation of the Family Therapy Development Fund.
2 Providing psychotherapeutic services for the family as a whole and dealing with other family members, with adequate usage of different types of complex multilevel therapeutic methods.
3 Providing the different types of medical aid for other family members including medicaments and also non-medicate ways of treatment.
4 Usage of different types of non-medicate ways, including cultural influence and healthy style of life.
5 Establishing the family clubs.

6 Dealing with groups of people and whole collectives:- usage of family therapy methods in work with whole collectives for their successful functioning,- work with individuals to increase their effectiveness in the family, in their professional and other kinds of activities.
7 Methodological assistance and co-ordination of the activities of other professionals who work both in federal and private enterprises and deal with the same activities. Development of the informational and analytical resources.
8 Active interchange of new scientific and practical achievements both of Russian colleagues and from other countries. Participation in international programs and projects. Exchange of specialists.
9 Training of specialists who deal with the medical, psychological and educational activities.

V According to all described above we think it is possible to ensure the necessity of wider use of family therapy as one of the basic integrative approaches for providing psychotherapeutic and other medical aid.

Medicinal Herbs in Psychotherapy

Use of phytotherapy in treatment of children and adolescents with psychiatric disorders

Galina Sannikova

Our experience of usage of phytotherapy (treatment with the medicinal herbs) in treatment of children and adolescents with psychological disorders based on the activity of the "Children and Adolescent's psychical health Centre".

Until recently the usage of phytotherapy in treatment of psychological disorders in children was considered only as an adjunct to treatment. Phytotherapy is used in psychiatry as a part of a complex treatment in combination with other methods of influence: psychopharmacotherapy, psychotherapy etc. Although our I0-years experience of using medicinal herbs in paediatric psychiatry shows that it is possible to solve a lot of problems connected with rehabilitation. Paying attention to the peculiarities of the herbs' action it is possible to influence the mechanism of adaptation disorders as well as on the constant postadaptational disorders, including biologically active influence of herbs on the thin metabolic, mediator and hormonal processes which can not be spread all over the other methods of treatment.

We dealt with 2038 children for a period of 1990 to 1997 years. Phytotherapy was used as an additional method in combination with traditional psychopharmacotherapy as well as separately and consisted of continuous step-by-step influence on the different parts of the pathological process (such as hypertension, seizures, excitability, phobic disorders sleeping disorders, cardiac and digestive disorders). It was the goal of indicating medicinal herbal drinks containing different plants with sedative, anticonvulsant, diuretic, spasmolytic and stimulating action. For correction of the side effects of traditional drug therapy we used also herbal drinks (so called "Herbal Tea") containing choleretic, metabolic, anti-inflammatory, immuno-stimulant and poly-vitaminic plants which have regulative action on the heart and circulation as well as on the digestive system.

The following schemes of phytotherapy were used according to the concrete indications:

I Basic phytotherapy- used as an isolated method of treatment in the cases when the usage of psychopharmacotherapy was contraindicated or hypersensitivity to it was registered
2 Additive phytotherapy- used as a method acting on one of the parts of the pathologic process which was not covered by official drugs.
3 Correcting phytotherapy- was used for decreasing the side effects while usage of drugs or continuous drug therapy.
4 Exchange phytotherapy- used in the cases of chronic somatic diseases such as obsession, diabetic mellitus etc.
5 Adaptation and preventive phytotherapy- used for increasing of non-specific immunity and in the cases of immune disorders connected with chronic diseases resistant to treatment.

Ten years observation of the group of 1796 children and adolescents shows that the usage of medicinal herbs in the cases of psychological diseases in children allows relief from symptoms of the disease, decrease in the severity of asthenic, cerebrosthenic, neurotic and vegetative disorders. It helped also to influence attendant pathology and to increase adaptive resources, to accelerate the healing process.

Of Note - at the acute stage of the disease necessary to use medicinal herbs for increasing the effects of the main official drugs, to decrease their side effects and to increase the immune resource, - at the stage of remission the usage of herbs may be preferable because of their mild and low toxic action, - at the stage of rehabilitation herbs may play the role of supplying therapy correcting all types of disorders with better adaptation.
So, our experience shows the practice of using medicinal herbs in the complex treatment of different psychical and psychosomatic disease on all the stages in clinical practice as well in the outpatients' practice and for prevention of decompensation of psychical and mental disorders.

Using ‘Project work’ with young drug abusers in a residential setting – Youth Support Experience

Authors - Diana Birch - Director; Esther Mensah - Senior Care Worker; Sonia Lucia – Student Psychologist.
Presented by – Lisa Bioletti.

Youth Support House is a residential unit which provides care in a therapeutic community setting for troubled young people suffering multiple problems. Many of our young women are also pregnant or are young mothers and their problems are added to when drug use or addictive behaviour complicate their presentation. Difficulties arise when the drug taking history is confused or unclear, the extent and nature of use prior to conception and during pregnancy can be underestimated or concealed with serious consequences for the baby - withdrawal symptoms and complications at birth, problems in feeding and developmental patterns in early life.

Baby Jed was jittery and difficult to feed while withdrawing from his mother’s methadone treatment, Carol took in an unknown cocktail of cannabis, alcohol and possibly amphetamine during her gestation and needed to be tightly wrapped to control her shaking, fed slowly and carefully monitored for several weeks after birth. Kate was using solvents - lighter fuel particularly during her pregnancy and died of a heart attack when her baby was only three months old. He also was jittery and slow to gain weight and showed slow early development. Janet was primarily an alcoholic and also used some cannabis her baby showed signs of foetal alcohol syndrome. Fourteen year old Pat used and experimented with numerous substances, her baby was small, difficult to feed and had bilateral talipes.

Covert drug use after delivery will cause behavioural and emotional problems as well as interfering in parenting and may place the baby at risk. Jill would get drunk and abandon her children while she ‘self harmed’ - including throwing herself into the Thames. Liz would become too stoned to feed her baby. Sara showed psychotic episodes on Cannabis with violent outbursts and extreme paranoia which were witnessed by her confused children.

Placement at Youth Support House provides an opportunity for the young parent (and this may include young fathers also) to receive treatment for their addictive behaviour whilst at the same time being able to continue caring for their child under the supervision of staff. Observation and assessment of parenting can take place without the trauma and damage to attachment and developing bonds which would occur if the young person attended a drug rehabilitation unit whilst the child was fostered. Our treatment programme includes group and individual therapy plus attendance at self help groups such as AA -Alcoholics Anonymous or Narcotics Anonymous (NA). An important part of treatment is the 'drug project' work on which all residents spend several hours per week. We will describe the drug project work and outline the value of this approach.

Although substance abuse is common among youth, being equipped with basic facts and having accurate information about the drugs used is rare. Use of substances is often seen as a way into a peer group the benefits of which appear to outweigh the costs. Peer group myths and beliefs about the drug culture are assimilated in preference to the 'health education' message. Street wise does not necessarily equate with knowledge.

The first goal of the 'project' is thus the acquisition of accurate knowledge. Here the learning process is self directed and patient centred. Our residents come from very different backgrounds - some have left school at age 12 years and may be semi literate or illiterate, some may have some school qualifications and one girl worked on an open University degree. Each works at their own rate and level using sources which use language they can understand and aiming to produce a piece of work which is useful and informative to herself. They are finding out the information they want and need and not what others may think they ought to know.

Most of the 'project' work results in the production of a booklet or drug guide which can be useful to others also. They are encouraged and helped to visit libraries, centres, health information resources, rehabilitation units and drug clinics to obtain information. They also share experiences and knowledge.

Project work begins with warm up exercises and brainstorming of ideas on various factual and emotional levels. Topics might include

substances usually abused - knowing names and street names; feelings about and effects of substance abuse - which can be a very interesting part as they include their own experiences - ‘I never felt like that’ or ‘I’m lucky to be here’ or ‘It did this to me.’ The work then progresses to the information gathering stage and finally to production - looking at art work and choosing a style for the booklet.

It is acknowledged that effective prevention or drug treatment education should be based on a) correct information and knowledge, b) exploration of attitudes and feelings c) acquisition and development of life skills. A young person with low self esteem and lacking in self confidence forms part of a vulnerable group who are unable to make informed choices about a range of health issues including drug use. An important element in our approach is the need to build the young adult’s confidence and help them develop their self esteem and a positive image. It is only when someone feels good about himself and confident as a person, that he can fully utilise knowledge and draw on personal inner strengths, attitudes and feelings in making decisions regarding his behaviour patterns.

Youth Support House has been using the above approach as part of the therapeutic programme incorporating self esteem building into group and individual sessions. Project work aids in the acquisition of self worth since the finished product is an expression of personal creativity - it is a unique item, stamped with their individuality in which they can experience pride. They are in fact so proud of their productions that they jealously guard them and it is difficult to get them to then share their work - the original idea was to produce a booklet which could be printed for more general use but each project participant wants to create their own special work and keep it after they leave. The personalisation of the work lends itself to self discovery and self disclosure - ‘Oh yes, I did that’ which in turn leads to deeper insights regarding drug use and behaviour.

The project can thus be seen as an important therapeutic tool in the recovery process. Information gathering begins a creative process enhancing self worth and aiding self discovery which leads to insights which channel and focus the process of change which is begun in the more formalised therapy sessions

Special Seminar S3
Sexual Education -
Training in Family Life Education

Barbara Huberman

My name is Barbara Huberman, I am Director of Speciality Education for organisation in Washington DC called “Advocates for Youth”. We are a third national organisation that provides advocacy training, research and dissemination of resources in the field of adolescent reproductive health. Our pioneering mission is adolescent reproductive health and believe me with some of the stuff that’s going on in the United States right now it’s a good thing I think that we are there. We are staff of 35 in our Washington office and the staff of 4 in our Los Angeles office, we have a very special project called Media Project and as a first step we are now in partnership with the Keiser Family Centre to try and re-frame some of the media messages produced by Hollywood, produced by television into much more positive healthy look at sexuality. So our staff people there work with the writers and producers in Hollywood and in New York to develop story lines, to incorporate strong healthy positive sexuality messages and disseminate good information, for instance I staffed for very instrumental in getting ER, the big big show, to incorporate a story about an emergency contraception which increased knowledge in the matter simply by watching this 14 second interlude on emergency contraception in the story line which increased by almost 35% the knowledge of women in the viewing public about the availability of emergency contraception.

It’s not easy, we know the kind of messages that we want are somewhat controversial sometimes, we’re working with several of them right now, so that when a couple is in bed make sure there is a condom on the night stand, make sure that there is some conversation about using contraception in a relationship when no pregnancy is wanted and certainly conversations around the prevention of sexually transmitted infections in any relationship. What I’d like to share with you this afternoon is some of my own now ideas, number one a little bit about some of the principles of training people in the filed of sexuality education, formal sexuality education as well as informal kind that occurs between families, between religious institutions and between agencies of organisations, share with you very briefly because we only have

an hour, to major studies that if you don't know about, that support what we call in America balanced, accurate, some people used to call it comprehensive sexuality education, to share with you those two major studies that ultimately affected my practice. First I would like to tell you how bad things are going to some extent and share with you two pieces of legislation that certainly are affecting our ability to train teachers, youth workers, camp leaders, top providers in sexuality education, but also the kind of information that young people are now being forced to have in our country. Then, I'd like to share with you the model of that I've been involved in for the past seven years of training sexuality education. Three countries Germany, the Netherlands and France are approaching adolescent sexuality, adult sexual health and reproductive health for adolescents. Just to learn about some of that and also some of the current messages and approaches that are developed in the United States. If sex education is dangerous, try ignorance that is certainly I think one of the first things that is important to me as I have tried to develop programmes to reach people, to improve ability and knowledge in sexuality education.

When we look at things that are effective, the teenager studies that I talked about, one of the first ones done by the World Health Organisation, looked at different programmes around the country, around the world, compared them against what we in America call the Abstinent Until Marriage Only Curricula and Programmes which means that by the definition the only thing you can tell the young people who are not married that they must not have sex until they are married. Generally in these tight educational programmes you are not allowed to talk about contraception, in some cases you are, but the only thing you can tell the young people is how dangerous they are and how ineffective they are, to try and scare them away. The world Health Organisation looking at programmes, this was actually done in 1993 when they were probably even more especially in the United States than programmes that there are today, but looked at these kinds of programmes and looked at the accurate balanced programmes and found these results: did any of the programmes cause earlier sexual intercourse? - No. Did any of the programmes caused more frequent sexual intercourse? - No, either type of them. Did any of them delay the first intercourse in adolescence? - Yes, and what were they? - They were the accurate balanced curriculum, they were not the Abstinent Only or Abstinent Until Marriage Curriculum. Did any of the programmes caused less frequent

sexual intercourse? - Yes, they were 16 of them, almost half of them that did and again you know which programmes that were that caused that, not the abstinence programmes, but the programmes that were accurately balanced. Did any of the programmes if they looked at the matter of increased heterosexual intercourse ? the use of contraception and/or condom? - Yes, absolutely, and - It was the comprehensive programmes. What was the least effective was the Abstinence Until Marriage Only or the Abstinence until Marriage Programmes that don't give young people complete and accurate information.

In the European Studies tour, when I was talking yesterday, I said that Dutch and the French and German teenagers said, it's stupid to have sex and not use contraception. That was a very clear precise message that they got not only from their educational programmes but they got it from their families, they got from their friends and as a result in a very short period of time that has become very clear behaviour that's expected of young people.

In America today you've had to be in a closet somewhere not to know that for the past probably two and a half years we've done nothing but deal with sexuality and especially oral sex, we know today in our country probably for the first time in a long time we've had incredible exposure to sexuality information. A lot of people are not happy with it, they do not like it and especially carers are very very concerned, confused and seeking help today, how do I explain these things as my child is learning about them. You can turn the television set off, but the children still hear it from their classmates and their friends. You can take the newspapers and you can hide them with the Starr report but you'd better believe somebody has got that report near here and will share it with the young person.

The welfare report measures decided in its wisdom that one of the ways in which we can reduce unplanned, unwanted pregnancies that require public assistance especially and also that most of these pregnancies which is a foul thing that occurs to teenagers decided that they would restore America to traditional values. So they meant it, not only that they meant it, but they meant it with 50 million dollars a year for Abstinence Until Marriage Only education. If they took the money, and they gave them out whether to schools or to youth agencies or to community organisations whoever the state decided would get the money they have to adhere to these

criteria all of which in some ways are troubling especially to those of us in the field of sexual health but there are a couple that very troubling I think, one is “You have to tell young people that they will suffer physical and psychological harm or damage of they have sex outside or before marriage.” Now in America less than7% of our first time marriages are virginal marriages. Can you imagine, our health department, a public health agency taking this money and then having to implement programmes, whether they are in the schools, whether they are in community organisations, at the clinic centres giving this propaganda with all the wrong models in our country virtually where young people admire movie stars, rock stars, pop shows, the people in the public eye certainly have not adhered to this closed value. It may be of religious value and I will certainly respect that if that is your religious value or someone else’s religious value but it is not a public value not only in America but in most countries of the world any more.

In America average fees to go to physician the average family planning visit costs 75 dollars in our country, the pill costs $22 in our country at pharmacies, Depo-provera is £65 a shot. Norplant Is anywhere between $ 700 and $ 1500. But young people tell us that the reason they don’t use family planning, the two major reasons are fear of loss of confidentiality and all of the research that we’ve done of why young people, especially those who did not access family planning when they first tried to have sex the loudest reason that came across was, “I was afraid my parents would find out” and in some cases misinformation, “I thought my parents had to give permission, I thought they had to know”. The second reason is embarrassment. And I think it was someone yesterday also from America, one of the physicians who did say that our big office has now relaxed the requirement, the requirement was to give someone oral contraception they had to have a pelvic examination. But there are still many many practitioners in our country who will not give that up.

Two thirds of our pregnancies in America come to 18 and 19 year olds, so we talk about intervention especially in family planning services, we are going to eliminate perhaps some of the 18 year olds, we are going to be in trouble at least in the term of numbers if that happens.

As I said Abstinence Until Marriage in no longer a societal value in our country, if you are in legislation, if you have to be self-sufficient

does that mean that just because you are trying to be self-sufficient and not use public assistance that you are not allowed to have sex? What about the people who don't use public assistance? Does this legislation apply to them? Imagine how classrooms of young people sixteen year olds feel sitting there in that classroom hearing this message when maybe their mothers never got married, maybe they are living in the house where one of their parents has a live-in or sleep-in girlfriend or boyfriend after divorce, I mean, these are realities in our world today. What about the young people who are living in a home where there are two parents but those parents for whatever reason chose co-habitation and not legal marriage. How they feel, seeing this, hearing this kind of morality being talked to them? The other problem thing in America is that we have strong history that's written down here that separated the church and the state and unfortunately for most of us what we are seeing happen in our country is that in some of the states the money is being given directly to religiously-based organisations who support this message. I worked with young people that have information and have experience as to learn about sex and sexual health that are positive, that are affirming, that are respectful that give young people choices, that understand that normal adolescents themselves, that are helping young people to grow and move and take different half-ways, also understand that a part, a normal part of adolescence is taking risk. And what we are doing is helping young people in their inter-sexual relationships whenever they occur to be respectful of themselves and their bodies and their partners, to be responsible for themselves and their partners and to understand what their values are and to never do anything that takes away even one little bit of their self-esteem when having sexual relationships.

Do I believe in abstinence? Absolutely, I do. I think it's one of the most important skills that in any of our health behaviours and any of our life behaviours that we need to be aware of how to implement that skill. Does that mean that I believe in abstinence until marriage personally? No, I don't any more, and I am not speaking from organisational view point I am speaking personally from my view point. I don't. My daughter is 28 years old and she got married and I was thrilled that she was that age. It means I've got to remember I am doing to be a very old grandmother, but I was thrilled because she had all those years. She had three very serious relationships between high school and being 28 and marrying the man she loves. And everyone of those relationships

taught her something about herself and about what it means to be in a partnership relationship and then what it means to be in a marriage. I am thrilled that she had that chance. But I know a lot of women who are my age as does occur in America over this abstinence and waiting until marriage who got married to justify the sex they were either having or wanted to have and were just so frustrated they just got married so that was legal in that sense. Got to remember our generation, the pill came on the market when I graduated from college so I did not have that available to me in my generation. The abortion was not legal until 1973 in our country. We are talking here about very very recent control ability for women to decide whether or not they will bear children.

“Saying birth control and sex education promote sex is like saying airbags promote head-on collisions“ And we know that’s not true. And I think we have a responsibility to train people as professional as people who somewhere touch the lives of young people, but also to ourselves in our families and in our extended families. Those young people who are important to us in our lives whether it’s professionally or personally to be there for them, to help them to become the generation that is not raised with fear, shame and guilt messages.

Until I came to Washington 3 years ago for 15 years I had built teen pregnancy prevention programmes in Carolina. What we’ve recognised over that 15 year programme was that we have very few professional opportunities for people who were involved in sexuality education in the world to support each other and to become advocates really for accurate, balanced sexuality education. We wanted to invest to train people and to give them an opportunity to expand what they have to offer to young people in the area of sexual health. And so we came up with the idea of a summer institute. A summer institute that would select 30 participants. We wanted a racial balance, we wanted a gender balance, we wanted geographical balance. We wanted people who were actually on the ground, who would be sexuality educators in some kind of sense. We started in 1993, we got a formal University recognition for a ninety six-hour graduate course of people who are taking or coming to the institute. It’s a very intensive process. We developed a complete syllabus that’s used during the classroom periods.

What are goals? Definitely one is to extent people's knowledge about sexual health and find that a lot of people come to us in the institute are years behind, really don't have the up-to-date current knowledge We want to increase people's comfort, especially people's comfort in the area of what we in America would call controversial issues and how to address them, how to be an advocate for making sure that issues like masturbation, homosexuality, oral sex, these are hot hot words in America, believe me. So we want to increase people's ability to deal with some of these controversial issues in the classrooms or in the community. A lot of my time is spent building skills with people doing specific exercises and interactive work with the participants, in groups, in small groups, in pairs and individually. There is videotaping of skills goes on in the institute and then after they leave the institute they can take what they learnt, go home, they have to design a programme and they have to videotape themselves and send it back to us for viewing and absorption and then we assign grades after that part of their course is met.

At the end of last year when we had done the fifth institute we decided that we had long long since heard how other countries were approaching sexuality education and especially risk reduction in terms of sexual behaviour. So to give ourselves a brightening and also kind of expand our knowledge we decided that this year we would not run the regular institute but that we would work with a facility a University in the Netherlands to design with us a two-week study tour to look at France, Germany and the Netherlands and why their rates of teen pregnancy and sexuality transmitted diseases and abortions were so so much lower than ours. So I am going to share with you some of the lessons learnt about that experience.

First take a look very quickly at the data. And you can see that there is an incredible difference between the United States, Germany, Denmark, France and the Netherlands in terms of their data on berths to teenagers. We are far far ahead of other developed countries in terms of addressing sexuality, adolescent sexual health. This was a project that we designed working with an organisation in the Netherlands that really is non religious even though it is called Catholic, but does a lot of continuing education and in-service education for teachers. And they organised in a lot of countries about 180 study tours to European countries each year, so this is one of their main functions. Linda and I designed

what we wanted in terms of the experience, we wanted to have an opportunity to meet the policy makers, and we wanted people to have the opportunity not just to meet with researchers and programme people, but people, parents, teenagers, on the street kind of opportunity so that they could really see whether or not things that we were learning in the classroom or on the sites that were actually things that were reality to the people who lived in those countries. So, we initially had 18 graduates from 6 Universities in 6 States who again self-selected and paid for the trip and to go with us, we had 22 national and local advocates from 12 States. We took with us 2 teenagers, so we took 17 year old young women with us. One is the reporter for teen journalism organisation, national in our country, called Children's Express. The other one was a teen reporter for Teen People magazine. And if you get a Teen People magazine in any of your countries, she is doing a four page spread in the next issue on how it was for the teenagers in European Tour Study , so it will be very interesting I think to see what her perceptions were. People were encouraged to do this: the things we arranged for them to do in the groups but also in looking at themselves in the countries and talking with people. We call them issue areas, we wanted them to go home with information that they felt confident about in these areas, the role of media and public education, the influence of family and community on adolescent sexual health, access to health care, education with an emphasis on sexuality education, public policy and controversy management and religion and its influence on public policy.

Well, to share with you very quickly some of the lessons learnt. I said yesterday, one of the huge differences that these countries have invested in massive public education campaigns. Have they did it on teen pregnancy prevention? - No. They didn't even know really what we were talking about when we said, prevent teen pregnancy, because their rates are so much lower. Their public education campaigns which have been treated into reductions in teen pregnancy they've learnt had been around STIs and primarily HIV. And their public education campaigns have mainly revolved around condom use. Something that has been long term, consistent, professionally produced, numerous, I wish I had time to show you some of the tapes, because I brought back some four hours of tapes of some of the public education campaigns in the three countries, just incredible. Some parents during the interviews told us, "yeah, my mother told me I should wait for marriage", I

didn't wait for marriage and why should I say that to my nineteen year old, why should I say that. The incredible thing in these countries is their young people start having sex even with the media, even with a lot of the things that we talk about in terms of abstinence and contraception over a year later than our youths in the United States. So in spite of this infiltration in the influence that they have of open sexuality they are waiting longer than our kids to get no-no messages, you shouldn't.

The next lesson really was, it really was the need to reduce abortion, the desire to reduce abortion that led these countries into promoting and putting in place some of the education campaigns that they did, but also their access to contraception that they see as a way to reduce abortions. So if we really want to reduce the need for, the availability of, the need for abortions and the reduce the numbers, we know that if we can give people what they need to prevent the pregnancy in the first place then we can prevent the abortions.

Sexual responsibility is not a religious value any longer. Sexual responsibility is a public health responsibility. Since World War II virtually the influence of religion on public policy in these three countries is almost nil. You just got to see across the border that a lot of it especially when it deal with reproductive health. This was difficult question for the interlock but we started and once we've got the way of little bit and again to think about our experience this came out loud and clear: the young people in these countries are valued, the young people in our country are looked at as disease, as weird, as demons, as delinquent, all the D-words in my vocabulary that I can think of. We Americans don't have a very positive view of our young people. We are trying to re-frame that but when we think about young people in our country very seldom do we applause the strengths that they have and for most other strengths, and one of those strength is sexual responsibility. Young people here are expected to respect their bodies and to act responsibly. I think that in America what has been happening to expect our people to delay sex rather than help them to act responsibly and positively.

In the Netherlands and Germany there appear to be in the parent interviews a much more higher comfort level in terms of sharing information within the family structure and in the community as a whole with young people. The system in the Netherlands and

Germany you go to the post office and there are racks of literature and all kinds of literature about sexuality and sexual health. I cannot imagine this happening in the United States' post offices in our country.

Being in an intersexual relationship especially for older adolescents is a normal part of their maturation. The Dutch speak of their sexual career history which we kind of get all trepidation from because we don't really understand it, really what they meant was learning about sex from birth till death and expecting that you will be a sexual person from birth till death. We also have a much stronger emphasis here on helping young people to be self-sufficient people not just as adults.

And the last one, certainly important. They all have national health insurance which provide health care and contraceptive access as little or no cost and accessible to young people without a lot of barriers. The transportation systems in Europe are much better than they are in America where it is difficult for young people to access public health systems and their cost certainly is one of the biggest drawbacks in our country for young people accessing the contraceptive service system.

Keynote Address - Chaired by Diana Birch

Runaway and Homeless Youth.

Richard Brown.

D.B. - I am very pleased that for the last keynote of this conference we have Richard Brown from San Francisco, some people talk about leaving the best till last in fact last time we had the conference here Dick MacKenzie did the final keynote and he said that he'd never heard of the keynotes being at the end of a session, they are always at the beginning, but he understood why I put it at the end because since he had jet lag he was just beginning to wake up then, so hopefully Dick Brown is waking up now, not that he appeared to sleep through the conference I must add. But most of you probably already know Richard Brown so I don't need to give a big introduction but he is Professor in Adolescent Medicine in California in San Francisco and he has done a lot of work of homeless and runaway youth not only in San Francisco area but also really throughout the world and particularly in Brazil, South America, and also in India. So it's really appropriate that he should be at this conference and he has asked that some of the people from different parts of the world who are also involved with homeless and runaway youth should join us on the podium here so that they can be involved. So I'd like to ask for Andrei Smirnov (Russia); Irene Adams (Brazil); Pamela McNeil (Jamaica); Dick MacKenzie (Los Angeles)

Richard Brown. Good afternoon. I would like to start by thanking Diana for this remarkable effort, and I had a wonderful time here getting to know so many people and sharing in so many exciting topics, this is very important time. Diana, thank you for this opportunity. I also feel a great deal of responsibility talking about this topic, there are so many colleagues of mine who are here and know more or as much about homeless youth, but this is an area that I've been student of throughout a good part of my career, so I am going to go over some of the basic issues regarding runaway and homeless youth.

At the HIV International Conference, the AIDS Conference in San Francisco at the beginning of the 90s we had a conference on homeless and runaway youth and at that meeting it was decided

that instead of talking about ‘high risk youth’ - for the safety of young people politically and all that we would talk about youth in high risk situations. So often they are victims of the circumstances of where they are and they are not a cause of what’s happening with their life but they respond to the results of the situations that they find themselves in, so the term that we’ve come to use is youth in high risk situations because it avoids a particular kind of stigmatisation.

There are a variety of high risk situations that young people find themselves in anyway normally in life. Adolescence itself, that has been very nicely articulated here in the research, but adolescence itself, issues of structure and freedom, psycho-sexual care, the normal life issues put youth at risk. Family stresses that we’ve discussed here, peer relations, gang interaction that’s become so prominent in any of our cities throughout the world, environmental and economic stresses and one of the things I will be emphasising is the whole issue of an economic base as part of the intervention that we do with youth in association with in-societal and cultural stresses. To begin I am going to emphasise some of the work that’s been done in the United States and then I want to talk more in global terms and then to give some illustrations of things that are being done that are quite exciting.

Some definitions - Runaway youth in the United States refers to the young people under the 18 years of age that are away from home at least overnight without parental permission, And those of us involved with run away youth find that it is rather an inappropriate definition in that for most of the time young people that run away are trying to escape from an untenable and difficult circumstance in their life, so of course without parental permission and that seems kind of a ridiculous terminology. In general in the United States young people run away within about 15-mile radius of their home in Los Angeles and San Francisco and also in New York for the most, they stay within their community. Young people can also go father, and there is on the West coast a sort of transition, a transit road all the way from Vancouver all the way down to San Diego and I remember one of our fellows who saw streetwise that was based in Seattle recognised some of the young people that she had cared for in San Francisco, so there is this mobility up and down the West coast. The estimates about the numbers of people that run away and all varies a great deal, it may

be some say as high as 2 million, it may be 1 million, it's not really clear, it's hard to count the numbers.

The prominent motivation for running away is something to have to do with the parents in 65% of the young people and many of them come from homes where both parents are not in the home. In terms of sex distribution the count is equal in number though more young women are in shelters and young men tend to travel further from home.

Throwaway youth is another term that reflects really the rejection of young people, they are really rejected from the home. An illustration of that is Arthur in San Francisco whose story was that he had come to San Francisco from the mid-west, he basically was rejected, he came out as a gay youth and was thrown out of the home, he came to San Francisco, and when he arrived he called his family to say that he had safely arrived in San Francisco and he said, this is Arthur and the father said, there is no Arthur in this family, we have no son and hung up.

Risk factors, young people are very much at risk in terms of engaging in a variety of sexual activities and sexual intercourse, I'll come back to this again later. There is a history of physical and sexual abuse very commonly, as much as 60 to 75% of young runaway youth have had serious physical abuse and it's even sometimes seen as higher with young women. Teenage pregnancy is significant in this population. Substance abuse as well, particularly alcoholism, young people in this situation are often in a co-alcoholic family situation where one of the parents may be an alcoholic and they are gnashed with the whole structure of that family and act out in part of it what's happening with the family and they need to escape from that.

I also want to define homeless youth and this is a major topic when we look at the international level. These are young people who lack any parental, foster care, institutional care, some of them have gone through the system: been rejected from their family, have been in foster care for some time and been in the juvenile court institutions and finally really flunk out from the whole thing and end up being on the streets ultimately. I am reminded in Rio of going to the institution outside of Rio where young people deal with gangs, deal with drugs in the street, are arrested, brought in to the centre and then episodically when I was there the gang

would go in and at gun point and retrieve the young people back out onto the streets.

And then system youth. These are young people who are in the custody of the state, really grow up within the system and are really eventually are on the own after they go through a series of placements, institutional care.

I just want to mention the issue of secrets, that young people at high risk situations bring secrets into relationships with us, I think we've talked about many of these here in quite a lot of care. A co-alcoholism and alcoholism is a very secret area, I find it one of the most difficult things to identify in working with young people. And sexual identity issues is another that needs care in terms of being able to ellicit in young people. Tremendous instability in the family, migration, separation and loss, the abuse and neglect, violence in the community, at home, gang violence and others, these are some of the secrets that young people bring that come to challenge us to draw out and to clarify.

Health issues are enormous for young people all over the world and the United States. Sexually transmitted diseases, malnutrition, pregnancy and premature death and homicide and suicide. And then in many countries there are immigrants and undocumented young people there that are significant part of the population, so that's an overview of the definitions that I wanted to cover between runaway, homeless, system youth. Where I have been a student is in Brazil and I had a very good fortune of being able to go to Rio and I've learned a lot about what happens in this beautiful city regarding homeless young people. This is Bodafogul bay and Christo and Corfado there, beautiful area I show this slide because of the beautiful lakes along, the streets there and beautiful hotels but dark in the background are the favellas where there is very little electricity and that's where millions of people reside and this is basically sort of gang run and very impoverished area. So the reverse of San Francisco high up in the hills of San Francisco the real estate goes up it just the opposite Rio and this is hard to see but it is the beginning of the favellas that are contiguous with the very high hotels along Copa Cabana, Ipanema and just in the back is the beginning of the favellas. So this is a very dangerous area in terms of intersection of the two and this is up in the favellas (slums).

So I want to talk about street youth. Street youth are young people who reside primarily in the streets in their life, they may be runaways, they may be homeless, they may actually connect with home and bring money back home but not stay there all the time, in and out, often they are connected somehow with home and they may be throwaway young people who are able to adapt and are able to really fend for themselves in the streets and I'll describe some of the ways that they are able to survive there. The estimation in the world are staggering in terms of the number of children and youth that really call the streets their home - 100 million. So these street children are young people who are in the streets either full or part time and the ranges estimates are all across board from a 30 million to a 170 million in the world. So that's quite a spectrum of estimate. The Children's Defence Council gives these estimates of 60 million - there are 23 million in Brazil alone.

UNICEF has divided street youth into 2 categories: one is children on the streets who are there much of the day, they aren't going to school, they return home at night with their families and this is actually the majority of young people are in this category where they basically just live there on the streets during the day. The other second category is youth that are on the streets where they really reside, they work, they live there, they sleep and they have little or no ties to the family. And example of this is Brazil the result of the economic impoverishment in the north east in Bahia, in Recifi, up in there where there's been really some desertification of the country and rural poverty has forced young people in mass to migrate down into the big cities particularly to Rio and that's my experience. But this Bob Blum has also illustrated is a massive phenomenon throughout the world in most of the mega cities of the world a massive migration of young people into cities and that also happens in San Francisco and other places that show us statistics that Bob illustrated - there is a tremendous number of young people proportionally in the world and they concentrate in the large cities. Now a common thing is the tremendous poverty of families and one of the questions was why young children in Rio in the favellas couldn't go to school, they didn't have the money for the uniform, so it's as basic as that.

So Juao is a young fellow in Rio who lives way out in the country and on weekends he jumps on the trains and he comes into Rio and actually lives there during the week and he is very proud that

he can, he is really good at pick-pocketing, he has some marginalised jobs resells things, he is very proud of what he can do and survive and he does so well in the week that he actually brings money and food and things back to his family later in the week or every couple of weeks. So he is really the breadwinner, the family is so impoverished that he cannot really stay at home but he can come in and in marginal kind of often illegal activity he can survive. He goes to the Cathedral in Rio, the beautiful Cathedral where they feed young people and conjures extra stuff, extra apples and things and then he actually can take that back to his family and his family expects this and sometimes he is even beaten if he does not bring back what he is supposed to bring. So street youth generally are working, they are very industrious, extremely creative and highly energetic. They are often like those young men you saw before are very tiny, they are quite malnourished they are much smaller than they appear but they have casual work, marginal occupations, informal sector, these are some of the terms that are used, they are kind of ridiculous terms, but many times they are out there in petty retail thing, they are pick-pocketing and stealing and very successful and proud of what that they do among other activities. So they resort to illegal activities and one of the activities throughout the world is in the sex area. So they are very vulnerable to exploitation because there isn't some sort of structural support, they are easily victimised and are involved with prostitution, drug-dealing, physical abuse and often hooked into this whole system.

There are financial implications of 10 million children under 17 who are regularly engaged in sex for money in the world. And this is distributed in many countries, it's especially prominent in Asia where a sex industry is a major industry. A few of us were planning to try to have a condom conference in Bangkok at one point and it was moving along quite well and we had Phil Donny from the University in California and had some people from Durex and suddenly it ended. And supposition was that there was some kind of threat to this major economy that resulted in discontinuation of the planning.

According to the International Labour Organisation about 90 million children between the ages of 11 and 15 serve in the world's working force. And this frankly is a very complex, difficult thing for many of us to look at because so often children in this situation are really major money earners in marginal societies and

without their nimble fingers and hands the family is in dire poverty and so it's humbling to think that we might think they should be in school but in many circumstances this is very far impossible and it is really a concerning conflict for us. In Pakistan there are 7 million children involved with really kind like slavery in brick kilns and carpet factories.

Probably a most sobering reality for those of you that are connected with Africa is the tragic thing that's happening there. June Grady who is one of our neonatologists works in Africa and is a Professor in a couple of the universities and she came back showing pictures of families and the family was a little 12-year old young woman and 2 little children holding their hand, this was the family. Parents have both died of AIDS and this unfortunately is not untypical in Africa, it really is a terrifying reality and it is escalating. Uganda statistics are that right now in Africa 10 million orphans are happening at this time. So AIDS is taking a massive toll in Africa also increasingly in India and so many countries.

We have talked about addicted youth and drug dependency it is a prominent issue when the young people are trying to deal with overwhelming emotions and the issue of sexual disinhibition, where sexual maters are concerned, using drugs puts it in an increased risk bracket. One thing that I haven't studied very well but is very real and I don't even like to think much about is really the murder of children in various countries and this was very much happening when we were in Rio where young people who were stealing in Rio actually being executed.

So I've given some of the overview about the enormity of the issues through the world, I want to go on and I also want the panel later to participate in it to look at some other possible ways of recognising and working with youth who are homeless and are runaways. Herb Friedman I think is then an inspiration to many of us, he's been here for a part of the meeting, one of his philosophies that had a major impact on some of us is his philosophy that the work needs to be generated from young people, it needs to come from their energy, it needs to come from their awareness, it needs to come from a non-medical context, it needs to come from a place in which we are going to impose something that probably is untenable to the young person, they need to create their stories and his research has been that of going to various countries in the past and actually having young

people generate the tales, the legends that they want about young people and about dealing with things, that's been very inspiring,

Let us look at a product of that philosophy which is from Bombay. A colleague of mine in San Francisco works with homeless youth in Bombay and he went there and received the stories generated by the legend which were made up I cartoon form from the stories generated by the young people. The youth tell the story, so I want to go through the sequence and remind you that this is generated from the young people. So let's call this young fellow here Sam, he is our main hero here, and a street-wise young fellow is another character and in the bottom there is a street worker, a social worker, so that's our main characters that they generated. They each call them different names, one maybe Mohammed at one time or whatever but this is the characters. It begins with Sam, he is in the country, in India, this is his context but he wants to go on and like so many young people in the world they move towards the big city. So what pictures were generated from the young people in homeless project in Bombay. Sam goes on a train, he hops a trains and he heads then for Bombay and then for the first time, looking at this big city and kind of overwhelmed by it all and then he is on the street and this is enormously complicated he gets beaten and stepped on and kicked around and he is hungry and he is suffering and can't find a place to sleep in, he is just flabbergasted, his mouth is open. He meets our friend which is a street-wise kid and he's happy to find somebody that he knows and there are all kinds of possibilities that this young man tells him, you know, you can smoke marihuana, you can get a job, you can do shoe-shining, you can have a lot of fun, it's just great thing on the streets.

As matter of fact a pause here, the reality is that the streets are very seductive. Young people get a lot of goodies in the streets. I mean there is often peer groups, there is drugs, there is sex, there is freedom, there is no school and it is a very addicting phenomenon, so many programmes try to grab kids as soon as they come out onto the streets and get them into a programme. We just need not to forget that. And so they get beaten up by a gang, street-wise kids are furious and little Sam here is crying, he is just overwhelmed. They sniff glue, they steal stuff and around the corner here look who is coming around the corner on the left there and here is the street worker, the social worker who meets the kids on the streets and meets Sam, there is Sam just thinking

there are possibilities here for him. And he goes into the shelter, he is sick, he is tired, he maybe withdrawing from drugs, but he meets also a friend who is in the programme there, but our other street-wise low guy, he is just not doing well, he is still on the streets, he is sick and he is in trouble and he is banged around and he is trying to steal, he is trying to survive and Sam is saying, you know, wishing God try to help you. So he has his friend and they have a good time together and street-wise little guy is not making it, rejects the intervention and dies.

There is an issue here for many young people that they don't have any real control in terms of what their life is , it's a script that you walk through and everything is sort of inevitable and there is not concept of planning, but even in India there is a philosophy and that for the most part things are going to happen as they will, but it's true even with kids here in the United States that they don't see that they can intercede in their life that they can prevent something, that they can plan things, that it's just kind of hand and mouth destiny and they are powerless and they cannot have any intervention, so a major task for us all is to see that that's not necessary, but a tool that these young people generated here is they believed in that kind of idea but they are powerless through life, and yet you can go up a certain way and make decisions along the path, and this is different from their point of view than the idea of preventing and intervening as such and so there are different options.

So this is an idea that they generated in order to see that there are different ways to go. One of the major efforts in so many programmes is interventions that are really based on ground roots economic development and it is found that a really very marginal economic support for young people stabilises families, stabilises young people and is a phenomenally important issue in the world probably reflecting the future health in the world. When people are economically totally marginalised there is trouble, there is war and there is strife, and we've seen that over and over again. I think that for homeless young people on the street they need to have, they must have some kind of economic base so I'll come back to that.

How can you plan programming with outreach activities is something that many people now are doing in various street organisations and I know people here on this panel are very

committed to this kind of thing, they are there in the community where the young people are and they are going out into the streets, in San Francisco with the Street Programme at night people put on jackets, they go out into the night with supplies, they do condom distribution, they do counselling, they try to get the young people in, they try to identify young people who are at risk, try to get them in to the programme, they are really out there in the community and it is necessary to be done. it's risky and for example the night I went out with the people from Lorkan Street we got stones thrown at us and such and we got a little too far into the drug dealing part of the Street, we went down there and it was not exactly the right place to be.

The more comprehensive collaborative wrap-around services is absolutely necessary. The medical model does not work, this is a real shocker for me that we can't just go out there and set up a little clinic and make everything, it has to be more broad-based. They do need medical services and there do need to be medical clinics. In Rio they actually have hired a lawyer who is out there in the streets and one of the nights I was out in the streets I actually called the lawyer because there was a young woman in labour and she was taken physically by the lawyer into the hospital to make sure that she was brought in and that she could deliver her baby in hospital, she was in early labour. And it was required at that level of advocacy physically taking her there. So that's part of that comprehensive kind of wrap-around approach that's very impressive.

Karate Kids is something from Street Kids International some of you maybe familiar with, it's another one of the film strips that's used on the streets, it's a HIV prevention sequence and it again it's something that draws out a discussion. And these tools actually are brought right out into little street areas - a video might be set up or a slide show and people draw around and then a discussion is generated right on the street.

Another thing that is necessary is that street youth themselves can be selected out and trained to become street educators and so there are various of what we call entrepreneurial kinds of interests in various countries of really helping people within the city learn how to advocate and work with other young people and so it is internally generated advocacy that occurs. The language is right, the cultural issues then are right, the words, the modelling, the

whole peer cultural thing that many of you are involved with anyway, so this is not any surprise I think.

I want to mention a little bit about a medical care issue. And I know that the panel here is very much, Irene here is really outstanding illustration of developing good health care for young people. Again it starts with a multi-disciplinary team, it is not just medical care, it requires peer help educators and street workers. It needs to be a group that's really sensitive to the diversity of the community particularly around sexual minorities issues, national minorities issues and sexual abuse, it needs to be specially selected and people need to be trained to be sensitive in these areas. And then there needs to be central locations, convenient hours which often are at 9 o'clock at night or in the evening and right out in the streets. Condom distribution is a major area of safety for the young people and where that is possible, many countries really don't have the resources for much of anything, I know that in several countries there is really not a resource for that, an example though is the Ashoka fellow, the Ashoka Foundation does social entrepreneurial work in India where a young woman is developed giving the condoms to the young women who are along the high way, the major means of transportation of industry in India is trucks so there are a lot of truck driven and along the way there are prostitution villages, whole villages that are basically prostitutes and this is really a hotbed then for spread of STD's and STIs I should say, I am learning here as well, and AIDS and there is an effort which I think somewhat feeble, but there is an effort to try to do condom distribution and education in this area.

So I mentioned social entrepreneurial projects and there are some outstanding illustrations of this in the world. I think one of them that I told you about was Jim Lease work in Bombay, but it is an area is that somewhat a frontier of helping with developing a basic economic base. Butterflies in Delhi is a project for young homeless people with the development of a restaurant and food distribution and the way of giving quite a large number of young people an occupation to be involved with and to be off of the streets and to have some sense of decency and respect. In San Francisco we've had a Ben & Jerry's franchise to open up Ben & Jerry's ice-cream parlours that are basically run by homeless and marginalised young people. In the other example, and some people on the panel maybe able to describe other areas of developing a social entrepreneurial effort. So that actually is a summary, I wanted to

make sure that we have some that panel also could be available and respond. I want next to read a poem of which I have copies here for you since it's such an overwhelming area of concern I wanted to end with some brightness and this is a gift for you if you'd like this poem, I use it a lot to describe issues of adolescents, I want to read it to you:

I am growing world,
I am reaching and touching, stretching and testing
I am finding new things, new wonderful things,

New frightening things,

I'm just growing world, just now.
I am not tall, I am not strong, I am not right,
I am just trying to be.

I am a person, I'm me,

Let me test, let me try, let me reach, let me fly,
Push me out of nest, (but not too fast.)

There is much I don't know.
There are things that I want,
Don't hide me from the sight of the world.

Give me room, give me time,
There are things I am not frightened to try.

Let me tumble and spring,
Let me go, let me be,
  …Wait and see.

I am growing world,
Water me with the wisdom of your tears.

Written by a woman 16 years old

I just want to review the poem again and I think, I just really like this kind of thing which is expressing something about the soul of young people. And this is a poem that really does if you analyse it illustrate a lot of the basic issues, the grandiosity in certain ways, the humility, the ambivalence, the scariness, the wonderfulness of

the time, the assertion of selfness that is often not clear, I am a person - that is very adolescent thing they are needing to say, of needing to test limits, of needing sort of structure, Push me out of nest, but not too fast, I need freedom and I need control, sense of humility, of daring, of messing up and being able to survive is something that we all do with young people, help the young people not be damaged by a tumble. And a sense of hope and a sort of tragic ending, a formal operation ending, water me with the wisdom of your tears, sort of joining in in the whole of human family. SO you are welcome to take copies of the poem. And this is written by a young woman in Lorkan Street Programme.

I know there is a paradise yet to be held by my open arms,
I know one day I'll see a rainbow with harmony over everyone's head,
And I will be free at last.

Thank you very much.

D.B. I think that using poetry like that such a wonderful way to express because young people do find it difficult to communicate with us and certainly we use other media like arts and poetry and story-telling a great deal in our work and especially I think that street youth who often not had a lot of education or that because of their circumstances also had difficulties in communication, I think it's great that we can see their poetry like that and actually get into their feelings.

Panel.

I am **Dick MacKenzie**, I am from Los Angeles, California, we have an active homeless and high risk youth programme in the Hollywood area of Los Angeles. We began our programme in 1982 and partly the stimulus behind our programme was: one, we were ignorant of what street youth were all about and two, we had a feeling that street youth can teach us a lot about life and adolescence. And with this programme we have evolved a number of what was referred to as warp-around services what I like to call "a seamless system of care". If there is one thing that high risk, at risk or runaway or homeless youth do not tolerate that's seams, that spaces between agencies that they just cannot seem to hop across and so we've created a seamless system of care in which entry into one door of the system puts you through all doors of the

system. And we've sort of taken some of the ideas that Richard has talked about and tried to put them into practice, sometimes with success and sometimes with not so much success.

I am **Pam McNeil** from the Women's Centre of Jamaican Foundation and although our main programme as I explained this afternoon is the programme for adolescents mothers, continuing education for adolescents mothers we have centres across the island of Jamaica, we noticed that an for adolescent mother comes in for her instruction from 9 in the morning to say till 2 in the afternoon and after that the centres were empty with all the teaching equipment and everything there and we saw the problem of the street children and we decided to open up the centres particularly in the rural areas to the rural street youth and that programme runs from 3 to 6 every afternoon and from 9 to 12 on a Saturday morning. And it's very successful. What we are doing there, yes remedial work and trying to get them interested back into education but we are also making education a bit different, as art and drama and football and everything else that the youth might like. In Kingston we do another programme and we work with other agencies as the last speaker was talking about, we work with the YMCA who do the academic instruction for the street children and they come to us for counselling and to our medical clinic for assistance and we also work with our government agency called LEYP, which is Learning and Education for Young People. And they can go there and they can get a bed and a hot meal and trade if they wanted. And we find work this is very very productive because we all doing different things , we are not duplicating one another but we are getting the children in from the streets. They are captive, they can go back if they wish, but we are finding more and more coming to be with us.

I am **Irene Adams** from Brazil, Belrizonte Brazil, not Rio or San Paolo, and I am from the clinic AMORE which is a medical attendance for street children but the intention of clinic is not provide medical attention, it's to use my access to them, which happens to be the fact that I am a doctor for providing education for life, life skills and in addition to the direct medical attendance which is delivered in educational way we have education where we work with educators of 34 other projects and with the children themselves involved in this project with the intention of creating within each project a nucleus of capacity people who are comfortable talking about sexuality, drugs, families and all these

very emotional things that all of us have to deal with and they are very difficult to deal with when you are an adolescent. I met Richard when he organised the first international meeting of street children in San Francisco in '81 as he said attached to the HIV Congress, the World AIDS Congress that was held that year. And I think it's important to point out I always have to ask apologies, I have to ask forgiveness eternally the rest of my life that I took ADIS to show me these children, you know, that here were these children, they were there all the time and we never looked at them we never thought about them, it never occurred to us and then suddenly somebody said, Oh, they might be at risk of AIDS and I think the first thing they taught me was that AIDS is the least of their worries. And we can learn so much, and as you said I could see that I am a student of street children since 1986.

I am **Andrei Smirnov** from Russia, I am a paediatrician and I am the Vice- President of a very new born independent charity Family Therapy Development Fund. I am here with my colleagues and friends. Although our Foundation is quite young, only one year, me and my friends have been working in paediatrics and psychiatry 15 to 18 years. We are dealing with the problems of the families, with the problems of adolescents and our dream is to make the things which our educational, medical services officials cannot do or more often do not want to do. And our dream also is to establish a family centre which is open for every family, for every adolescent, for every adult, for every child and baby, man and woman who need the help there in our country. We try to do it.

Question - How the street children perceive themselves what terminology that they use, is it the same as us and do they call themselves street children?

A: Dick Brown - It's a good question, I don't know all the answers in different places, I know that in Brazil it's "maninos de rua" and it's a very organised structure by the young people, actually the young people organised that with that name and posters and all, so I do think that in that country they do very much identify with that terminology that it's sort of a political stance, I think in terms of that term, but it's a good question, I don't know how it is in other places.

Irene Adams: I can tell you that in Brazil until 1980 the expression used was abandoned youth and that was the ignorance of those

dealing with them, they simply saw them on the street, the police rounded them, up took them to juvenile centre and assumed they were abandoned. And from 1980 onward there was a movement to try to do an alternative approach and to try and really sort the thing out because everyone realised this model was not working and then you had creation of outreach workers, street workers and then we discovered that almost all of them had families that they were not abandoned. And as he rightly points out there is even a national street youth movement, so they have no difficulty with that, but at least in Belrizonte we have adopted a new term because the theory is that no that they accept it by it may stigmatise them to say, I am a street youth or I was a street youth, or this is an ex-street youth, please hire this ex-street use. So we now use the expression “meninos contragitore de rua”, children who have had a passage through the streets to emphasise semantologically that this is not a quality of the child, this was a time in his life.

Dick MacKenzie: I think your question is an excellent one because we have to be very careful as to what we call young people, as to how they experience their time at that period of their life. For instance, a lot of adolescents do not even know what an adolescent is, they don’t call each other, Oh, here’s my fellow adolescent. They don’t understand our terminology and kids on the street are kids on the street and when you, we have a fairly extensive research programme that goes along with the clinical programme and one of the simple obvious facts that we learned through one of our projects is that kids on the street are not a homogeneous group. They have different belief systems, they have different affiliations, they have different social circles and so when you design a programme for what we call street youth, we say, which group of the street youth you are designing your programme for? Because just to develop a programme and make that the panacea to prevent AIDS in the streets or to access services by streets you are only going to hit one part if any of them if you don’t take into account various aspects and the same thing when we look at young people themselves, each one is an individual within himself and we must take that into our understanding so that we can relate to them as individuals rather than as groups.

Pamela McNeil: We don’t call our programmes “programmes for street children”, we call them “activity programmes for children”.

And they are children 9 years old to 14-15. And that they are very independent and old for their years and that they can teach us a lot is very true. But also they are very scared, when we told them about the LEYP project in Kingston for example, they definitely shied away from that, and one little one came up to one of my counsellors and said, Well, Miss, if you will come with me I will go. So she said, Fine. So what she did was take them to LEYP for just an hour for one day, and they saw everything and they had a meal, in her car and then she brought them back. And this went on for a few days until they got used to the idea of going and they liked it and they liked what they saw. But I want to emphasise that they are children and they need a lot of our love and care and understanding. They may seem to be street-wise and they may seem to know a lot more than us, but they really need us as almost as surrogate parents.

D.B. One last comment to sum up.

Dick Brown: I am just grateful to all these people here today and all and they are my teachers, half of them I know well and also Diana you are very centrally committed to this kind of work and I congratulate you and what you've created here in London, and great pleasure to be able to be here, thank you.

Closing
Diana Birch

Thank you. If you just bear with me for a few moments more. It really happy and sad occasion all at once, really, to have to do a closing to this conference because it's just been so exciting and so many people came and I really don't want to see you all go and I am really terribly grateful to everybody who has come here, I think we've learnt an awful lot, in fact we've learnt so much and so many different things that it makes it impossible to really sum up in any way at all the academic side of it. So I will keep my remarks to thanks and also thinking what we can do together is the future. Somebody asked me yesterday when I am going to do the next conference and I must say I am not sure except the fact that we have got one planned in Italy in April '99 as I mentioned to do with traumatic stress, but I think when we do the next conference and what we do next is very much dependent on all, for you to come up with your ideas and what you want. We tried to do a slightly different format this time from the last time, last time we had 2

parallel sessions sort of plenary session like this and we didn't have workshop sessions, we just had lunch discussions and this time we thought, well, let's put in some workshop sessions at the same time. When people were booking they were sort of anti that, well, why, you know, why do we have to choose, we want to go to all of that, I think it is a matter that we are adults, supposedly, so we do have to make choices, but I think it actually seems to have worked out OK and people have liked the sessions that they have gone to and it will all eventually be written up, I mean it's going to be a bit of a gargantuous task this time I mean doing to for one day took long enough, but doing all this is going to take a while, so actually get it written, but I will do it, I promise, as soon as I can, and then you can all buy the proceedings. But I would welcome ideas for future conferences and I think actually London is very well placed for international conferences because you can come from all over the place to here, we are pretty central. Depends how you print the atlas, really. But I do want to thank very much all the participants that have come and of course the audience is really important in this situations, I've thanked the speakers, but I think without an audience we'd look pretty silly. But there are so many speakers that I can't thank you all individually, so I think you bear with me. We actually had more than 70 speakers altogether. A lot of people actually wrote and said they wanted to come but there were some people who were actually invited and I am very grateful to the people who have come from a long way at their own expense for this, because you know we are a poor organisation and we cannot afford to fund people to come so I am really really grateful. So I hope that none will feel left out, I have a few little gifts for our friends who have come from overseas and who have been our main speakers and you know, I just apologise that I can't give a present to everybody, I wish I could. But you all have my warm good will. Thank you all very much for coming and good-bye.

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