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

Letter from the editor -

Dear Colleagues,

So this is the big `conference year' the International conference in October is really shaping up and the number and variety of presentations are truly amazing! Please book up early and encourage colleagues to do so too. With such a large audience we do need to process applications as soon as possible - both for participants and for audience. SO apply now to avoid disappointment.

We are also accepting referrals now for our semi-independance unit / half way house - details overleaf.

Best wishes for a prosperous 1998 and I hope you will keep in touch with Youth Support and our activities throughout the year.

Diana Birch
Director Youth Support

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* CONFERENCE ROUND UP *

- Personal views of those attending recent conferences -

' Reclaiming the Black Family '
Nurturing the Black Child's Positive Self Concept -Pat Freeman -Team leader, Youth Support House

A two day intensive course run as part of Lewisham's Black History Month '96.The aim was to focus on black children from an African and Asian perspective. Training aimed to provide participants with skills and knowledge required to provide positive self awareness in black children and to foster within them a sense of self worth and empowerment. The group consisted of teachers and project workers who worked with children from a multi ethnic background. Through group and individual work many of us achieved this and more. We looked at ways to apply the work to our practice.

1. **What is in a name?** Each person introduced themselves by their name and was asked to tell the group what their name meant and why they were given that name. A name not only identifies you but can also be representative of culture, century even the region in the country.A name may involve history which incorporates story telling to be passed on from generation to generation i.e. an African child need not feel ashamed that his name is different from the widely used English names of his peer group. If he is true to the significance and importance of his name with pride, self love will follow.

2.**Blackness & Invisibility** Debate in small groups on how we made ourselves invisible during our childhood,when we did not want to make ourselves noticed due to feelings of inferiority.This gave insight into how a child feels in minority groups and ways in which they deal with it which may range from obscurity resulting in lack of development thus not achieving their true potential, to un-acceptable behaviour to draw attention to the fact that they are different from everybody else and their needs are different which has not been acknowledged by wider society. Negative images of black people have evolved through history. The future of any race is largely dependant upon the care, education and nurturing of its children.Family is the mainstay of provision here but other systems have a share in the black child's development such as education or the care system taking on the family role. 'Culture' is a process which gives people a general design for living and patterns to interpret their reality. Not just about clothes, food and music. Namonyah Soipan looks at the ways in which the positive concept of the black child can be enhanced.The culture must participate in educating the black child for instance using history sessions involving story tellers from different cultures. Secondly become aware of and respect the holidays black people celebrate. Third- Monitor what black children watch on TV or cinema - much negativity is portrayed of black people usually the villains, under achievers. Do not accept negativity by exposing them to this. Raising the black child's positive self concept relates to their blackness, emphasising positive qualities of being black rather than creating a superior attitude.

First International Conference on Health and Culture in Adolescence
- (continued from last edition) **'The Israel Experience'**
Comment by Esther Mensah, Senior Care worker Youth Support House

Having been associated with the Christian faith all my life, the opportunity to visit Israel for an International Conference on Health & Culture in Adolescence, November 1996 was a blessing to me. Visiting Israel has always been a dream which became a reality. All the difficulties and sense of hopelessness, faced at the initial preparatory stage were worth going through for the experience. The brief glimpse of a small part of a country with so much religious history made a deep impression on me and I am grateful to be one of the delegation of four from Youth support who attended the conference.As my other colleagues have written in their accounts about the conference, I have decided to write about the "lighter" issues of the trip and my experiences in general. Our departure from Gatwick Airport on 22 November 1996 was without problems and on arrival in Israel we were met at Ben Gurion International Airport, Tel Aviv in the early evening for a drive to Jerusalem. Being the beginning of sunset on Friday, we noticed the roads were almost empty with just a few cars around. Our escort quickly explained to us that it was getting to the "Sabbath" quickly triggered a wave of thoughts in my mind and a sense of excitement that we were actually in the biblical land. As dusk was setting in we didn't see much; the landscape, buildings were all hidden to unfold as a surprise the next day. The landscape was breathtaking and it made the greatest impression on me. All around were hills and valleys of white rocks and stones.Buildings particularly in Jerusalem were built with these white stones making the built areas long stretches of uniform colour interspersed with greenery of trees and shrubs. Jerusalem seemed a city of "ancient and modern" merged together where one sees very old buildings with cobbled roads and just close by very modern 20th century buildings- the lifestyles of the people showed this diversity. There were Bedouin communities (living according to tradition patri-lineal patrilocal, patriarchal, endogamous and occasionally polygamous) There were the very orthodox strict practising Jews and Muslims who were recognised easily by their clothing. There were alsc those living liberal lifestyles who were unorthodox in any form or shape.
Despite the busy schedule we had the opportunity to enjoy various biblical places unique archeology the beauty of Jerusalem as spiritual centre of three great religions existing through 3000yrs, energy and vitality of the modern state of Israel.

The first biblical place we visited was Bethlehem, birthplace of King David and 1000 years later of Jesus. It was just 7 miles south of Jerusalem in the Israeli occupied territory of West Jordan (west bank). We visited the famous Church of Nativity, clustered together with the Grotto of Nativity,chapel of the Manger, Saint Catherine's church and Milk Grotto Church serves three major Christian confessions in the area catholics the Greek and Syrian orthodox eastern church and the Armenians.

There were visitors from all over the world and every group had a tour guide explaining things in different languages. The icons in this cluster were very inspiring. The next place we visited was the Mount of Olives and Garden of Gethsemane where we saw olive trees said to be dated from biblical times. We sat on a rock claimed to be used as a resting place by Jesus and his disciples. Masqda, an archeological site on a high plateau, was a famous historical place. We rode on the cable car conveying visitors to the site where we saw one of the bases of Herod the Great, King of the Jews. Ruins of one of his palaces showed an intricate swimming bath for the king. Other places visited were Nazareth, Tiberias, Capernum in the region of Galilee with a boat ride on the famous Lake of Galilee. On our way back from Galilee we went to the Dead Sea where we had a dip in this famous sea. At the river Jordan we saw a group of Christians being baptised by submersion and the singing and cheering after baptism was inspiring. We drove through the Judean desert where long stretches of rocky mountains without trees were spectacular There remained a few interesting sites we did not see, but the experience will always be treasured.

Saving Children from their Monsters

Priya Kanthan - Teacher and nursery teacher at Youth Support comments on a newspaper article which has resonances for our own practice at Youth Support House -

"Michael, you are sitting up beautifully", "David, I love the way you put your hand up to ask a question" and "Now Anthony, you are ready to come back to the lesson now". Six year old Anthony had been taken from the room after throwing himself to the floor, crying and shouting trying to disrupt the lesson. This behaviour has always helped him to get attention, in his old school. So Anthony would be taken out of the class quietly and he could rejoin when he calmed down. This is a very typical scenario when you are a teacher dealing with some of the most disturbed and chaotic infant-aged children.

A centre in Kingsmead in Derby, is the only pupil referral unit for infant school children in Britain. The Centre costs 3 million pounds per year to run, and supports 114 children who attend regular schools around the city. The Kingsmead children, most of whom have been statemented for special education behavioural needs are supported by a team of specially trained educational and care officers.

Most of these children come to the Centre for four afternoons each week because their behavioural problems are so severe that they cannot cope with full-time education in an ordinary school. Despite their age most have been excluded for violence in the class, throwing furniture,swearing at and abusing teachers or other children. It can hence be seen how disruptive this would be in a normal class. One child has never been to school because of a history of disruptive behaviour in his nurseries. The head of the Centre said that the work done in

this unit is vital because if children with problems at this tender age were excluded and no other school will take them, they are referred to a special school and it is very hard to get back into mainstream.He also adds that these children are effectively toddlers who cannot collaborate with other children and their play is very self-centred. The Centre's job is to encourage them to understand that they are real people and have true feelings and that they are valued by us adults

Nearly all children sent to the Centre have suffered major trauma in their short lives. One 5 year old child had been in a 19 foster homes already. Such children cannot be expected to sit down and follow a National Curriculum when their lives are in chaos.One of the children will scratch herself until she bleeds, if disciplined. The teachers in the unit have learned to sit still with folded arms, as a response, rather than leaping forward with tissues. Another child may stab himself with a pencil for attention if the teacher would praise another child, he would then cry out "Ow, it hurts, I'm bleeding! I don't like doing this work!".This is a typical response and often to 'ignore' helps.

The Centre has a large classroom decorated with the children's work. The room is sectioned into reading area, play area. The work done here is very structured and the staff's aim is to bring consistency into the children's lives. The general rule is that when staff say something it will happen including a punishment for bad behaviour; it happens.
The children arrive around 12 noon and are immediately subject to a routine. The session ends at 3pm with a drink and a biscuit

It is vitally important to have this early intervention. Any infant or Nursery Teacher can identify a child who is going to have problems but if you can break the cycle of violence and disruption at this age then you have a better chance of having a positive effect on their educational and life chances. WE also can avoid some of the problems that re-surge in adolescence causing disruption and teenagers excluded from school or society. We should be more aware of the problems in very young children and methods of tackling them. This unit works in partnership with the regular schools and helps to avoid the devastating effect one child can have on a general class. One little child was seen to be very quiet and withdrawn in the unit and was building something with bricks. The child's parents had died recently when asked what he was building, the child replied "A safe house where monsters can't come".
We have similar children at Youth Support House. Paul was a 4 year old boy who had a series of emotional problems, he was a damaged child with unacceptable behavioural patterns. He had a very unstable home and was separated from his natural mother and put into foster care until re-united for a short period with his mother at Youth Support House giving both mother and child help in terms of education,counselling and therapy. Eventually Paul returned to foster care due to mother's rejection.Paul lacked love, security and above all consistency. His behaviour continued to be disruptive and abusive, physically and verbally. Will he now continue to slide towards a disturbed and insecure school life and adolescence?

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

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

Poverty and Neglect - Deprived Youth in varied societies.

Continuing the transcript of IRC institute 1997

`Deprivation among immigrant Youth'

Dr Manny Chigier - Israel.

My own experience in the last twenty five years is of working with an organisation in Israel know as the Youth Alliah devoted entirely to the resolution of problems and educational advancement of adolescent immigrants to Israel. We have established what we call youth villages - that is young people living in residential settings which provide both the education opportunities and also social and educational advancement as such.

In the last eleven years we had the rather unique experience of Ethiopian adolescents, immigrants from rural Ethiopia, into the modern western technological society of Israel and in the last 5 years we have been working with adolescents from the former soviet union. We have to realise that many immigrants from Russia actually come from the eastern states which have a very distinctive cultural pattern of their own.So this has resulted in the need particularly in my own work for me to become not only a physician partly a psychologist or psychiatrist for which I have had the opportunity of training but also to become knowledgeable in health anthropology. I wish to emphasise that word because as Bob Blum indicated in his talk that is particularly important we need toconsider ethnic minorities existing all over the world.

All over Europe,or middle east, we cannot work with ethnic minorities without understanding their culture of the environment in which they grew up.The subject is deprivation so let us just list what happens when a young person moves into a different society -what deprivation occurs. The most important one is the loss of a role model. Parents who come as adults into a new society have difficulty coping with their own adjustment and they have great difficulty in providing an adequate, positive role model for their young people-not the young children, but the adolescents. Another thing they lose is the knowledge they have of being able to do things in their own environment. The new system is entirely different, the language, the experiences-imagine you are a fifteen year old Ethiopian and you have never been to a doctor in your life.You come to Israel and after three months you have a cough, you go to a doctor and he examines you and gives you a little note and he indicates down a corridor to another room where someone in a white coat summons you into a darkened room and tells you to take off your shirt, put your arms around some metallic monster and tells you to

stop breathing and then runs out of the room! He thinks it's crazy, there's no logic in that. One of the things I emphasise is the lack of cultural logic to fit the events.There are many obvious things like housing and jobs and lack of food. Another important issue cultural bereavement - the mourning for loss of culture was brought to the fore by a Marius Isenbrook an Australian psychiatrist who had worked in Cambodia. So how do people who have lost something react? There are three reactions - one is idealisation - we speak well of someone who has just died and think of the marvellous things he did and so when you are in another country and you begin to experience difficulties - you can imagine how much better it was in your own `lost' culture. We hear how Russia and Ethiopia was so much better from these people - idealising what they have lost.

The next reaction is denial - I can't believe this has happened, I can't believe this person died and so they cannot believe that forever they are not going to be in Russia or Ethiopia or Turkey for instance. Perhaps this is temporary and we will go back.

The third reaction anger - what the hell are we doing here - why did I get into this situation? A particular example comes from the work that I was doing with sexual counselling of the disabled - one young man was accidentally shot by a fellow soldier in the spine and developed a paraplegia and his most immediate and intense desire was to know can I be fertile? Do I have sperm - well we took him into the spinal injury clinic three times to check the results of his fertility tests,eventually I told him that he had an infection following the injury and he had practically no sperm at all - and he looked at me and said `One of these days you are going to get it from me - I'll see that you get `fixed' for what you have just told me'. Well we all know of the bad messenger - he who brought bad tidings - they killed the messenger in medieval times because he brought the message to the king. The Army is destroyed - so kill the messenger. We as doctors have to relate to people we are often the bad messengers - we tell them they have TB, that they have malaria and so they are angry with us - we have to understand when they do not co-operate, when they are angry - that is a kind of reaction.

Another response is to wait for miracles - wait till tomorrow and everything will be marvellous - sure Ill get over my tuberculosis - give me a week and I'll be finished with that. So miraculous expectations as such. Bob Blum has mentioned the importance of a belief system in common - which is one of the few things that the Ethiopians and the Israelis have - a common belief system - this can work in two ways. An example of people who were involved in the holocaust - they can come out of such an experience completely disillusioned with the concept of a superior being - how could there be a superior being in care of us Jewish people and allow six million to be destroyed - on the other hand there are those who come through the same experience and say - how can it be that I have come through all this and survived when so many others did not - there must be a superior being that allowed me to survive. It can work both ways from that point of view. So what do adolescent immigrants bring with them into the new country - the new environment. One thing they bring is their bodies. We had a very interesting presentation at our health and culture conference - a physician from Norway who deals with immigrants from a number of cultures. She felt that since they bring their bodies -

the development of those bodies was a very important feature - so body building for the adolescent males is important to them - comparing who has bigger triceps and seeing who has the `better' body. We as doctors work with their bodies - so care of these bodies is something we should be encouraging. For an Ethiopian girl - it is very important for the girls to braid their hair - this is part of their body image - also one should understand that they do not consider themselves black but dark brown - a joke in Israel is of two Ethiopian girls who see two Yemenite girls in the street and say - gee these Scandinavian girls are beautiful So everything is relative.

One problem with image is that whenever we have a new wave of immigrants from one part of the world or another - many of the officials cannot understand the names in Ethiopian or another tongue - so they give them new names - the only thing you have with you is the name you brought with you - now that is lost too.

They bring with them notions - certain notions about the world - for example - there was a refusal to have blood taken for clinical investigation - and if you look at anthropology you will see that their notion is that the amount of blood you have is a constant and does not replace itself so why should somebody take ten ccs of blood from you - if someone took ten dollars out of your bank account you would object. Local therapy was given in the villages - if you had a swollen foot you were given a poultice.Where is the logic in putting something in your mouth to cure a swollen foot

Tradition in Ethiopia forbids marriage up to the seventh generation. The extended family would keep a trace on who these relatives were so you might find you cannot marry your boyfriend - though you may be 14 and pregnant because you discover he is only three generations apart. You must accept this tradition or be rejected by the family.
Let us go on to some clinical considerations. A very strong reaction to a problem is psychosomatic illness - for example stomach pain from a problem - in Iraq it was more `I can't breathe' so a lot of asthmatic illness - others may say `it hurts my heart' - so chest pains. For Ethiopians it is the stomach - they have a saying, `the stomach is larger than the world' in other words you swallow the problem. Eventually there may be an abdominal problem. There may be pseudo psychiatric symptoms - perhaps almost looking schizophrenic, very vague, losing interest - we worked with an adolescent psychiatrist who did not immediately put people on medication right away because they were in an ambulant situation. Give them a week in the place and you discover what is called an adjustment reaction - when people are reacting too much they need time out and everything will settle down. They may begin to act in a confused state but medication is not the answer. You just need someone from their own culture to come in - no doctors, no medication, just someone who has been here a year and can identify with what they are going through.

Of course there are psychiatric problems - but most are pseudo-psychiatric. If you have someone in this state, you put them on medication, they don't cooperate, then you have to restrain them. You have created a dreadful situation. Where can you go with them after they have had 3 months treatment and are in this sort of state? There's nowhere to go- you are classified as an Ethiopian,an adolescent, a psychotic - that's it! Then there are problems such as suicide -taking up negative

aspects of your new society - what happens when you learn a new language? The first things you learn are the swear words - and so they want to go into smoking, sexual patterns - things that make them seem more Israeli.

What can we as physicians do to help these people, to improve their health situation. First is to avoid being judgemental - we always have a tendency to consider people from different backgrounds who are not coping as inferior somehow.Talk about class differences - there is always that -they may not be able to use the toilet - have come straight out of the countryside and have never seen flush toilets. My reaction to that is that if we took you a qualified physician and left you in an Ethiopian village and you had to find your way through a forest or a jungle for ten kilometers - how the hell would you cope? So they don't know what they don't need to know we need to give them information. We have another example - we use young people to teach hygiene to the older immigrants - these are sixteen year olds who have been 2 or 3 years in the country. One of the stories that someone obviously had quite a severe infection of the skin and this young person said, didn't you go to the doctor- yes I went to the doctor - and what did he do - he gave me a little note - what did you do with it - I hung it around my neck.He assumed it must be an amulet - nobody seemed to think he needed to be told -you use this note to get medication and then you use the medication in this way .. Another point is to go beyond the initial complaint - we all know an adolescent will come with a pain in their ear when they really want to ask you about something else.They throw you the question just as they go out the door - by the way I think I'm pregnant! One could say so right at the beginning - so it's important to have a little check list to go through. The name - that's important - what is your name and what does your name mean - it only takes two seconds to ask that question but already you have personal contact and have broken a barrier with that young person. Doctors never have time, but it's a question of how you use that time where you put the priorities.

Using a few words in their own language is very powerful - Harry Belafonte was performing for 20,000 people in the local park there and he said `le- itra -ot' which means see you again , and the whole crowd went crazy. President Kennedy walks into the 100,000 people out here in Germany and says `Ich bin ein Berliner' - nonsense! but they remember him 30 years later that he went there and said `I am a Berliner'. When our prime minister was assassinated President Clinton spoke on TV and he said `Shalom ha bere' Farewell friend - three words - what did we get three thousand stickers in Israel saying those three words - stuck on walls, on food every sort of thing - amazing to use these words to make such a connection with somebody. Another thing I like is to keep communication going - not close the case -say `if you feel bad come back, or you can always write to me' something to keep the door open. It's amazing how people remember, come back ten years later and say - remember you said if I needed you I could come back - I didn't need you , but I remember you said that.

Lastly a find of way to work with other staff - multidisciplinary - using social workers and other disciplines makes life much easier. The indirect method can be useful - I have a friend who had this problem. Rather than -I think you have this vaginal discharge because you had sex -

one could use an indirect approach - you know last month I had someone come in who had the same problem as you and it turned out to be caused by having sex - do you think that might be the case for you too? An indirect way of leading into the question.

In health education we often use movies to help - and one we often show when looking at adjustment is called `Victor'about a Mexican kid in California trying to be organised and in Israel we say - well could this happen here? Two little stories to show what could be done.A girl of sixteen managed a record for Israel,she gave birth at the youth village two years running quite unexpectedly because she was wearing the voluminous type of dress that wear and she came to medical attention because she denied having sex at all a psycho - social problem. What was the first thing she needed?- to avoid getting pregnant again whatever the reasons so we arranged an adolescent gynaecologist from a private clinic to have an IUD inserted.Now she got the message- I am now protected. First pregnancy resulted within the family the second by a driver on the last bus station on the way home - both cases of sexual abuse and she cannot talk about these events. She had a period of anorexia nervosa and during treatment she had her IUD checked regularly, she attempted suicide. Two years later she is rehabilitated working in the army

Another Ethiopian girl kept vomiting- not exactly bulimic but she was making herself quite ill. She refused psychiatric admission she had gone with a group of Israeli adolescents to visit some holocaust sites in Europe, where youth are taken to help them understand something of their history. This seemed to awaken a problem for her,the youth village would not take her - she was considered too ill and difficult to handle. So I tried the use of metaphors- instead of vomiting out all this food- why not vomit out your problem. That caught on with her and every time she came she would say that she was helping to vomit out the problem and she started to eat the food. I continued the ritual of weighing her - when people are in bereavement it is important to continue with the ritual as a form of therapy. Now she's doing well in school and is very bright I use the metaphor of the sun being out and everything rosy and happy - but then a cloud might come and block out the sun and everything may seem dark and depressing - but the sun is still there behind the cloud even though we can't see it and it will come out again. So when working with ethnic minorities I stress again how important it is to be a medical anthropologist, speaking in terms they understand

Marginalized Youth in British Columbia

Roger Tonkin, Vancouver.

I don't know how many have been to Vancouver - your impression probably is that of a beautiful city in a marvellous setting with a fair degree of affluence in the society. Even then despite those features we have our population of young people who are less well served by society or in greater need and I will talk briefly about them this morning. I will share an anecdote but indicate that material I present is population based information not about individual patients or scenarios. It is important to recognise that adolescent health care is based on population as

well as individual cases and we cannot focus on one to the detriment of the other. When thinking of population based approaches we need to think how that translates into action, programmes benefiting somebody other than ourselves to give a paper or publish in a journal. We have just appointed a Children's Commissioner under mandate from the Justice Dept. One thing they are mandated to do is review all deaths of children & adolescents in the province, they were only looking at deaths of young people under the care of the state when they realised they should be looking at them all.

The case I want to talk about is of an infant who died in foster care of sudden infant death syndrome - that case is illustrative firstly because sudden death syndrome means the child was under six months of age. The child was born cocaine addicted and immediately placed in foster care and it turned out this was the second infant death to this mother and had cocaine addiction. The first child of three is also in foster care alive not born cocaine addicted apprehended early on for neglect. The reason being that the youngsters mother was a hooker, an aboriginal working in the province - remember our province if you travelled 1000 miles north you are still in BC and the same East, only 3mill people in the province so we have quite a spread out population. When young people leave their reserves they get onto the streets, especially young aboriginals. This mother and baby I review was 14 when she hit the streets, getting into all the street scene and 17 when she killed herself. We are talking about a very young life associated with an incredible amount of misery which does not come through in the population based statistics. That is why I told you this story.

Let us look at two populations - just under 16000 students in all regions and 110 kids who live on the streets in Vancouver. This population is special, reviewed in December by us. The others are only there in summer or weekends. Almost the entire street youth population is in Vancouver, the media make it big but it is small. We divided youth into 9 groups of population based on very simple splits - if you carried a weapon you were violent - it didn't mention whether you were the victim of a fight, carried a pocket knife, if you fought once in your lifetime - simply that you were involved in violence. You can see students in school are largely non violent and street people are involved in violence in some way. Mostly grade 7-12, population of really young are much less so- they tend to be older youths. Males are a little more violent than females certainly in our province, a high proportion are Asian so you see the Asian population is high risk as are aboriginal as opposed to others - not living at home, mother employed full time, could have given same information for fathers but usually the families are more well off of other groups. Interestingly the majority on the street said they did like school and a fair number were thinking of returning to school. Where did their income come from? They had jobs, we did a poll in 1993 and the Govt have just changed the welfare system so that if you did not have 3 months proven residency you did not get welfare - some get money from families, a fair chunk are involved in the drug scene and

prostitution. That is for income, not necessarily trading a place to live for sex. When we compared youngsters in school with those on the street it was interesting that with the exception of cavities both groups had the same standards of general health. When you looked at more specific areas of healthcare giving them labels you can see a higher incidence of TB, anaemia and more concern with acne as well as more allergies reported in street population. This may be part of the answer of why there are complaints of respiratory problems because almost the entire street population are smokers and in both male and female it is a less common reported problem.

You can see from chart 95% of school attenders have never tried cocaine whereas the street kids are more likely to use it, and similar findings were available for marijuana etc. Sexual activity - basically the norm, this population remember being slightly older - but school attenders are less sexually active than the street population although interestingly the numbers are different to those presented earlier. When you look at partners over six months remember only a small proportion quoted prostitution as a way of gaining income whereas school attenders have no partners or one. Certainly they practice monogamy. First of interest is self recorded levels of emotional distress during preceding three months and you will see high proportions of both males and females presented more as emotionally disturbed than school attenders.Perhaps it was slightly more obvious as a gender gap in street population than school. We believe this study is one of the few based on population approach involving self reported physical and sexual abuse but I am sure it is of no surprise we can confirm the biases. You can see the females on the street have a history of physical and sexual abuse, their lives are an experience of youth and the same applies to the males on the street having more physical abuse than any sub group which gives a sense of a population who are experiencing more abuse in a serious manner. Again there is the traditional gender gap but the street group have a higher incidence of having been involved in or been attended to for violent or suicidal attempt so suicide is very much a piece of their life. They tend to get good medical care but mental health services are not so good so efforts are being made now to address this group.

Remember first overhead of various groups of population there is another group - this is pure speculation and small piece of methodology. When we first presented this we left out the non violent group which represented 5 or 6 kids but if you look at this group 100% heterosexuals the higher proportion of groups in school 95% of them considered themselves heterosexuals, and this was based not only on practice but of the street people only 20% of them see themselves as heterosexuals and when we looked through we stumbled upon what we think is a different group on the street - more likely to be suicidal, less likely to be violent, and we are not sure what that means so we have a project working with the gay lesbian community looking at the issue of suicide in the gay population. Another example of statisticians throwing this stuff out but from listening to the

kids they are saying we have to look at this. We produced a report for release to the general population on street people in a user friendly format,data is used for looking at marginalised adolescents to motivate programmes. My pitch is that when looking at adolescents whether street people, gay, aboriginal or kids with chronic illness we have to look at population comparison and at what data tells us and how to get them involved in whatever the issue may be.

Comment from the president of SAM

Dr Gail Slap

I am delighted to be here, one reason enjoying SAM growing internationally and secondly because only 12 hours ago I arrived from Asia where I have seen first hand some issues that provide care for adolescents in that part of the world and I am convinced that we need to keep together and provide judicial planning for adolescent service. I think this community within SAM has grown amazingly and you are a testimony to the effectiveness of that testimony - an extraordinary turnout increasingly recognised. Talking to people in the international community about work with adolescents is a joy for me. I realised for the first time what we are talking about when we go to other parts of the world particularly the developing world. We are probably as international as most in the field of adolescent medicine but my work has increasingly pulled me into areas like China Russia India and parts of Malaysia and what I see is terrifying to a western eye, hard for us to know what goes on for youth in the rest of the world. As those problems become global we have to learn lessons from each other. Learn why families stay together, learn how to prevent HIV in adolescents - the only way these things are going to happen is if we co-operate more. My own personal work is more drawn to that international arena, one of the most exciting things. We can change more the situation of developing countries now than we can in the developed countries because so little has been done particularly in parts of India. I congratulate you on your work, you are the biggest institute this year, the ideas and energy give a deal to be proud of. The lions share of leadership was due to Diana Birch I say a big thank you to her, she pulled this group together and produced a wonderful programme

Nutritional issues affecting Youth

Dr Semi Sznajderman, Israel.

Nutritional issues affecting youth - deprivation poverty and neglect and I am bringing the other side of the coin. Numerous problems pertaining to adolescent and nutrition, nutritional needs are greater at puberty than at any other time except infancy. Unfortunately less attention has been given to this despite long term consequences. Nutritional issues impinge not only on immediate need and development but lifestyle leading to chronic disease such as cardiovascular disease, cancer and osteoporosis.

In developing countries malnutrition is the major problem faced by adolescents and I would like to concentrate on the nutritional problems related to the disease of affluence, obesity, eating disorders and specific nutritional deficiency resulting from unbalanced diet. These problems once seen only in the so called developed countries and increasingly is prevalent in developing countries due to the widespread adoption of western values and lifestyles. Although this issue is not so prevalent in developing countries as affluent countries, long term implications and the likelihood of their increase may lead to serious implications and merits effort in prevention. Unfortunately most doctors in nutrition are from USA or Europe and little has been done on diet styles of teenagers in developing countries however much may be learned by studying the surveys done in developed countries especially in low socio economic groups.
Nutritional requirements in adolescence -The major issues are relatively high fat and saturated fats recommended level is 30% Recommended dietary allowance for adolescence in terms of energy requirements in females 47% before puberty and 40% after but few attain these levels. All nutritional needs are increasing during this period, and the main deficiencies in this period are of calcium iron and Vit A.

Understanding current diet habits of adolescents is important in order to identify problem areas and suggest correction. In Western society adolescents have greater freedom and increasing buying power for snacks and beverages. They can do that without parents help. With decreasing parental supervision of nutrition and diet the path is set for unhealthy eating pattern which contribute to disorders, skipping meals, breakfast, snacking is common and reported in 80% of adolescents. Junk food tends to be high in saturated fats, cholesterol and sodium.

TV and computer games account for a substantial amount of daily routine of teenagers. This sedentary activity coupled with snacking in response to advertising leads to a cycle of poor nutrition setting a lifetime habit leading to long term problems detrimental to health. Slimming is the ultimate response to glamorous multi million dollar advertising programme of weight loss products and globalisation of communication internet and western ideas is likely to be adopted by non western society with similar results. Our research study included a study of the report by Susan McNab "Report on the Dietary practice of black and white girls 9-10 years old over a 5 year period" They took 5379 kids, finding skipping meals, snack food, use of fast foods were common. Black girls were most likely to report any of those behaviours. The reason was unclear. May have been related to behaviour and differing perception of weight by the different social and ethnic groups. This study highlighted the difficulty in generalising about diet practices of socio economic and ethnic groups without taking into consideration cultural differences.
Little is known of eating habits of developing countries and because of lack of information it would be useful to assume that habits are related to adolescents in poor socioeconomic groups in developed countries rather than

high socioeconomic groups. It is revealing to look at changes in morbidity in cardiovascular disease among African American populations over the past decade, relating diet to atheroschlerosis which has risen dramatically.

Recently Johnson studied the intake of diet of adolescents between 11-18. Deficiency in calcium, Vit A & B were common as well as over use of saturated fats and sodium. African American from poor socioeconomic groups were most at risk. This is not confined to the USA, in England 80% of children aged 12-13 in a poor area of London were in excess of 11% of total dietary intake, 25% of the girl's calcium intake was below recommended level and 30% ate no vegetables.

A report from Korea gives an insight into dietary trends in developing countries. Population of Seoul rose from 2.5 mill 1960 to 10 mill 1990, economic change created a gap between low and high income groups in dietary practice. Meat fish and dairy produce increased six fold in high income group compared with low income, more than 30% of calorie intake coming from fats and 20% in poor group. Also lower income group suffer from anaemia and malnutrition. In the higher income groups cardiovascular problems have increased in Korea accentuating the potential danger of adopting western diets and creating new problems of over-nutrition of wealthy in parallel with malnutrition of the poor. In developing countries diet practice means insufficient calorie intake - for example a study done in street food by Nigerians in 1995 showed that all major food groups were represented in street food - 50% of mineral and vitamin needs and 25% of daily energy needs indicating that contrary to the situation with snack and fast food in developing countries street food has good nutritional content and contributes to good dietary intake by teenagers in Nigeria. Unfortunately the study did not analyse fat content.

Obesity and anorexia - eating disorders where calorie ingested is in discord with amount needed resulting in energy imbalance. Reports from US National Health & Nutritional Examination Service showed 22% prevalence of obesity in 12-17yr olds between 1963 and 1991. In 95 cases there is no medical aetiology and 75% persist to adulthood. Several factors are relevant- increased availability of high calorie foods out of home leading to decreased levels of activity in front of computers leads to increasing obesity, leading to medical and psycho social complications leading to bulimia and hypertension causing cardiac disease and ill health. Long term morbidity and mortality of obese adolescents was studied in a 55year follow up of 550 students at Harvard showing increased mortality in all types of cardiovascular disease. The same group in 1993 studied social problems showed a lower academic achievement in overweight adolescents, lower income and decreased likelihood of marriage in male and females. Obese adolescents fared less well than adolescents with chronic medical conditions.Contribution of genes & parental size is unclear. Data is available for developing countries from a study of a poor neighbourhood in San Paolo Brazil investigating prevalence of obesity and malnutrition found a rate of 21% obesity in girls and 8.8% in boys whilst malnutrition was 12.6% in girls and 15.5 in

boys in the poorest society. It is difficult to assess the social implications in developing countries but it is clear that cultural differences will affect the way that people react to differences in weight - in parts of the black community in America slight overweight in girls is preferred to underweight for ulterior reasons - it may give the appearance of strength and the idea of beauty in the subculture. In a 1994 study British and Uganda students were compared with their rating of the female figure ranging from anorectic to obese. The most striking difference was the fact that whilst British students found the slimmer figure more attractive, Ugandans found under-weight less attractive and rated the obese figure most attractive. Such data may hinder preventive measures in anorexia and bulimia and obesity. Conditions thought to be extinct in developing countries are becoming more prevalent with increasing awareness of the medical community and also secondary to the influence of western culture on adolescent societies with exposure to international media.

In 1994 an Egyptian screening for eating disorders in secondary schoolgirls in Cairo -11.4% scored positive for abnormal eating patterns and 1.7% were victims of bulimia. In Israel a screening of girls in Jerusalem found a 1.10% rate of abnormal eating disorders, much higher than expected from an earlier study and similar to the levels expected of a western country. Attitude towards eating and diet was dependant on country of origin of immigrants. Mothers emigrating from Europe rated as having greater weight concerns than those from the east Asia or Africa - this shows the effect of acculturation on eating disorders -adapting to western values and eating habits girls exposed themselves to obesity, eating disorders.Similar problems were appearing in developing countries Calcium deficiency - Calcium is essential for bone formation about 40% of the bone mass is laid down during adolescence.Long term consequence of low intake during this period include osteoporosis and low bone mass. Replacing milk as a source of calcium and increased use of carbonated drinks aggravates this deficiency.Calcium phosphorous balance is also adversely affected. Normally milk and milk products account for 50% of the calcium intake at this age - studies have shown that 40% of adolescents may be deficient in calcium intake and intake decreases with time. Girls suffering from anorexia have a high risk of osteoporosis. Iron deficiency is most likely to occur during peak growth and be made worse by blood loss during menstruation.Daily need increases from 12mg to 15mg during peak growth and up to 30 mg during pregnancy. Iron deficiency is one of the most important dietary problems in developing countries -as well as developed - it is worse in pregnant and vegetarians In Rajistan India 74% of 10-14yr girls had iron deficiency anaemia and a high level of malnutrition. These problems are compounded by the high needs of pregnancy.

Despite importance of dietary needs in adolescence only recently have deficiencies in this area been researched and recommendations formulated.Less is known about the nutritional status of teenagers in developing countries. We are seeing diseases of affluence in developed

countries becoming prevalent in developing countries and poorer communities hand in hand with adoption of western diet and values. We are seeing the spread of obesity, anorexia and bulimia and poor eating habits of the west becoming prevalent in developing countries thus aggravating deficiency diseases such as iron deficiency anaemia and diseases of malnutrition found previously in the poor.

Deprivation in Latin America - How are Youth Affected?

Dr Gustavo Girard - Argentina

The Simon International English-Spanish Dictionary gives these definitions for the following words: ***deprivation:*** privacion *(privation);* carencia *(lack);* perdida *(loss)* ***deprive:*** **privar** *(to dispose of);* despojar *(to divest)* ***despojar:*** to strip; to rob.Something has been taken away something has been robbed. It keeps being taken away and robbed The same thing happens with the word ***neglect,*** translated into Spanish as ***despamparo.*** Lack of protection. The second version of ***deprive*** refers to dignity.
This the basis on which I will make the following consideration about youth in Latin America. Let us study what **neglect** consists of, by going through different situations that are closely connected with each other.
POVERTYlevels of poverty in Latin America are those of a Third World Country -or a **developing country**, whichever you prefer. Adjustment policies and ill-distribution of public expenses and wealth, tend to increase the irritating social inequalities, showing no signs of a reversion of this process. The information provided by the most wide-ranging sources only confirm what is already known to all.The prospect is even gloomier when we analyse the lack of functional, well-grounded alternatives to modify the system. The "*death*" of the ideologies, although liable to be argued about, leads to a certain quiet and passivity, which forecasts no good for the future. Together with material poverty, it is possible to observe the settling in of an **affective poverty**. Endeavours made to overcome the economical problem have their inevitable side effects upon the family, whose members must multiply their work efforts. The number of families capable of subsistence based upon the income of only one member is steadily decreasing. This is an important unbalancing factor in the structure of the traditional family tipping into crisis.
NUTRITION Malnutrition levels are continuously and permanently increasing. Those concerned the most are the children, origin and end-point of the already typical vicious cycle of poverty. Forty thousand deaths per day due to malnutrition and illness that are avoidable. This fact, by itself, is significant. It comes from the *Cumbre Mundial de la Infancia (World Summit for Infancy).*
EDUCATION One of the main characteristics of present society is the high degree of *competitiveness.* Education performs here an essential role. Education means knowledge, and knowledge means power. As an antithesis, we can state that lack of education in itself leads to marginal situations.
We would be facing what has been called **cultural malnutrition.**

In three Latin American countries we have found that:-
* In Argentina 88 % of the population complete the primary education; 26 % of this group complete the secondary education while 2 % of this last group finish studies at the University.
* In Costa Rica the same thing happens with the 34.4 %; 21.3 % and 9 % respectively. While in Brazil only 17 % complete the primary education; 8 % of this group finish secondary education, and only 1.8% of this small group accomplish University studies.
These figures provide partial information, since they refer to quantity and not quality. What is profitable is high technology, and it goes without saying that our countries can only have access to borrowed technology, *if* and *when* it is allowed to them.
100 MILLION CHILDREN aged 6-11 are without school education
Another figure provided by the *(World Summit for Infancy)*.
HEALTH Latin America is a replica of what happens world-wide in other ***developing countries.***
Comprehensive medicine is preventive and interdisciplinary, and that is not easy to achieve in areas which lack resources.
The share of the already scant budgets intended for Health turn out insufficient, and the requirements of a society with educational and nutritional deficiencies are greater.
Reproductive health: unwanted pregnancy, abortion and AIDS; the inappropriate use of drugs, accidents and/or violence.
Pathologies that go beyond merely biological facts, due to their highly psychological and social implications. All social groups are affected, but each with characteristics of its own.
Unwanted pregnancy: and its consequence, abortion, imply a higher death rate in areas of fewer resources.
AIDS: as it is correctly said, affects *poorer, younger* and *more female* subjects every day.
And as to **drugs**, Latin American countries were traditionally considered as producers, or countries in which drugs were "*in transit*".Nowadays, unfortunately, drugs have reached our countries to stay. The decrease in the price of many substances has extended the use of drugs to the most varied circles. When considering the topic of drugs, several regional, social and cultural connotations must be taken into consideration and respected, since they bring forth consequences on health quite different to those expected, when regarded from another point of view. **Accidents**, formerly patrimony of developed countries, show an important increase in Latin America. Argentina reaches the sad number of 30 deaths per day, due to traffic accidents, over a total population of thirty five million. The higher speeds of modern vehicles do not match deficient road infrastructure.
The connection accidents-alcohol is the same here as in other societies. Teenagers and youths are a large proportion of injured Latin America bears an important share in another report of the Summit World. 150 MILLION children in the world suffer from deficient health conditions.
THE TRANSCULTURAL PROCESS The problem brought about by **the transcultural process** has an important impact upon the health of our teenagers and youths. The migration in search of sources of employment, both towards the interior of the countries as to neighbouring countries, is greater every day. The migration from outer rural areas to the

city originates **belts of poverty:** slums *(villas miserias)*, favelas. The communication media encourage a desire to acquire consumer goods and life styles unattainable for the majority of the population. The "American Dream" is also exported into Latin America, and if it can be considered frustrating in North American society itself, little can be said of what happens "South of the border".

VIOLENCE From all I have said so far derives one the main problems in the health of teenagers and youths: VIOLENCE. Our societies are more and more violent every day. As paediatrician I deal with recurring consultations from kindergartens. The reason, the child does not know how to defend himself. Children that have been brought up with affection in moderating homes (containing homes) face from the beginning of their socialisation violent components for which they are not prepared. It is as if there were no room for a healthy, non-aggressive child in the present society. Violence reveals itself in many ways: right from handling a gun, down to an irresponsible practice of sexuality, or high-speed driving.

CHALLENGES FOR THIRD MILLENNIUM

On the threshold of the third millennium, it is right to consider the various challenges that our Latin American society is due to face. Whereas human life upon this earth is computed in "*thousands of years*", machines as we know them hardly date back *two hundred years*. Development of science and the technology of the century about to end match those of no other period in the history of humanity. Therefore, the integration of *human factors* with the *progress* that has been achieved is far from being ideal. Teenagers of today will play the leading roles of the next millennium. Post-industrial society is already being forged by high technology. Automation is replacing many jobs, with unemployment as its main outcome. These advances, fruit of complex and costly investigations, will keep growing. As a paradox, our ***agro-exporting*** countries will find their incomes relatively diminished, in terms on exchange with ***technology-exporting*** countries. The consumer society will not weaken its pressure; it will be increased as a result of its necessity to place its goods. The breach between what is offered and the possibilities of acquiring it will grow larger, and this will lead to logical negative consequences.Development in communication media will keep "shrinking" the world. This takes place at dizzying speed. Nothing happening in the world can be ignored by the international community. This aspect will act as an important counterpart to the differences between rich and poor countries. Nations will no longer be able to regard what happens in any other country as something beyond their concern. True leadership will be based on the ability to foresee and circum-vent problems. Otherwise the solution will only lead to increased individual, regional and international violence.

This world-wide tendency to go back to *village kind of life* will have a strong impact on ECOLOGY. Man is no longer a lonely inhabitant of the planet. Large human *(settlements)* produce harmful effects of Nature. The balance is in danger. The heating of the atmosphere, the melting of the polar ice, the green-house effect, the nuclear waste, and so on, are only some aspects of what is really happening. Development of new vaccines will increase the

preventive aspects -immunisation against HIV is to be expected. Health costs will be greater and greater. Who will be able to pay for them? We can immunise against hepatitis A or B but the cost rises beyond $100. This is what high technology offers to a population with a yearly income of $300 per head. *Genetic manipulation* will create ethical dilemmas of increasing difficulty

PREPARING FOR THE MILENNIUM The magnitude of the facts so far may produce a paralysis or immobility fruit of panic;or on the contrary may act as motivator for change. The development of humanity must engender natural optimism. Very few years ago, the planet was on the verge of destruction. Nuclear armament had reached such an extent that it could annihilate life on Earth completely. When the fate of mankind rested on the push of a detonator,solutions formerly unimagined,came to mind. We professionals dealing with teens by virtue of our closeness to youth are responsible for their future and that of humanity. In answer our concern is to strive for:-

***comprehensive education** suited to future demands. Information grows so fast that encyclopaedic approaches must be left aside, with the certainty that however hard he strives, man will only be able to learn a tiny proportion of available knowledge.Creative potential must be stimulated, in a continuous educational process.

***adequate NUTRITION** answering the needs of young people and their idio-syncrasies. We cannot solve the problem of malnutrition of large populations but can achieve positive results by making better use of scarce resources.

* **individual responsibility** for own health and that of those around him. It is essential that man should value himself adequately in both respect and dignity. On this basis, all efforts should be directed to primary prevention,on individual and community levels.

* **ECOLOGY** in many communities, young people have a stronger conscience than adults. Humbly acknowledging this reality, we must contribute our experience and knowledge to it.

*An important contribution to health of youth has been provided studies on **RESILIENCE**.In the make up of the resilient being we find an important working tool. It is not a closed process but is open to the reality and present of the individual and society in which they are immersed

* **development of SPIRITUALITY** Throughout history man has given transcendental importance to spirituality. Professionals entrenched in western philosophy (dissociation of body and soul)maybe due to over emphasis on individuality have largely excluded the spiritual from health practice.

* The doctor patient **relationship** is essentially a human meeting, a vital encounter-as such it must not be undervalued.Reduced to the intellectual mere transference of information, little benefit is obtained nor behaviour modified. One of the richest, captivating controversial personalities in our times, **Teilhard de Chardin**, describes the human being as not created, but *in the process of being created*. There are few similarities between Stone Age cavemen and Modern Man. Today we would be ashamed of our ancestor. What characteristics will future man possess? If we work hard with dedication and passion for youth, we will have contributed without even knowing it, to take a step forward in human development.

Living on the streets - Health concerns of street Youth in Brazil

Irene Adams - Brazil.

We need to consider basic definitions. What we are talking about,how do we get information, to what use do we put that information What can we do for street children who are not just deprived, they are marginalised and not just marginalised but criminalised. You have no right to go out there and collect any information at all about them unless you ask yourself the question what do street children get out of this research? I have worked for the last ten years in Bello Horizonte where I have the clinica amor-for street children. Brazil has 140 million people. The state of Sao Paulo has 25 million and the city 13 million - its very modern and up to date any western business man would feel completely at home there - but there is another Brazil - a Brazil more like the Ethiopia we have heard about - from which Manny's immigrants come from.

My clients,the children of Brazil are those who live love and sleep on the streets. My clientelle - they go around in bands together. There are children on the streets and children of the streets. Children on the streets have a family of sorts to go back to at night - may spend the day on the street selling chewing gum-but he has a reference point, someone he might listen to who he respects. He is not my client, my clients are of the street. How many children? Any statistics you are given, figures are probably wrong - it is a dynamic situation - there are those coming into the pool and those going out- we do not know how many are on the streets at any given time.They come from poor neighbourhoods but they may bounce back and forth going back to another area or to a family when the police are putting on pressure. Some have come from rural areas with their family and some may come on their own having left their family in the countryside. The longer they stay on the street the harder it is to go back they lose reference and become part of the street. They may come from another city - from Rio the death squads are more active in Rio -our town is safer -drugs are more in evidence in Rio and cheaper and so when they find it more expensive here they will go back to Rio. The only people who care in general for these kids are church groups - many have no help from official sources. Until 1989 a child on the street would be taken from the street to a government institution, by virtue of the fact that he was on the street but now they have the same rights as adults so technically are allowed to be on the street - however if they are on the street and steal they can be arrested just like an adult can. This is a radical change - you won't find as many street kids in the government institutions now. Their role is being redefined. When do you count the kids if you want to find out how many - the best time is at night- but you will have trouble finding them - they are so well hidden, huddled together you can't tell how many are there or differentiate adults from children - if you count in the day they can get from one end of town to the other so fast- you can count them two, three four times. A survey found that 400 children were on the street - but workers were giving them meal

tickets and many attended several times,had 3 or 4 meal tickets at least 60 of 400 had been through the survey three times.

How about their health - speaking in the physical, emotional and psychosocial sense. There are massive queues for health care - people sleep in the queues-health care is very poor for these people in Brazil. With regard to health care for the street kids - I bring the clinic half way to them - but they have to come half way to me.There are many projects working with street chidlren - we work in Bello Horizonte together - there are more than 25 projects church projects, national street kids movement,city government projects and we all work together in an integrated way to deliver health care as part of this integration. We have different goals for different kids and different goals for different steps this child is taking. The model is like the twelve steps of Alcoholics anonymous - the first step is on the street. The goal when he is on the street- the Rua is simply - make friends with him see what his reality is like establish a trusting relationship -don't make demands of him - you have no right to - you can't set limits at this stage. But if he will come to my open house then I can offer him more - we can set some limits at that stage - to come to the open house he has to abide by our opening hours - has to arrive without being under the influence of drugs and if he's stolen something he's not allowed to bring it in - these rules were made with the kids themselves. With regard to my medical care,on the street I could offer just first aid but in the open house I can offer a broader range of medical interventions and work on medical needs - convincing him that they are of importance.

When he has been able to come to the open house - we hope he will be able to step up to a residential project - there he will have to accept even more limits. In addition to stopping drugs, he will have to keep regular hours, will have to study to prepare for a profession or job and medical care will have to change also - he will have to learn to use the government system. He's no longer on the street,he has to go to the health post and learn to exercise rights of using the government system from which they were excluded when they were on the street. Finally once they leave a residential project where they have daily supervision they move on to a hostel -a bit like a boarding house where they all have jobs and they share the rent and household duties and the function of the clinica amor is to refer them on- whatever their health needs are. Our motto is educating for life through health The clinic is behind the open house. At the clinic they need to learn to wait-wait their turn and not need instant gratification - like when they need something on the street and they will steal a watch - their records are also something which they can 'own' and they will be encouraged to be interested in their weight, height and share the information with the staff. Much of the information on the kids comes in their 'check ups' - they are pleased to be able to make an appointment, and attend for 'their' 'check up' - which is a sharing experience between the staff and the kids. The open house is run by the church - the church have no problem with the legitimate use of condoms - they

support AIDS prevention - the open house has broken glass in the windows because these kids have very short fuses, a problem can easily cause them to flare, break glass - hit your friend over the head with a chair - and many of the girls have babies. Body image is important to them - but they have no way of seeing their bodies - we have a mirror in the open house which they love to stand in front of - it has never been cracked! We do courses with the girls and sessions devoted to looking at being a girl on the street, being pregnant and being a mother.We teach hairdressing,sewing making things to sell in the market as an alternative to stealing. Success for me means that a girl can get off the street have antenatal care and then come and see me with the baby. Another street boy became a street educator - he went round in a van and made friends and encourage them to come in for care to a project. Street problems vary - in other cities prostitution is the norm, in our town the girls do not - it is not acceptable - they do not want to. In Rio the kids go hungry - the police is a heavy presence - in our town they are not hungry. Health care can be a bridge to these children - so that in the end it is the kids themselves who benefit from our intervention.

Attitudes and Practices of physicians in Israel regarding Adolescent Medicine

Dr Daniel Hardoff, Israel.

OBJECTIVE: To study perceived skills, practices and desire for training in adolescent medicine among paediatricians, family physicians and internal medicine specialists, as a basis for further developing the discipline of adolescent medicine in Israel.
DESIGN: A random sample of physicians completed a self-administered questionnaire sent by mail. It included demographic data and 17 items regarding attitudes and practices relating to specific topics in adolescent medicine. A total score (ranging between 0 to 51) as well as 4 sub-scores for medical, sexuality risk behaviour, and psychosocial issues were calculated.
RESULTS: 306 questionnaires were completed. 42.2% of respondents were paediatricians, 34.6% were family physicians and 23.2% internists. Their mean age was 45.2±9.6 years. 86.6% of all respondents treated adolescents. Family physicians perceived themselves better trained for treating adolescents (mean score 42.0±9.9) than paediatricians (37.9±10.2) and internists (35.1±8.8) $p<0.0001$. 98% of paediatricians, 97% of family physicians and 94% of internists desired further training in at least one topic in adolescent medicine.
CONCLUSION: Although the majority of the above specialists treat adolescents, they perceive their training insufficient and request further training in adolescent medicine. The national health authorities should therefore develop appropriate programmes to cater for the demands of Israeli physicians caring for adolescents.

'The Bridge' Semi-Independence Unit.

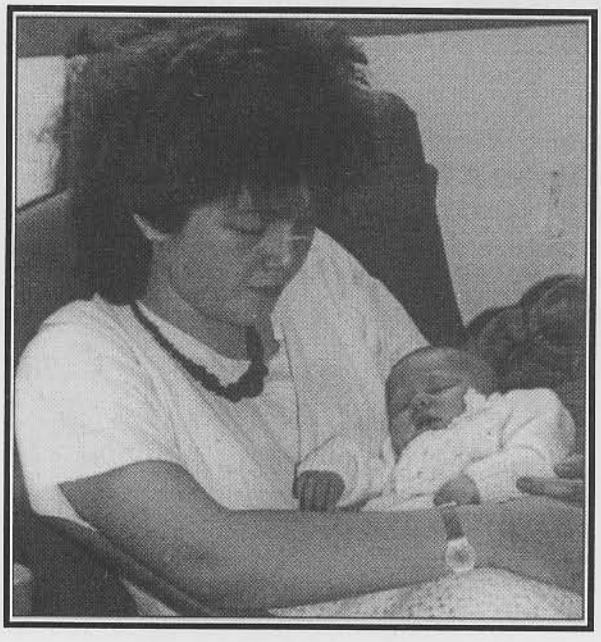
Leaving Care
Semi-Independence
Aftercare
Half Way House

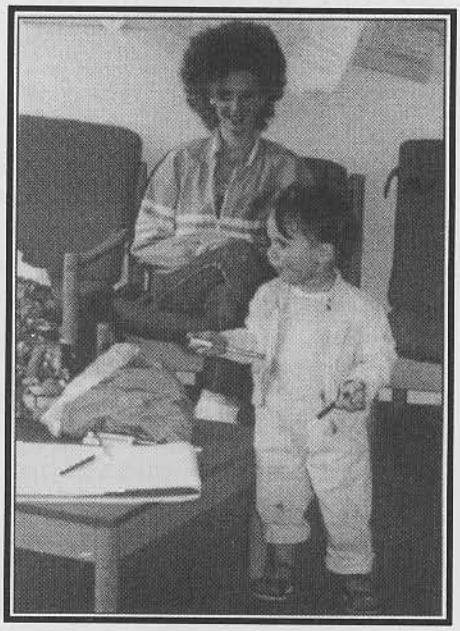
'The Bridge' provides accommodation and aftercare in our half way house, where individuals, couples or parents with children can be offered a semi-independent lifestyle. They are able to move on to their 'own flat' with staff available for support. The ethos is generally that of an extended family - like having an aunt to call on for support and advice. Clients also have access to the services of therapy, counselling and occupational opportunities run by the charity both in Beckenham and in Penge.

Accommodation is arranged in four self contained units and a fifth staff area accessible from the same common hall way. Units have their own gas and electric key meters to aid budgeting and there is a common pay phone.

Each unit consists of a 'bedsit' room, second bedroom, kitchen and bathroom. They are suitable for single occupancy / double occupancy / a couple with or without children / mother with baby or child / parent with baby and child.

"Finding your own place to live can be hard - and with a baby to look after too - I sometimes felt desperate..."





"I have never lived on my own and I was so scared. I needed to be able to call the staff at night... Now I have a nice flat and I can cope with my daughter - we're happy!"

Who is eligible?

Young people leaving care - their first step to independent living - Often young people in this situation find it hard to obtain suitable housing, they are both excited by and afraid of being in the outside world and they are unused to being on their own. Our units provide the opportunity for 'befriending' and support and there is also the possibility that two young people could share a unit.

Learning disability - Emotional vulnerability. - Those who for various reasons may be emotionally vulnerable or need a helping hand in living independently. Life skills education and 'empowerment' may be incorporated in their care.

Rehabilitation in the community - families or parents who have undergone an assessment and rehabilitation programme may not be ready to move straight from residential care to the community and there is a danger that much of the hard work done to help them achieve a measure of independence and self confidence may be lost by being exposed to the community at large. A 'half-way' situation with support and guidance is invaluable.

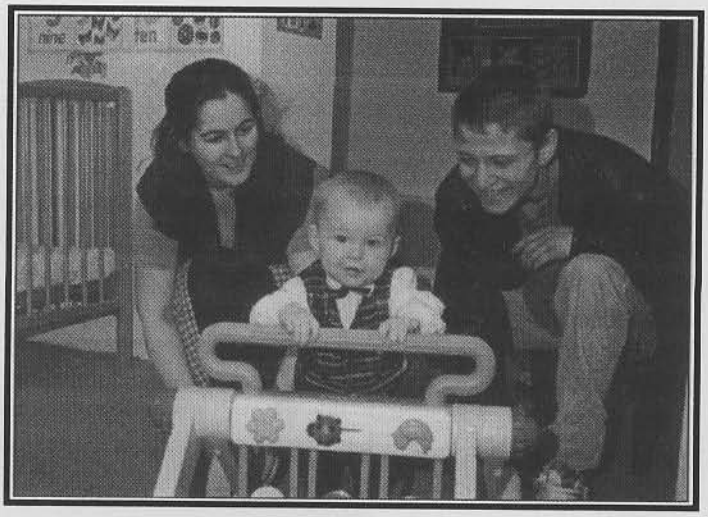
Aftercare / rehabilitation - Those who have undergone successful treatment or rehabilitation programmes such as substance abuse / alcohol will also be considered for half way house if they are substance free and committed to aftercare.

Child protection / monitoring - there are some families where despite a successful assessment and a positive period of rehabilitation, a measure of 'risk' remains. In such an event it is beneficial to continue longer term surveillance in a 'half way' house.

Levels of Service -

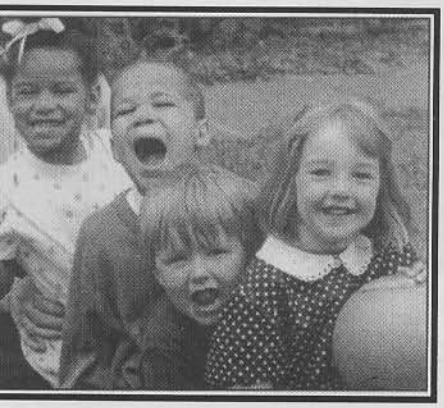
A. Semi Independence - with basic assistance. Staff calling in and staying for short time to iron out problems.

B. Semi Independence with high level of assistance. Staff on premises most of the time, helping with and teaching life skills, cooking, washing, shopping and assisting with parenting if required.



Also available as per individual requirements -

- Night staff - on premises throughout the night - or on call night staff.
- Therapy - group and individual - and support in attending self help groups (e.g. AA, NA).
- Child care and full day nursery service.



Referrals -

Referrals are normally made via social services or a similar support network. Occasionally applications will be considered from individuals or other voluntary organisations. We are a charity and hence keep fees as low as possible but we do need referring agencies to take responsibility for payment of fees and charges. A proportion of fees may be eligible for housing or other benefits - any such claims remain the responsibility of the referring agency.

Units of accommodation at 'The Bridge' are not intended for long term housing and it must be emphasised that this is a service provision - not merely a housing provision. Hence residents will not have tenancy of the units and will only be able to use the accommodation for the duration of the agreed placement.

Enquiries to -

The Manager
'The Bridge'
13 High Street
Penge SE20 7HJ

Tel - 0181 650 6296
Fax - 0181 659 3309

* YS - Substance Abuse / Alcohol Programme *

We are a residential unit providing care, assessment and treatment in **a therapeutic community** setting. The unit operates on a philosophy of **complete abstention** from alcohol, drugs and mood altering substances and residents and family members are expected to comply with this policy during their stay. In accordance with this policy and to aid patients in maintaining abstention we do monitor residents activities, agree on periods when residents will not for example be allowed out unaccompanied and regularly monitor items which may have been brought into the unit. We also may agree a regime of drug testing with a particular patient.

Family Work -

Placement at YSH provides an opportunity for the troubled parent 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 for example if the parent attended a drug rehabilitation unit whilst the child was fostered or cared for elsewhere. We also encourage family placements which again enhance bonding and cohesion within the family unit while also allowing the partner to receive treatment in parallel to the substance abuse programme followed by his or her spouse. Substance abuse and addictive behaviour causes a great deal of stress, unhappiness and disturbance within a family and within a relationship even if other family members are not themselves 'users'. It is important for family members to be involved in the treatment programme, to understand what their partners or parents are going through and to develop some insight into how they themselves have been affected by the addiction. Relationships often become highly 'dependant' and mutually harmful. **Family therapy** and **couples work** help us to address these issues.

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