"Youth - Our Resource for the Future"

Proceedings of the Conference on Adolescent Health and Welfare held on Thursday 24th October 1996

At The Royal College of Physicians to mark

The Tenth Anniversary of Youth Support

“Youth - Our Resource for the future”

First edition 1997

Published by “Youth Support”
13 Crescent Road
Beckenham
London BR3 2NF

Charity No 296080

All proceeds in aid of our work with families and young people

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Introduction

"Youth - Our Resource for the Future"

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

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

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

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

The afternoon choices were no easier - 'Teenage pregnancy and sexuality' chaired by Pramilla Senenayake (IPPF) and including the youth support experience of fifteen year longitudinal survey of school girl pregnancy, exciting presentations by Fay Hutchinson and other colleagues from the Brook, Pamela Gilles from Nottingham to name but a few - vied with 'Social and Behavioural challenges' including Christine Ferron from Lausanne presenting a study of

school drop outs, Dr Aggrey Burke on the challenge of race and Leon Polnay on the needs of young people in care.

The day ended with a keynote presentation ‘Looking to the future’. Dick MacKenzie (Los Angeles) had the audience visualising youth wandering through the ‘shopping malls of life’ picking and choosing experiences, risks and positive growth when they are ready - putting what you want in your own trolley.

We learned a great deal from the conference and perhaps the biggest lesson was that more people do have an interest in considering the needs of young people, there is a lot to learn , a lot to discuss and we need much more time! Hence our next conference will extend to two days and have alternative plenaries, workshops, posters and free paper sessions. Dates are 22nd and 23rd October 1998 at the Royal College of Physicians, London. I encourage your attendance.

Youth Support has flourished in the last ten years and the conference was a celebration of the energy, commitment and dedication of all our staff and friends - and particularly of our youth. Let us hope that we will continue to grow and serve young people for the next decade!

* * * * *

Opening Address - Roger Tonkin

Youth Empowerment: Illusion or Reality?

The New Oxford Dictionary defines empower as 'to give power to; to make able'. Since its inception ten years ago Youth Support has 'walked the talk' of what, in today's parlance, we call youth empowerment. The organisation's very name signalled the direction that its founder, Diana Birch, wished it to follow. It has not only been supportive to youth, but has actively involved them in its evolution. The imagery of liveliness, togetherness and interaction, and cheeriness dominate the Youth Support publications and are reflected in its day to day programmes.

But my question to you is, does that same ethos extend beyond individual programmes such as Youth Support to mainstream youth oriented services or even to society in general? Is what we celebrate today an illusion nurtured by a few outstanding programmes or a reality reflective of a shift in our social values concerning contemporary youth?

In our work with young people we find that they are quick to challenge us to show that we do care. They assume that we and the services that our programme staff provide are competent. Over the years Youth Support has successfully met that challenge thus justifying the confidence placed in it by it's young clients.

However programmes such as Youth Support do not operate in a vacuum and their future will be shaped by what happens in the larger system and the newer models that fiscal realities and organisational restructuring are thrusting upon our major health care institutions. We must consider, in a studied way, what will such challenges do to support youth and to foster youth empowerment within the emerging system.

Surely, Youth Support has a leadership role to play in this regard. Surely, in the coming decade, Youth Support must not only continue to show that it cares and is competent to serve the needs of its clients, but also that it is on the forefront of responding, in a youth positive manner, to the challenges of change within the larger system.

Let me suggest that over the ten years of Youth Support's existence there has been a paradigm shift within the field of Adolescent Health. We are shifting from a problem focused process to a resiliency based and coping process. The shift has been from an expert driven, medically oriented, disease club or

fragmented model towards a consumer driven, peer support, family based, health oriented, comprehensive or holistic model. Programmes like Youth Support have contributed, in a positive way, to that shift.

Countries such as Argentina, Canada, Finland, and Israel have been among the early leaders in the field of Adolescent medicine. However, the modern model of adolescent Medicine, is credited as being developed in the USA and largely due to the leadership and inspiration of the late J Rosewell Gallagher. The American model has been exported to many other countries. More than fifty countries now have some form of Adolescent Medicine initiative.

The model, while exemplary in many ways, is not totally transferable to other countries. You have but to look to the examples of it being developed here in the UK to see that the model is being adapted to fit different cultures, different health care systems, and different youth health needs. Indeed, some exciting work on adolescent or youth health is going on at centres in London, Nottingham, Oxford, Glasgow to name but a few.

As the numbers of countries and centres within countries with adolescent health programmes expands and the involvement of international bodies such as WHO, UNICEF, IPPF and UNFPA grows it can be predicted that the traditional medical model that we have long accepted will have to shift its emphasis. Indeed, we have much to learn from the approaches being employed in other countries.

I believe that the model will move towards a more supportive but competency based network of programmes that not only treat disease and injury and promote adolescent health. It is my impression that that is what more holistic programmes such as Youth Support have tried to do. It has tried to practice what others sometimes only preach.

As we move from an expert driven to a consumer driven model we will need to know what the consumer thinks about health and health care. What does health mean to youth? Is it an issue for them? Research on adolescents that actually asks adolescents what they think about their health and their health care needs and concerns is beginning to emerge. For example, a recent study in the UK revealed that adolescents, especially the younger ones, see family and peers as the principle sources of help and guidance while health professionals are much further down the list.

Indeed, UK youth differentiate between the listening style of approach used by family and friends and the lecturing or preaching style employed by most professionals.

This is what individual adolescents or youth tell us. Each of us can listen to their messages and adapt our individual professional practices accordingly. However, that does not necessarily shift the larger system.

There is also a need for broader population based information about the determinants of youth health. the Health Education Authority here in London is to be commended for its recent initiatives on behalf of understanding the health perceptive of the broad population of youth in the UK. In my own province, we too have studies adolescent health status and risk behaviours. The data, generated from the replies of some 16,000 grade 7 to 12 students, has been released to the public and to youth in each region.

We have been able to identify important regional, age, and gender based differences. There are differences in health and behaviour based on ethnicity, presence or absence of chronic conditions, and sexual orientation. the data is very powerful, especially when presented publicly in a positive, non-judgmental way. In our province it has heightened awareness of the needs of youth and is promoting an important shift in how we respond to those needs.

The results of our own survey are revealing but not necessarily international news. The topics covered in today's conference are the very same health topics or problem areas that youth in BC identified. They reflect the new morbidities and are primarily issues of lifestyle. They can also be addressed by promoting behaviour change and introducing preventive strategies such as universal Hepatitis B immunisation, safety helmet legislation, or tough drinking-driving enforcement.

To be effective, these measures must be accepted by youth and be regularly practised by them. For this to occur, we must help to make them 'able'. For this enablement to happen youth, as a group, must be involved in identifying priorities, proposing solutions, designing implementation strategies, and evaluating the results. They need to feel part of the response process, not just the object of it.

With new information about the perspectives and needs of youth at our fingertips we are still faced with the challenge of what to do about it. The expert driven system would respond by designing a system, lobbying for money to implement it, and then put a multidisciplinary team together to work on how to use the less than adequate funding that government then provides. There would be no money to evaluate and little time to ask youth or families if it was working. This is part of the dis-empowered reality facing today's youth.

A consumer driven model, on the other hand, would respond by getting together to solve the problem with the resources available and decide how much of it they could do for themselves. Self-help, peer counselling, indigenous worker, consumer advocacy groups are but a few examples of the multitude of important initiatives that have emerged within recent years. They too are rarely evaluated. They certainly are more humanising but do they really influence outcome or merely contribute to the illusion of offering a more empowering service model?

While we have learned a bit more about what youth think about their health. We have much to learn about how to convert that knowledge into a more empowering model. In my country there is a trend towards increasing youth participation in national conferences and consultations about health care reform.

At provincial level a new system of regionalisation of health services is being introduced and youth are being invited to participate in a variety of advisory councils. Our Premier has established a youth office within his own office and is focusing on ways to create educational, recreational, and employment opportunities for our young people. In each instance the same questions arise. Who speaks for youth? How do we get a youth to sit on our committee? How do we engage youth in a meaningful way? What powers or authority should they be given? What is a Youth?

We have been trying to address these questions? It is not an easy process and we are finding that there are a lot of pitfalls. However, we are convinced that the process of answering them will help us down to the path towards a less illusory youth empowerment process and the ultimate goal of helping them to realise their maximum potential and health. What have we learned so far?

Firstly, that it takes longer than you might think or wish (years not months). Secondly, to be wary of political pressures for quick fixes and instant solutions. Thirdly, to trust in the good sense and positive motivation of today's young people. Fourthly, to learn how to see the world through the same positive lens as do most youth and see the challenge or opportunity in each situation. Fifthly, to find ways to provide youth with the skills and supports they need to participate, in a meaningful and enriching way, in the shaping of a youth positive society. those ways include focus groups, training workshops, information packages, theatre, music, and art programmes, and, of course, the creative use of the electronic highway. Sixth, we must always remember to laugh together and maintain a sense of humour.

I believe that a Youth Positive Society is one that values youth, ensures that they are empowered, and respects their rights. to create such as Society we need to work together to shift the youth health paradigm even further towards a new

form that fosters intergenerational collaboration and problem solving, promotes more effective networks between youth and youth serving organisations, and creates a caring, competent system of youth friendly human services.

It seems to me that as it celebrates the decade past and looks to its future Youth Support is well placed to play an important role by contributing its energy and experience to the task of helping individual youth but also by involving youth in guiding the process of redefining the model.

Mental Health and Behaviour Problems -

Chaired by Professor Eric Taylor

Bonnie's story - read by Laura Clarke.

Peter Wilson - "What is mental health in Adolescence"

Dr Troy Tranah "Juvenile Delinquency"

Dr Ueli Buhlmann - "Emotional Issues in Therapy"

Professor Patrick Alvin - "Teenage Suicide - a challenge to common ideas"

A personal story - Carol Kremer - A Story

Bonnie's story - read by Laura Clarke.

This is not my story … but it could have been. It is an example of a young person not receiving help. This is Bonnie's story and the book "The Child that Rocks the Cradle" is dedicated to her.

Bonnie's Story ....

"I think Mum must have sent you ..."

Danielle looked so uncannily like her mother that it was difficult at times to make the mental adjustment ...

Bonnie had her problems at school. ... She never really liked it and missed as much as she could, often slipping back home in tears. She was a sensitive but troubled girl, bullied by the stronger pupils and easily led into situations she could not control.

Throughout her life she felt she had to 'fight for herself' but was often too 'straight' about her feelings and actions - she could not be devious - was too 'up front' and so when manipulated and led into trouble by others - it was often Bonnie that took the blame. She was branded at school as a trouble maker even though it was usually other people's trouble that she fell into.

Like the time when she was ten years old and bullies stole her gold cross and chain - ripped it off her neck in the playground - and later stole her best leather coat - the one her mother had saved up for months to buy. They threw it in a bin. When this was reported to the headmaster the other girls denied it and Bonnie was blamed with making up the story. The head actually had her stand up in assembly , before the whole school , and told the children "I do not want any of you children playing with Bonnie - she is a thief and a liar!" Hardly a helpful strategy to support a troubled girl.

And there were troubles at home ... Mum stuck up for Bonnie and did what she could for her but she had problems of her own which preoccupied her and took up most of her time. Like raising her four children and another she 'took in' .... without the support of a man around the place. She wanted to help Bonnie, but was left lost not knowing what to do for the best.

Ivy is a very genuine, warm and caring woman - very down to earth and a staunch supporter of her family. If anything she is a 'bit soft' with them - always ready to jump in and help out - the sort of woman who has always been

surrounded by children and those who need her readily supplied love and affection. Bonnie took after her in many ways - she too was a bit soft and cared too much for others - often not thinking of the consequences for herself. Danielle is very much like that too ...

During part of Bonnie's early life her Dad had been 'away'. He left when she was three and was not released until her thirteenth birthday. Then he came home for the last time .. but in total he had spent thirty five years of his life in Jail.

Bonnie took her father's absence particularly hard and missed him deeply ... while Mum took some comfort and support by being active in the 'Circle Trust' - the prisoners' wives organisation.

Sadly, once a child becomes 'type cast' as a trouble maker, that reputation follows them in school reports and documents going from one school to another. So Bonnie's 'reputation' proceeded her from her primary to her secondary school. She was misjudged in secondary school with serious consequences.

In secondary school bullies are bigger and stronger and their actions can be more violent and extreme. Bonnie had begun to try to fight back by this stage. An incident arose when she was attacked by another girl and a fight ensued. Both grabbed hair and some strands came away in their hands. The strands of the other girl's hair which were found in Bonnie's hand, were put in the school safe 'for evidence in case Bonnie is taken to court'. Never any mention of the part the other girl played.

Another incident at the age of twelve had more sinister repercussions. Bonnie felt unwell and fainted on the school steps. She was told off for play acting and told to stop it and get up. She tried to pull herself together but could hardly stand, she was feverish and had severe stomach pains.

'Oh the trouble maker again .. there's nothing wrong with her ..'

After many protestations she was taken home and eventually to hospital. Again her reputation proceeded her and it was some time before anyone would take her seriously. Nurses, junior doctors and more senior doctors pronounced her as having 'a stomach bug' 'gastro-enteritis' ...

'Take her home' Ivy was told.

Thankfully she did not but insisted on the consultant being called. ... In the operating theatre some hours later Bonnie's appendix was found to have burst

and she had raging peritonitis. This infection laid the ground for the abdominal pains and adhesions which Bonnie would suffer from in later years.

The school rang Ivy the following day saying that Bonnie would be disciplined for defying the teacher and pretending to faint on the stairs. Ivy put her straight!

Bonnie never learned to read and write properly and certainly missed any sex education lessons that there might have been in her school. In later years she was quite saddened by the lack of support and education which she received and felt left out by her lack of reading skills. Other girls might be able to read leaflets and contraceptive advice ... she could not.

Bonnie's life reached a dramatic climax when she became pregnant. At the time she realised this, she had been going out with by an older mentally disturbed man. Bonnie never really understood why she went with him in the first place ... it was just one of those acts of rebellious bravado which you recognise as a huge mistake right from the word 'go'. ... but he discovered that she was pregnant and abducted her so that she could not have an abortion, and would be forced to give birth to the child who he claimed was his.

For eight long terrified weeks Bonnie was held captive in a squat in Margate, a seaside town, empty and windswept cold out of season. The police had been alerted and family and friends were searching for her .. He did not give up without a fight and finally it took a police raid to rescue her from hell.

... Some years later this highly troubled and intensely violent man murdered his wife and then , afraid to face the consequences, committed suicide.

"Every day he scared me half to death ... he said he wanted to make sure I was all right and that the baby was growing OK but I don't know how I survived it. He never let me out of the flat ... I thought I was going to die. He said he would kill me if I didn't have his baby and that he would blind me so that I would never be able to see the baby after it was born. When they got me out of there I was a wreck ... I never thought I would get over it and I was so worried in case the baby would be affected. Anyway .. my family helped me a lot after that and then I had a boyfriend who was good to me ... he was a good Dad to Danielle and we had everything we needed for a while ...."

The golden haired little girl was doted on by the family who fell over themselves to do everything they could for her. Bonnie was besotted with her daughter and never once regretted having a baby when she was so young.

Sadly, for Bonnie relationships were not so easy .. Bonnie married and divorced .. . and married again ... and separated ... she never really found the support that she looked for or deserved in a man. Her father cared deeply for her and has been her staunch supporter since he returned home .... but Bonnie never really filled that gap caused by his absence while she was growing up.

Bonnie's real problems began when the stresses and anxieties of her life caused her childhood asthma to return with a vengeance. She spent weeks and months in and out of hospital, placed on stronger and stronger drugs.

She had not had a comfortable relationship with the medical profession. It was yet another case of a false reputation having been built around her. Even when I had first seen her in her teens I was warned about this 'awkward, disruptive girl' involved in dramatic situations of her own design. - I found someone quite different - a sensitive, vulnerable girl who sometimes did seem to attract problems like a magnet, but who was not a natural trouble maker.

"Sometimes I think they don't take me seriously. I have been ill so may times ... and often I get a lot of pain. Nobody really explains things to me properly ...."

This was her plea when, beset with gynaecological complaints and stomach pains, she begged for a full medical investigation. Again she was thought to be exaggerating her symptoms and perhaps partly making them up. Again she was vindicated by a last minute operation which found adhesions from her past appendix problems had caused internal complications.

Perhaps it was true that Bonnie's problems were partly psychological - but in that case did she not deserve help for her emotional problems .. for her anxiety .. for the depression into which she slid from time to time?

... perhaps a lost, frightened, young girl needed to be listened to and reassured. Certainly her symptoms were probably exacerbated by her anxiety ... but however you look at it ... Bonnie was in genuine pain.

Sadly Bonnie's health went from bad to worse. A defective heart valve sent small blood clots through her body making her suffer a series of mini strokes .. almost un noticeable at first .. causing a period of deafness, loss of balance .... some transient symptoms which were regarded as malingering before their significance was realised.

She was placed on stronger and stronger drugs. .... These had side effects which made matters worse. Steroids ballooned out the once pretty face.... her body became distorted and bloated. Eventually infections weakened her to the state where her frail body could fight no more.

Bonnie died on 10th October 1995. She was twenty nine years old.

When we made contact again with her daughter Danielle, she was angry and bitter. Acting out angrily at school and at home.

A young girl very much in danger of slipping into the pitfalls that beset her mother ... so alike ... so bereaved. Bonnie had collapsed and died at home just after Danielle returned from school. The young girl had given her mother mouth to mouth resuscitation in a desperate attempt to save her and was left sitting in a chair 'talking to Bonnie' and clutching her night-dress. When an aunt tried to get her to move she shouted at her to go away. -

"I was so angry. Why should she still be there and my Mum gone?. They told me she died in the ambulance .. but I knew it wasn't true. I knew she was dead at home .. I could feel it. ... I said to them 'Why are you taking my Mum?' I wanted them to leave her with me.

But now that's Mum's gone I often think - 'How am I going to do it on my own, without my Mum?' .... but it's OK now ..."

"Do you think it really is OK?"

"No. ... It isn't. .... It isn't OK"

Danielle lives with her maternal grandmother and grandfather in a small but happy household where she is able to keep her pet rabbit and lumbering Rottweiler dog. .. But living with grandparents is not the same as being raised by parents ... a pension does not go far towards buying teenage fashions and sometimes the generation gap is just that much too wide ...

Life has been hard ... thus the remark .. "I think Mum must have sent you.."

Perhaps she really did .... Danielle has responded to some attention, to being remembered, and to remembering us ... to seeing her mother talking on a video clip of a television news programme ... one of those perennial programmes when people are asking "....what can be done to stem the flood of teenage mothers?"

When really the question should be “What can be done to *help* teenage mothers?”

She cared to the end ... even to planning her funeral service .. she knew she was dying and wanted her family to suffer as little as possible. The songs she chose for the service were “I will always love you” ; “You’ll never walk alone” ; and “One day at a time, sweet Lord”.

She then asked that the congregation leave the church to the strains of “Always look on the bright side of life” . Very ‘Marty Pythonesque’ and very Bonnie!

Danielle is a credit to her Mum and I am proud and privileged to have been able to share their lives a little .

.. I wish I could have done more.

Bonnie’s story is the only story in this book that is unchanged - names are original and facts are as they happened. I asked the family if they wanted it changed to be anonymous or to keep things confidential and they said -

‘No, Bonnie would have wanted it told straight - how it is!’

Which is what I have done.

* * * * *

Peter Wilson - What is Mental Health in Adolescence?

I want to talk very briefly about what is mental health in adolescence, that is my simple question to you and in fifteen minutes I hope to make it clear. Basically mental health is not mental illness, surprise, surprise! I am going to talk about it in relationship to young people, to adolescents, and just think about the kinds of problems they have.

The title of my talk is extremely important in terms of the title of this conference. Youth being a resource for tomorrow. The essence of mental health, is about emotional well-being, it is about the capacity to learn, the capacity to relate, the capacity to enjoy relationships, it is about the capacity to be surprised, the capacity to be imaginative, I could give you a long list of capacities. But if you add them up, if you listen to every one carefully, it is really what I think you would hope you had or your children had and your teenagers had. These capacities that the human being has to learn, to live, to relate, to grow, to find out, to contribute, to give, and so forth.

That sounds like a rather idealistic set of terms, and of course nothing is as easy as it seems. If we had further time, for discussion, and got down to the nitty-gritty of what you think a mentally healthy adolescent looks like or is, we would have a lot of discussion, and it would clearly vary a great deal according to where you come from, what your culture is, what your background is, what you value, how you think people should live with each other in a society, what you think the relationship is of this life to another life. All kinds of things come into the way of how we consider what is good for people to live and to live with each other. The worry about talking about mental health in that rather idyllic way is that we can become rather moralistic and holier than thou and think that all mentally healthy people are like me and all mentally unhealthy people are like you. There is a danger of becoming very narrow.

Mental health is more than the absence of mental illness, mental health is about health. I want to try and broaden the concept out, so that is isn't just the province of psychiatrists, shrinks, people down the road that we can forget about. Mental health is about the soundness, the well functioning-ness and the robustness of the mind. That is all it is, and the mind is how we feel, think, anticipate, remember, and so forth. So, I want to try and capture the sense of a healthy mind. A mind that is actually functioning on all cylinders, using all the capacities that are there.

Now, in the same way that we talk about physical health, none of us have wonderful physical health all the time. We've all got our dimples, we've all got

our pains, we've all got our worries about our bodies. None of us feels absolutely marvellous all the time - we might be today, but not tomorrow and so forth, and similarly I think it is the case with mental health. We must not be looking for perfection all the time, but just for that kind of capacity, that readiness, that sort of strength to make the most of a given day, a given circumstance. So, I think it is very much about the capacity of a person, of an adolescent, to cope with the pressures and the anxieties that he or she might have. That is what it is about, mental health is measured according to these coping capacities.

Now, let us just think about young people. You know them as well as I do, you know them in your families, in your work load, and you know them in yourselves. You all sit there, looking very adult, but in fact there are all kinds of young bits, childish bits and adolescent bits there, so don't pretend that we are talking about people out side. Let's think about yourself and what you remember. And think about the pressures and anxieties. I think there are two ways of thinking about it. I think there are a lot of very strong, powerful internal pressures, which all young people of all kinds of shape, size and whatever go through.

They have to come to terms with their bodies. And I am going to give a sort of elemental, sort of mini-lecture on adolescents for a minute, the body, puberty, the changes, the impact on the mind, secondary characteristics, menstruation, emissions, the capacity to impregnate, to be impregnated, all of those things, first time, big, big for a young person, body growing at great rate. That is the fundamental task of adolescence, to come to terms with all that, and all of the sensations, all of the fantasies, and whatever else, which are aroused by that, and get to some sort of adult state, - (we will not discuss in 15 minutes what is an adult) - when you get to a state really where there is a capacity to relate comfortably with ones self, with ones body and relationship with others.

The other task is to establish a sense of identity. To be able to get a sense of oneself as a distinct human being, separate from ones parents, able to stand on ones own two feet, and take some kind of responsibility for oneself. That is a big, big task. I have said it very quickly but I think that they are the two key tasks, and some how coming to terms with the limits of what one is able to do as an individual.

These are things that all young people are struggling with internally, and I think it is taking them longer to do these days than it was in say, certainly 100 years ago. Puberty arrives much earlier, which is, I think the onset of adolescence, and in these days where there is so much more economic uncertainty, so much more unemployment, so much more difficulty for young people to get their

niche in society, I think that adolescence is prolonged. I think there is now about 15 years where people are going through this adolescence, where they are going through a period of youth, before they can be something more than that. So, I think it is a combination of these internal pressures, and living in today's complicated society.

It is very difficult really to figure out how you are supposed to be these days. The media is enormously powerful, we don't know the half of it - what it's effects are on young lives. But enormously powerful images, knowledges, what ever else, come through the television, the tube, the super digital highway, a mass is coming in. We are living in a time when families are also changing so it is very difficult to get a sense of what a normal family life is. I have used the word normal for the first time, I thought I would try and not use it in my 15 minutes, but it is very difficult. What is normal? What is not normal? These kinds or pressures, issues about gender, changing notions about role and so on. So you have young people struggling to find an adult self, with these basic teenage anxieties, in the context of a society which has a lot of uncertainty and change built into it. I do not want to sound alarmist because I think the majority of young people, say three quarters of young people in this country get by pretty well. They live fairly lively, interested, good lives, they have a good laugh.

I have been very moved recently, reading a piece of work done by some people in Scotland about health promotion, they did a fairly large survey of young people's attitudes, they had about 4,000 people in the survey, and it was very moving to read about how young people essentially talk about they mental health status. They feel ready to take on the challenges, they get up and they want to go to school, they enjoy school, and they like their friends and they can't wait to find out what is going to come the next day - there is that forward movement, there's that readiness, there is that capacity to have a real good laugh, which is I think a very appealing feature. And they know what they value. School matters a lot to them, family matters a lot to them, i.e. schools that care, that respect, that stimulate, and similarly families who have been backing them up for years. Friends mean an awful lot, friends come up top of them all. The capacity to have a friend it a measure of mental health.

There are a lot of young people who do not kind of positive kind of living, and find it difficult to have friendships because they are envious, or because they are so sensitive to feeling rejected and neglected, and they live in their adolescent isolation with a great deal of distress. I was very struck reading this survey, which had really taken my imagination, because what comes across is young people talking about themselves and their lives and what matters to them and so on. One of the key things that comes through so strongly is the diversity of

feelings that young people feel. There was one young person who put it very clearly, it is a very ordinary statement, but it is very straight-forward:-

'Some days I feel trapped. Homework sometimes gets on top of me, but I still find a way to do it. Some days I feel great. I play football, and if I am lucky I score a goal. And sometimes, some days I just can't be bothered. Some days school is great and it goes in fast. Some days, it's rubbish and very, very, very slow. Some days the teachers seem to be on your back. Some days they seem to help you a lot. Some days I am angry at my sisters, and some days I don't want to annoy them at all.'

Simple ordinary statement. But what a mixture, what a buffeting about. Some days. You could sing a song, not 'Yesterday' but 'Some days'.

Another one said:-

'Today I don't know how I feel. I change every five minutes, my life is very weird.'

And another one says, and this is even more to the point:-

'I feel quite depressed, but happy today'

So it is not surprising that another one said:-

'I keep on asking myself questions and wondering if I am normal or not'

I think it is a big question, what is normal? Which parent thinks which kid is normal and so forth. It is the capacity really to tolerate that kind of perplexity, that contradiction of emotions, that kind of buffeting around from one day to some day to all the rest of it, the capacity to tolerate that, bare the anxiety of it and somehow create from it which I think constitutes the core of mental health.

So the big question is, how do you cultivate it? Well I think we know how to cultivate mental health. It is very easy. You love your kids from the word go, and you care for them and you contain them and you protect them from abuse and so forth. And we could speak more about that. But the trouble is there are a lot of youth that don't get that kind of background, and they feel very frighten and very angry, and tormented by their feelings, to the point where they really cannot function and either they withdraw into themselves and become very isolated, loose themselves into drugs, or they become very angry, defiant, or they become suicidal.

There are all sorts of ways in which young people can tell us that they are not feeling healthy mentally. And I think that those young people, and there are many, many of them, I said that three quarters of them are 'OK', which means really that there are about 7 million kids that are 'OK' in this country, but maybe 2 million kids are not 'OK'. The NSPCC this week said that 1 million kids are being abused. People say 'really, one million?', but that is only one in ten. There are an awful lot of young people, however, who are stuck, frightened, terrified of themselves and the people around them, and they cannot get to the mental health status that they wish. The majority of them are not mentally ill, they do not have a major disturbance in their reality testing, in their feelings about their bodies, their image and so forth, but they do have significant mental health problems in the sense that they don't have the things which I think define mental health.

Some of them tell us, some of us show us that they are in distress, in the way they behave and their symptomatology says to us 'help'. Others are resistant, they are too ashamed, they are too frightened, they are too untrusting, and they just push people away. The great challenge to us all in this business is not to be pushed away by young people, who may want to conceal their distress, but to stay with them and to try to facilitate them to live mentally healthy lives.

Dr Ueli Buhlman -

Emotional Issues in Therapy

Dr Birch has kindly given me a very open title. I would like to talk to you about the treatment in our hospital for young people with Psychosomatic illnesses, but I am not a therapist, I am in fact a paediatrician and our hospital is not a psychiatric institution. Young people that are admitted to our hospital are usually in some sort of pain - so my talk is might be entitled … 'when the stomach hurts, but the soul remains silent'

Although we have heard probably the most fascinating case story this morning, I would still like to give you two case histories as well.

The first one is about a young girl, aged 16. According to her chart from the surgical department, family history and patient history have been unremarkable. At 16, Margaret had been admitted with a history of acute abdominal pain. The medical work up led to a diagnosis of acute appendicitis and the patient underwent an appendicectomy. The operation and post-operative care were without problems. About three months later Margaret started to suffer abdominal symptoms again. On several occasions she was examined and constipation seemed to be the cause of her pain now. Never-the-less, six months after her appendicectomy, the patient underwent another surgery intervention, this time it was laparoscopy for endoscopical division of adhesions. After the second surgical treatment, Margaret remained well for about two weeks. Then abdominal pain re-occurred that the patient was seen repeatedly at the unit. It became obvious that constipation was not the major problem, but the surgeons could not find any pathology, so finally Margaret was admitted to the paediatric ward.

At the age of 16 , Margaret is a good example of what can happen when a patient is referred from one department to another - in her case from adult surgeons to the paediatricians. On referral to the hospital we run into the first problems, and that is why I have used the particular age of 16. Because that is where, by tradition, paediatrics ends in our country. So anybody who is around 16 years old, is sort of not a child any more and paediatricians, if they do not find anything tend to refer the patient to the internal medicine department. They usually say that the young woman or man are now grown up. After a while the internists are just as frustrated as the paediatricians were before, and usually the patient is referred back to the paediatricians and so on back and forth with this game between departments.

Another case history. - Christine is a 15 year old with an unremarkable history up to the age 14. Then she decided to get rid of some of her extra pounds as she put it, to explain the fact that she was eating less than usual. As the change in her appearance was evident, teachers had the school psychologists involved. Although Christine started regular counselling and although she seemed to get better, she continued to loose weight. Her parents, more and more worried, decided to get another therapist, and even agreed to be involved in family therapy as well. To cut this long story short, Christine was finally admitted with a weight of 31kg with a height of 167cm.

What I wanted to show with these two examples is that there are many patients, and in particular adolescents, where it is very difficult to say where they belong. It is also very hard to make a choice of one way or another. Whenever we do not know which way to go in Paediatrics, we go back to the large text book on paediatrics, and that is what we did. I would like to quote a few things from Nelson's text-book on Paediatrics which is the widest used book for paediatrics - a short of gold book. The 1992 edition which is now in use is a volume of nearly 2,000 pages. However, there are only 4 paragraphs on page 57 and 1 on page 58 about psychosomatic disorders!

'Any kind of emotional distress may be associated with any type of psychosomatic disorder in a child or adolescent. Particular types of feeling or conflict do not produce specific kinds of psychosomatic illness. There appear to be both innate constitutional vulnerabilities and environmental factors, neither of which are well understood that determine why one organ or system becomes dysfunctional rather than another ...' - I could go on, but as you can see it is of little help in dealing with the increasing number of adolescents which are being admitted to the hospital with psychosomatic problems.

We have tried to define the basis of work with young people suffering psychosomatic symptoms and have produced the following working definition. *A trauma, which exceeds the actual capability of being worked on, or a psychological disturbance which has been in existence since earlier childhood which has found it's somatic outcome in disease.* This is a very open definition but as you will see, it helped us to find an approach to treat people better.

In Switzerland, except in a few hospitals, including our own, there is a real gap in care for people of between 14 and 16 with not enough psychotherapeutic institutions for adolescents. Because there is no structure to take into account the health care needs of young people, we have difficulties in education and training, not only for physicians, but also nurses and all the medical professionals. Along with the problem goes, the difficulty of people seeing their position within the hospital, and because of the lack of tradition for adolescent

medicine or adolescent health care, we face a situation of feeling that we are still living in a developing country. Nevertheless, although there are quite a lot of obstacles, we decided to still try to work with these adolescents, and I would like to show you the three principles that we use as a base for our daily work.

1. The first principle is that adolescence is an age during which there is much displacement of psychological problems. This means that the psychological approach to the adolescent is always difficult. Body changes, during puberty, and the difficulty of accepting them, can lead to a very great insecurity in the patient, and it is this link between the psycho-social changes and the psychological problems in response to puberty changes that links somatic and psychological issues so close together.

The tendency of splitting will influence the behaviours on the ward, making the work difficult as sudden mood changes or even an attachment to particular nursing staff or another patient, may make the work more difficult.

We react on two levels. We work in a very structured setting, most of the time using contracts in terms of a therapy plan. And at the same time we give them enough flexibility, and remember it is a paediatric ward not a special adolescent unit so we need to ensure that they still feel comfortable and at ease as young people in a paediatric setting. And the second and most important thing for us is that we have a very tight schedule with frequent team meetings.

2. Principle number two says that when the soul remains silent it is the body that speaks. The more difficulties adolescents have in talking about psychological problems, the more they will be prone to react with their bodies. The consequences in our work are the following. We carefully monitor our steps on somatic evaluation. Which means that we always think that we might reinforce the tendency to somatisation with our investigations. This translates to an approach where we really discuss step by step whether X-ray or lab work should be done at a certain point with the psychologist in the team.

Instead of confronting the patient verbally, we use other techniques. Techniques which could be summarised as creative therapy, like painting, sculpture and so on and we have made the experience that very often within the team discussing the therapists that does this kind of work will bring in key issues for further discussions. We include the physiotherapist, in particular in the treatment of the patients who have anorexia nervosa, very early during the course to try to work on that somatic perspective of psychosomatic disease.

3. Finally our third principle is that the displacement of the somatic level can be caused by different psychological disturbances. We do not approach the

classic psychosomatic disorders like the intestinal problems or others, but we try to use our way of looking into patients personal issues for all the adolescent patients who come into the ward.

Based on such as perspective, we left the traditional patient/doctor relationship behind and replaced it with a team approach - with a psychologist, physiotherapist, nursing staff, teacher (who also acts as the person who does the creative therapy). We have found that our team approach has already proved to be a big advantage in comparison to the traditional setting. We carefully monitor the patient on a comprehensive level, we have very frequent team meetings and we have strict settings and flexibility for the young people. The goal is that when the patients are discharged from the hospital they are still very much individuals but look happy and hopefully are in good shape again.

Troy Tranah - Juvenile delinquency

What is Juvenile Delinquency? The term is not in fact medical at all, but a legal administrative term, and given it's reference it is tied very much to an age range from 10 to 17, and so a juvenile delinquent is a child between those ages who has been found guilty of an offence. I guess the Jamie Bulger case highlighted the fact that for the earlier age group from 10 to 14 there are issues around the individual knowing they have done something seriously wrong rather than just naughty.

It is not easy to have a clear cut line between delinquents and non-delinquents. Researches, such as Farrington in Cambridge and others, have often come up with figures such as around 80% of adolescents have committed a criminal offence, so it is a majority of the population have committed offences, but yet not all of them have been caught, so not all of them get the classification of delinquent.

Just to give you a picture of how many people are indeed breaking the law, you can see that for the youngest age group 1,200 per 100,000 in the 10 to 13 age group have been found guilty or have been cautioned. (I should say that these are indictable offences, that is the more serious types of offences which usually go to crown court - not the summary offences which might include the less serious offences such as motoring offences etc.) Delinquency rate comes to a peak around the age of 17, and you can see that for the 17 to 20 age group there is a roughly equivalent rate of offender. It drops then drastically from the early 20s onwards. It is coming up to 17, and this is partly that someone cannot be found guilty of an offence before the age of 10, but then after the age of 20 there is really a marked decline.

Within the adolescent groups there is a clear chronic offender group. The Farrington study that looked at adolescents in South London, found that less than a quarter of the convicted youths were responsible for half of all the crime in that particular study.. They also found that there is a continuity in those who are offending earlier which gives us the picture that those who are offending earlier are do have the worst outcome. Of those convicted between the ages of 10 and 16, three quarters were again convicted between the 17 and 24 yrs age span and half again in the 25 to 32.

Moving to the causes of offending, I am just going to look at two psychological theories which might explain offending, this morning.

Reinforcement theory - which suggests that behaviour is acquired and maintained by reinforcement, so if you do something and you receive a reward reinforcement, you are likely to repeat that behaviour in the future. If you look at the actual pattern of offending for adolescents, the vast majority is inquisitive crime - robbery, theft, burglary, so there is clearly a link there with reward. They are rewarded for offending in that sense because they gain the financial reward, it also terminates them having no money or a desire for money to buy. There is also a clear social reward within some of the groups of offenders, that having committed crimes they gain approval from their peers. Of course offenders may be caught and if you are looking at a reinforcement theory you have to take that into consideration. Typically within this sort of population, when we look at their learning history, reinforcement and punishment, there is a sort of erratic nature in the punishment that they have endured. The punishment from parents may be inconsistent parenting or rather harsh punishment has not always been linked to what they should or should not do. So whether they are making the links between punishment and not doing something is open to question.

Social learning theory - which suggests that learning is again involved (which would include reinforcement) and modelling within a social context - family, peers, school, etc. An important aspect in Social Learning theory is social cognition, the way one thinks and social skills. Social cognition is thinking, knowledge concerning other people and their behaviour, and our own behaviour in relation to other people.

With relevance to offending this would include -

- Empathy - being able to empathise to the situation of others (for example when you are taking their goods). A number of studies have indicated that juvenile delinquents have lower levels of empathy than normal samples. Locus of control is where you see the factors that control your life, your behaviour as coming from - whether you are controlling your life or there are external factors controlling your life. Particularly for violent offenders, they are consistently found to feel that there are outside factors that are responsible for their behaviour. Self control, again with violent offenders, is found to be lower.
- Moral reasoning - a number of researchers, including Farrington, have suggested that there is a delayed development in moral reasoning consciousness in adolescent offenders.
- Social problem solving. Problem solving itself is identifying that a problem exists and then to generate possible solutions and identifying which solution is most likely to succeed, and then putting that into action. That is problems may be stemming from actually identifying that a problem exists and then generating actually appropriate solutions rather than sitting down and

discussing the problem they may just strike out and hit the person they are having the problem with.

Social skills is again linked to understanding social signals or cues, and acting appropriately in social settings.

I am now going to look at researchers who looked at Juvenile delinquents, looked at their background and history and compared them with other samples of non delinquents to see what factors the delinquent have that are over represented in the sample.

- The first one is social economic deprivation. This is a collective term for income, housing, unemployment and other factors.
- The second is anti-social parents and siblings that would include parents that would have a history of offending or alcohol or drug abuse .
- Poor parental supervision is not knowing where your children are for example.
- Harsh erratic child rearing which has come through in many many research studies. The rearing or the forms of punishment are both harsh, over the top and erratic. That is that a child may do something wrong which is one day left and the next is severely hit for what is possibly a minor thing.
- Factor five is low intelligence, school failure and types of school were found to come up in research. Low intelligence doesn't necessarily mean all these children would have learning difficulties, but it was significantly lower than the normal sample.
- Impulsiveness, that would tie in with the problem solving approach - that they don't stop to think about an issue, they are immediately going for a reward for example.
- The delinquents were always found to have delinquent peers, so they are within a similar group. That's most likely linked to school failures, so if someone is excluded from school there is a certain rejection by normal peers, and then these children form into groups what Farrington terms as delinquent peers.
- Irrational decision making. There is an element of this in a lot of the delinquents. I recently saw a young lad who was finally going to court for over 100 offences, and he must have thought that after committing 50 offences and not being apprehended, that it made sense to commit another one. And the money he gained from the first 50 must have been very rewarding.

So Farrington took the risk factors and put them together for his theory for offending. Which includes -

- Factors which might be seen as coming *from the child* - impulsivity, hyperactivity, desire for reward or sensations, tendency to take risks, which then collaborates with these other things such as a poor ability to grasp

abstract concepts which would include empathy that came up as a risk factor, a low IQ and that goes through to the school failure.

- Then we have the ego-eccentricity and selfishness which Farrington suggests may come *from the parenting* and separations, many separations which the child may have experienced. Again similarly weak conscience or remorse. These may be picked up in the social learning process, picked up similarly to the one before, modelled from peers or from parents, if the parents have been consistently offending.
- And *motivating factors*, desire for material goods. If the adolescent has left school at 16, after basically failing at school, his ability to get a good job and gain the money he wishes to buy good clothes, cars etc is very limited, so one option is to offend.

Looking at treatment approaches. There isn't and never should be a consistent treatment approach for juvenile delinquents. Everyone comes with different sets of issues, problems, history and background. The tendency is to look at the individual and see what the actual difficulties they are presenting, such as anger, social skills, problems for may be a sex offender, problem solving for someone who is stealing money to buy drugs, and not to ignore the emotional needs that the person may have, separations, bereavements - everything which is going on for normal adolescents is going on for these too. Basically, research would suggest that conference behavioural therapy and perhaps family focus therapy for the younger offenders is the preferred choice. Positive outcome is most likely if the therapy, what ever it is, is focused. There is a behavioural element and development within it. The practitioners and whoever else is involved are properly skilled and it is community based.

Discussion -

A question from the floor asked about gender differences and the fact that rearing male children in single parent families was perhaps harder than female chidlren.

Regarding gender of juvenile delinquents, there was one study in Newcastle, 1,000 family study, which looked at families over a 30 year period and offending for males was 31%, the figure for females was 6%. So predominately male offenders. Regarding the parenting issue, the other treatment which I have not had time to discuss in my talk, is Patterson's parent training approach, which deals with developmental theory of anti-social behaviour, not just offending, in the sense that problems with parenting lead to conduct disorder, which leads to school failure, which leads to a child being ostracised generally, delinquent peer

group offending. So I think parenting should be taught at school basically - I think it is invaluable.
Another question from the floor questioned why it might be that there is an over proportionate number of black children who were taken to court for offending.

- I don't have any studies to give reasons for this. I work in Blackwall and see a large number of black adolescents. Whether it is a factor or housing and social depravation being linked to race, I am not really sure, but it might be something else which is effecting the figures rather than it being a clear-cut issue.

Teenage Suicide - A challenge to common ideas

Patrick Alvin

Whether carried out, attempted or merely considered, suicide is a highly sensitive, controversial. and stigmatising issue. Even today, suicides and suicidal behaviours, when they are not denied or disguised as accidents, often remain family secrets. The violence and apparent irrationality of suicidal behaviours may trigger powerful defensive interpretations, and there is some confusion as to the respective roles of individual mental status versus family and other environmental factors.

On the whole, we professionals have not been well prepared for the subject (Alvin P, 1992). We often avoid the work 'suicide' because it is distasteful; and we speak of committing suicide, as one 'commits' crimes, incest and the like. This is quite ironic, because suicidal young people are themselves often victims of abusive environments, and a proportion of suicidal girls actually have a history of incest.

In the most recent survey of the French high-school population, conducted three years ago (Choquet M, 1994), suicidal thoughts had concerned a quarter of all teenagers. Eight percent of girls and 5% of boys reported a history of suicide attempt.

There are many commonly held ideas about teenage suicide. Most derive from over-generalisation or over-simplification, and it is my purpose to briefly question a few of them.

1 Is Adolescent suicide a clear-cut and visible clinical entity? It is restricted to adolescents having completed or attempted suicide?

The domain of suicide covers a very broad spectrum of behaviours and emotional states. Only visible are the correctly diagnosed suicides and the small fraction of attempted suicides registered through hospital admissions. Below the visibility line is a much larger area where we find all other suicides, attempted suicides or self-harm, behaviours, suicidal threats, suicidal thoughts and related depressive states. Finally, a whole set of unaccountable 'self-sabotage' behaviours, best described as suicide equivalents, must be included in the general picture. These situations, which often appear as paradoxical ways to 'survive', may include overt suicide behaviours as well.

In other words, the domain of suicide should rather be seen as a probability risk area, and suicide vulnerable adolescents as moving in and out of suicidal risk, as their mood and life circumstances fluctuate. Many remain unknown or unacknowledged, and of all who enter the risk area, a few will indeed finally kill themselves.

2 Are adolescent suicide attempts just one expression of the 'adolescent crisis'? Do they result from pressures caused by social or family violence?

It is true that suicide behaviours often follow a painful or stressful event, and that some are a genuine and critical 'cry for help' directly destined to the family. But common adolescent stresses or circumstantial motives like fights with parents about parties, boyfriends and the like are nothing but triggering factors, in no way enough to 'explain' such acting out behaviour. Failures, conflicts and separations are part of any normal life.

A now well-known factor for behavioural and suicidal risk among adolescents is prior physical or sexual abuse. School drop-out is another example. Suicidal adolescents actually often come from families that show overt or covert discord; they are surrounded by a poorly supportive or scapegoating environment and some have known previous social or foster care interventions. But environmental problems cannot either be an explanation alone. We all know adolescents having grown up in dramatically dysfunctional families without ever attempting suicide.

What is really in question is the adolescent's hopelessness when confronted to all these situations, and not being able to find any issue to suffering, other than suicide (Ladame F, 1994). Suicidal adolescents defy all stereotypes in terms of psychological make-up. Yet they obviously tend to share a common profile or psychic vulnerability, characterised by narcissistic fragility, difficulty in controlling impulses, intolerance to loss and excessive dependence on parental ties (Jeammet, 1994).

In fact, teenage suicide always involves the synergistic intersection between external factors, which derive from biographical events and various environmental stresses, and internal factors of vulnerability, which have to do with the given personality. Each of these sets of factors should be analysed separately.

3 Is suicide insane? Does adolescent suicide mean overt psychiatric illness?

This is quite a touchy subject. Most teenagers who have attempted suicide would claim that they are not crazy. Besides, the majority is not necessarily thinking about death per se, but much rather about their living situation being intolerable.

The question of mental illness in adolescent suicide behaviours has always generated endless and sometimes confusing debates (Ladame F, 1995). Historically speaking, suicide has always evoked 'insanity'. Among adults who complete suicide, a strong relationship with psychiatric illness has been found, and according to psychological autopsy studies, the same could be true for adolescents. Besides, suicidal adolescents are often depressed or may have personality disorders.

But trying to attach adolescent suicidal behaviours as a whole to the known psychiatric entities has always been a failure, leave aside the fact that the term 'psychiatric or mental illness' may evoke different meanings, particularly at that age. The truth is that the problem of suicide is not dependent on a specific illness or mental state, and cuts across all diagnostic categories. The best we can probably say is that suicidal adolescents usually experience great pressure, isolation, and mental suffering, but that the psycho-pathology of many of them does not meet the definition of what we commonly call a 'psychiatric illness'. On a practical level and in our experience, only a few are deeply depressed, psychotic or remain acutely suicidal, and less than 5% of our patients require transfer to an in-patient psychiatric family (Alvin P, 1992).

4 Is the 'seriousness' of a suicide attempt directly related to its medical severity?

It is often heard that the lack of a true wish to die is not really suicide, but rather 'suicidal gesture'. It is clear that the lethality and especially the severity of intent of suicidal acts are of great importance, given their known 'predictive' value for repeated self-inflicted injuries or subsequent fatal outcome. But with adolescents, the line of intention is particularly difficult to draw. Moreover, every suicide attempt has its own degree of ambivalence and impulsivity, and the severity may depend on circumstantial factors like the nature of the home pharmacy's supplies or even sometimes the mere availability of a loaded gun. In other words, beyond the immediate life and death issue, the overall distinction between major and minor, 'serious' and 'not serious' suicide attempts is inappropriate and dangerous. Assuming that only significant or major attempts

are worthy of serious attention is irresponsible, because a minor gesture may very well reveal a terrible life situation or concealed personal drama.

5 Does a missed suicide have its own dissuasive effect for later repetition? Does it only exceptionally progress to completed suicide?

Self-poisoning, a preferred female method, accounts for relatively few adolescent deaths in our countries, where there are plenty emergency care resources. This, and the much higher proportion of suicide attempts versus suicides in adolescence could comfort the idea that only a minority of adolescents who attempt suicide progress to completed suicide. However, in one Finnish follow-up study, the global annual risk of dying from suicide or violent death was 20 times higher among adolescent suicide attempters (Kotila 1992). So the so-called 'cathartic', or 'self-therapeutic' effect of suicide attempts is a dangerous concept. The estimated risk for a repeated adolescent suicide attempt approaches 40%, with the period of greater risk being the few months following the first attempt. But most importantly, and again beyond the life and death issue, suicide behaviours during adolescence are always symptomatic of a more or less dramatic risk for later developmental harm (Granboulan 1995).

Of course, prevention should aim at reducing repetitions. However, the rationale of what we call tertiary prevention of suicidal behaviour, and suicide repetition is nothing but one possible event within a broader dysfunctional context, the evolution of which depends largely on what may or may not change after a suicide attempt. In other words, preventive efforts only make sense if they stem from a thorough analysis of the given situation of a given person, and address first the various and usually long-standing factors of vulnerability, interpersonal difficulties and other dysfunctional areas brought to light by the suicidal crisis.

I will now briefly discuss **intervention and prevention**. In terms of care of the hospitalised suicidal adolescent, the best time for working with the situation is the immediate time following care in the emergency room. The suicidal crisis is best 'exploited' during this privileged period, which promises optimal mobilisation of the adolescent, and even more importantly, of their family (Alvin P, 1992).

There is of course not one single and ideal model of care. But any active intervention should incorporate a set of concomitant goals at the outset: The co-operation of the patient and his family for the understanding and management of the suicidal crisis, a complete medical and psycho-social health screening including interviews with the parents, and an appropriate treatment and follow-

up plan. This cannot reasonably be done through a single and stressful post-emergency room evaluation and besides, these patients' well known poor compliance with appointments after emergency care (Litt I 1983) is an argument against the idea of exclusive out-patients management at the outset.

Working with these patients ideally requires a few days of observation in a protective, transitional and non-stigmatising medical environment, with a staff emotionally prepared and well equipped for multidisciplinary work with adolescents and their families.

On a practical level, adult psychiatric wards are not usually suited for teenagers. The best environment appears to be general medical, behavioural or psychiatric adolescent units, or structures specifically devoted to the care of suicidal adolescents. But most hospitals do not have such units. And the possibilities offered by Hospital child psychiatry are also limited for teenagers, especially in terms of emergency care.

In our country, general paediatric wards - with or without specified adolescent beds - have become more and more actively involved in the care of suicidal adolescents. A recent national survey in general hospitals (Gasquet I, 1994) indicates that more than 40% of these patients are admitted to paediatric services, which provide a fairly factorable milieu for them: Compared to other wards, they offer suicidal adolescents a longer stay, an often multidisciplinary team approach, and a better follow-up with a more frequent post-discharge liaison with the family doctor.

In our experience (Alvin P, 1992), follow-up should not be planned as relying solely on psychiatric consultations. It should be anticipated that many patients may initially refuse engaging in psychotherapy, while better accepting a general medical or social work follow-up. This stresses the importance of a good experience in networking. The weight or the influence of external reality may be quite important in these situations, and the therapeutic possibilities of psychiatrists or psychologists will often depend upon the presence and the quality of a parallel supportive medical and social follow-up.

In terms of suicide prevention, numerous studies have consistently identified factors found in significantly greater frequency among adolescent suicide attempters (some are family and environmental factors such as suicide or mental health problems in the family, separation or divorce, history of abuse, etc. Others are personal behavioural or symptomatic factors such as alcohol and drug abuse, school problems, running away, depression, frequent physical complaints etc.). The problem however is that in clinical practice, the lack of specificity and the poor predictive value of these so-called 'risk factors' may be quite

discouraging. The same is true for warning clues such as a recent drop in school performances. However, we should always keep in mind that the best single predictor for suicide behaviour is a history of past suicide attempt.

We all know that a morally distressed adolescent only waits for his suffering to be acknowledged. But troubled adolescents often avoid whatever may evoke psychiatric services. Moreover, they usually don't quite know what to expect from health professionals in general, nor what they may be ready to accept from them. Suicidal adolescents will rarely spontaneously declare : 'I think about suicide'. Instead, they will display various unusual physical symptoms or behaviours.

Ideally speaking, prevention should rely on every significant party or primary health care provider close to or prone to meet adolescents (Pommereau X, 1996). One condition, however, is for these persons to be able first to establish a good enough rapport with a troubled and possibly suicidal adolescent, and second, to know how, and to whom, they should guide this young person for more specific help, in case of suicidal threat or other serious needs. Epidemiological studies among adolescents now routinely ask about suicide on their questionnaires, without any particular back thought. But in clinical practice, the situation appears quite different, and most professionals still experience great fear or embarrassment at the idea of addressing such questions with adolescents (Slap GB, 1996 - Capelli M, 1995). Yet it is quite clear that raising the question of possible suicidal thoughts or past suicide attempt in the context of a thoughtful clinical interview is in no way intrusive or dangerous. On the contrary, it provides a privileged opportunity to talk more openly about 'what may be going wrong'. Teenagers who feel they are not concerned will simply say no, while hearing that it is acceptable to talk about such things.

I will conclude with three simple messages, particularly for primary health care providers:-

1 Any adolescent who seems sad, anxious, depressed or who displays deviant behaviours should be asked directly the possibility of feeling like dying or of a past suicide attempt. Prescribing anti-depressants or tranquillisers should be avoided as much as possible. What is really needed is talking about the problems and counselling;

2 Theoretically, all adolescent suicide attempters should be sent to hospital, and remain at hospital for a few days, for a sound evaluation. Trying to avoid drama can only add to the real drama in the long-run.

3 Primary care health providers' role after hospitalisation is crucial, in that they can check that follow-up is effective, and that problems have not been set aside, if not simply 'pulled down the drain'.

“Helen - A History”

Carol Kremer

- {Carol was due to present this story at the conference and was prevented from doing so by illness - however we felt it should be included in the proceedings.}
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What happens to a young person who falls victim to a major mental illness? Helen was just fourteen when she began behaving in ways that were out of character: she became withdrawn and retreated to her room. To her parents she seemed traumatised, although nothing had happened to explain the frightened look that she now wore. They went, all three, to the GP who fastened on the idea of food deficiency and recommended vitamins and iron.

When Helen swung into the hypomanic phase (although no one at that stage recognised manic depressive symptoms) her parents consulted a private psychiatrist. They knew, despite the fact that Helen’s behaviour had by that time involved the police, that their daughter was ill. The psychiatrist talked about a shock syndrome.

So did the doctors in the adolescent unit of the mental hospital where Helen was next sent, and where she was held for five months while her condition was assessed.For four of those months she was denied any home visits, and she was sedated daily with major tranquillisers. Her parents watched helplessly as her physical health deteriorated. Still, they thought, she is ill and doctors and hospitals are where you turn when illness strikes.

They lost faith finally after Helen had been transferred to an adult ward on the grounds that her behaviour was unmanageable, where she was eventually Sectioned. So deep was her distress that she had not only run away but cut her wrist and cheek. The authorities’ response was to lock her up on a secure ward. Any trust that her parents had placed in the system had long gone - they wanted Helen home.

She was now on Lithium - but because her blood levels fluctuated she was accused of not taking it, and her parents were disbelieved when they confirmed she was complying with the medication as prescribed. She spent further time in hospital being monitored. Hopes of a family holiday in Italy were dashed; her brother and father went alone, she and her mother later in the year when she was finally discharged from hospital.

She is now over sixteen years old and almost entirely dependent on her family. Two punishing years have left her isolated from people of her own age, although

she attends college for a day and a half each week despite suffering panic attacks and difficulties with concentration. She also attends three sessions a week at a day centre, but the people she meets there are no solution to her feelings of isolation. Her mother is her closest companion, her confidante, and Helen's needs have to be met within the family whatever stresses may be created by that.

Helen's family meet stress with strength and face the future without self-pity, but is this the best that can be done for young people and their families? Does treatment have to be so punitive? And do families have to cope with so little support? The mentally ill are always vulnerable - a young person's life is especially so. Nowhere in the system is there any real provision for people like Helen, no attempt to assess the special suffering experienced by them and their families.

Perhaps there are countries where these things are handled differently, where there is something on offer at weekends for instance, where parents are not expected to assist the recovery and repair of their damaged children utterly unaided. If so, we must learn from them fast before there are too many other Helens with a story like this to tell.

Health and Physical Challenge - Meeting the Need

Chaired by Professor Neville Butler

Dr Aidan MacFarlane - “Substance Abuse”

Dr Frank Besag - “Epilepsy in Adolescence”

Anne Philpott - “A white coat and sensible shoes” - young women’s sexual health.

Dr Rosemary Kirkman ; Maggie Flint - “Y-Wait”

Dr Elizabeth Heycock - “A young person’s confidential Health record”

Dr Aidan Macfarlane - 'Substance abuse'

I want to talk about the broader aspects of drug abuse and exposure to drugs, and I want to really mix my talk between given you some quotes from young people and giving you some facts about substance abuse itself. I am also going to give some advertising for a book, 'The User - the truth about drugs, what they do, how they feel and why people take them', it is written by myself and my 26 year old son who had considerable first hand experience of drugs, and what we did was interview a lot of his friends who were in the drug taking scene to actually look and see what it was like, rather than all the sort of talk that goes on about it. So the quotes I am going to give you, and the facts, are in the book itself, so if you don't want to take notes you can buy the book instead!

The first quote I want to take is from the child call Sammy who is 13 years old, comes from the outskirts of Birmingham and I just want to use Sammy to illustrate the exposure at the moment to drugs. She is 13, she is going to go to a Catholic upper school, she has a younger brother aged 10. She says:-

> 'I think the thing with drugs are getting quite bad because there are so many people doing it, like all the people dealing in it. They either get into groups, or gangs and go to people and pressurise them into it. I learn about these things from reading about it in the newspapers, from seeing it on the telly, or in magazines that I read (Mizz, just 17) have articles about drugs in them about how kids have been given something at a rave party somewhere and they didn't know what was in it and they end up in hospital or something. I think you have your fun without taking drugs though, I don't think people should take them really. Most of them take them because they are pressurised and there are people taking them in front of their mates, to impress them and then when they are out to have fun. Smoking ordinary cigarettes, I think, is stupid too. I tried one once, I was kind of slightly drunk at a party *(and this is a 13 year old girl)* with my mum and she didn't know and I didn't know what to do. Somebody put one in my hand and so I took one puff and it didn't really have any effect or anything, like feeling sick, but that was the only time. Mum is really strict about these things and I like that. The only time we have a drink is when it is like a birthday party or something.'

That is the exposure. The exposure I would like to suggest now, and I will come onto the facts, is pretty universal to drugs.

What I would like to do now is to look at the wider aspects of substances which people take. If one is looking at a drug taking ladder, and thinking that one

progresses from one drug to another, and I will come back to this, caffeine is the most commonly used drug in the UK, by the young and old, in tea and coffee. It is pretty universal. Any one here who does not drink tea or coffee? Although it doesn't alter mood, or rather alters mood to a mild extent, there is no evidence that it alters people's immediate behaviours to any great degree (I have put *in any great degree* because some of us who drink a lot of coffee, start to shake half way through the morning!).

Alcohol is the second most commonly used drug by young people. Nearly 90% of all boys in the UK and nearly as many girls have drunk alcohol by the age of 13. It is the second most dangerous drug in terms of the number of deaths it causes. In terms of deaths both from the immediate results of taking alcohol, the causes of accidents etc. and of course the long term effects and I will come back to this.

The one I quite naturally, and not surprisingly to some people, mind about most is tobacco. Why do I mind about it? Because we are exulted by the government again and again to try and stop young people to stop smoking, but do they play their part? Do they ban advertising, do they really put up the price of cigarettes? Why should we as health professionals be struggling to do something about tobacco when the government themselves are not actually doing their part? And until we stand up as professionals and actually start saying that we are wasting our time doing our bit unless you do your bit, we are not going to get any action. Now by approximately the age of 16, it is very easy to remember, one third will be smoking and continuing to do so, one third will have tried smoking have given it up, and one third will not be smoking. And again, like caffeine, it does not change people's immediate behaviour to any significant degree, and if you give up smoking by the age of 24, you will probably get away with minimal health bad effects. But it is extremely addictive. It is thought to be as addictive as heroin.

As far as the illegal drugs are concerned, I am glad to say that cannabis is still the most common. But I think there is increasing concern that cannabis is actually smoked with tobacco an awful lot of the time, and it is the tobacco which is the addictive part to it, and therefore if you mix smoking, if you roll a spliff with tobacco in it and you smoke it, what you are doing is becoming addicted to the tobacco part, turning you onto tobacco which is in the long term a more dangerous drug. Not to say that cannabis itself doesn't have dangers.

I now want to go on to a quote from another child. This one is called Rachel and this is a drug taker, because I am now going to concentrate, having just talked about the abuse of other substances, to put it into perspective on the kind of number of deaths that one is talking about per year related to drugs, illegal

drugs, about 1,200 deaths in England and Wales, total number of deaths from alcohol is about 30,000, and total deaths from smoking is about 110,000. So, if you are going to get things into proportion, here is a government who is keen on tackling drugs together, and yet something that is causing 100 times as many deaths they are not willing to take the kind of action which I think they should be taking.

Now Rachel's story, as I said I am now going to come onto illegal drugs, Rachel is 16, she is taking her A levels at a North London school, she lives with her parents in North London, her father is a doctor and her mother works in an advertising agency. After university she wants to make documentary films. She says about starting drugs:-

> The first time I tried drugs was when I was about 11. It was on holiday in Wales with a group of mates who were all older than me, most of them were 15 years old, I reckon. I liked it. It was a kind of cool thing, if you know what I mean. It was fitting in that mattered. I mean after being a kid I really enjoyed it. I puffed before I smoked any fags. I was 13. Me and Chrissy went down to the local bay. We didn't know anything about it, we didn't know how to take them, what they'd do or anything, we didn't have a clue. We went down, it was half term, and once we had taken them once, we took them for a whole week. We thought they were wicked. We must have taken them four or five times. It blatantly changes you. It's puts a new perspective on things, you just see things differently. I think for a while, I thought it made you a bit more perspective about things, like relationships. Also with trips on acid you can find something interesting about just the most boring things. That's a major attraction, you don't actually have to do anything exciting when you are tripping, it's just that. It's a bit like being born again, it takes you back to when you were like a little child, all innocent, just sitting them, finger in your mouth looking like a geek. At my age you spend so much time sitting round with your mates, and you are not really doing much and you don't have that many interests so there is nothing to stop you puffing. Puffing just allows you to be bored.

Now, I think that that is a very interesting remark - puffing or taking drugs allows you to be bored on them - and I think that if you are looking for interventions may be that is an area we could look at further.

Now, the facts about exposure to drugs. Studies done by the Exeter Schools Health Unit, John Balding's unit, would indicate that by 11 to 12 years old, 1 in 5 children of both sexes would say that they know somebody who is taking

illegal drugs. From 13 or 14 years of age this has risen to half of all children, and nearly three quarters of 15 to 16 year olds.

So how many take illegal drugs and how many don't take them? Different surveys show slightly different figures, but really they all add up, if one wants to make generalisations, to a fairly clear picture. By the age of 13, only about 10 in every 100 people will have been offered an illegal drug, and 6 in every 100 will have taken it. For 14 to 16 year olds in the UK, between 50 and 75 percent will have been offered drugs. So, the actual exposure is the majority are being exposed to drugs. Again, amongst 14 to 16 year olds in the UK, between 30 to 57 percent will try illegal drugs and these numbers will apply to each year group from 15 through to 20, although the proportion being offered illegal drugs and taking illegal drugs will go up. The maximum age of drug taking is about 18 to 20 years of age.

Now one of the most important things, I think, one needs to know about is actually the types of drug takers. Just to remind you that Cannabis is, has been, and will always be (I think), the most common drug used, followed by amphetamines, natural hallucinogenics such as magic mushrooms and ecstasy. I usually ask the audience before I begin how many people have actually tried drugs, but have not done so today, but recently I was at the Royal College of General Practitioners, training general practitioner, and I asked them and about 25% held their hands up, so that illegal drugs are used right across the board.

The main thing which I think you need to know is that there are three main types of illegal drug users. By far the largest group are the experimenters who try say, cannabis a couple of times and leave it for other things and other experiences. Neville Butler was saying what other addictive things I would be talking about, I have talked about cigarettes and alcohol, well may be sex should be another thing is addictive to some people - much nicer to be addicted to than some of the other things.

The second most common group, which is also widely represented, is the social user, who tries drugs, uses them in the same way one might go down to the local pub and they are much smaller relative group than the experimenters.

The smallest group of all, if you take all drug users as being 100% then these represent just 5%, are the serious compulsive drugs users, or abusers, or addicts. And my own feeling is that we must concentrate on is not stopping young people from experimenting on drugs, but asking the question why do young people move from experimentation to actually becoming addicted. And one of the interesting things in the area is whereas experimentation is right across the board, all social classes, all types of young people, when you actually look at the

addicts in there they tend to be people in lower social class with quite a lot of mental health problems. So you can see that the experimenters to me are quite a normal healthy group who have got something on the menu to try, and they try it and go onto other things, and I don't think we should be concentrating a vast amount of time and effort on them. But really asking the question why you move from that to the relatively small group who actually abuse drugs.

Why do people take drugs in the first place?

Well I am sure a lot of you will have experimented with drugs yourselves and I don't really have to answer this question for those people - because the effects are pleasurable. And that is what we have to stick with in our memory, because people take drugs because they are fun, they don't take them because they have ghastly effects. they take away feelings of shyness, anxiety, lack of confidence, their friends all do it. Sometimes they take drugs because they make them feel different, rebellious, and individualistic. And some take them because it makes them feel they are fitting in groups. Some will try anything once out of curiosity. For some people taking drugs there is a more bearable alternative to other kinds of life. I first came across drug taking in Boston about 30 years ago, if you lived in the black ghettos there, or if I had live in there I would have been taking heroin like a lot of people would be, because life was so unbearable, and it just helped people through it. Sensations being offered are better than being bored, or the reasons, in most cases are a combination of those things.

The answer to why young people themselves take drugs:- 50% say they take drugs for fun or out of curiosity, 30% because their friends are all doing it and as I said 20% because it is a better alternative than their ordinary life.

I think that one interesting thing which has come out of the research on drug taking is that there is a very strong association between different forms of experimentation. I hate the term risk taking by the way - young people do not risk take, they do not see things as being risky - what they are trying to do is learn by experimenting with life. Most of us actually learn by experimentation. But it does appear that as some people are very tall, other people are short, there is a range of experimentation in people. High experimentors tend to experiment right across the board and low experimentors don't experiment as much. So, if you smoke you are more likely to drink beer and alcohol, are less likely to wear cycle helmet or seat belts, more likely to have started earlier sexual activity and have more sexual partners. All these things seem to run together, and I don't think it is at all surprising. It reflects life, some people like to try everything and some people are more cautious.

Why has there recently been an increase in the use of drugs - both world-wide and in the UK? Because believe me if you go to Europe you will find the problem is everywhere, Russia and everywhere has an increasing drug taking in their society. Well for one thing, they are much more available, there are more of them - increase in variety. We live in a materialistic market orientated world where our values is in making money out of anything including drugs. What you have got are highly experimental teenagers on the one hand who will try anything which is on the menu, and on the other hand you have the market orientated world who will flog you anything as long as they can make a profit out of it, and you put the two together and you put the two together and it is quite likely you are going to have a decent market going.

My main concern is that we fear drugs so much. That we run away from them. Instead of getting informed about drugs, and on the whole people are not informed..... are there any GPs here?...no not one..... general practitioners are the ones young people generally do turn to for advice from time to time, most general practitioners would feel very badly informed, and would feel that they know actually less than their patient. Is there anyone here that they feel that on the whole they know more than a young person in the drug scene? There must be some here who do...OK great. Of course you could all be directly involved in taking drugs too in which case you could not actually answer that question come to think of it!

So I think that one of the problems - and it happens again and again when something new comes along - there is a great amount of fear. And what we need to do is to get properly informed about what the scene is actually like. I think the very illegality of drugs makes the price artificially high, and that involves as we all know, a criminal element. But I think you have to understand that most of drug taking in this country does not have a criminal element. What will happen is, in the most common incident, a kid will go to a party and before he goes he will avail himself of his next door neighbours cannabis plant, he rolls half a dozen spliffs, in much the same way as he would take a bottle to the party, he goes down to the party, he floggs in order to get himself a little bit of pocket money, at a pound a time or something in the same way you might sell of your beer if you take more than one bottle, and that is your main dealer at shop floor level. Now, how much you want to get that down to criminality and whether those people should actually be seen as criminals I leave up to you. But the message I want to leave you with is by far the biggest part of drug taking in this country - it is purely experimental, with relatively harmless substances, and what we need to understand in our society is why some people actually end up at the hard end of drug taking. What is it in our society which leads people to think that that alternative is better than real life. Can we not provide a society where real life is decent enough that they don't actually have to do that?

“Epilepsy in Adolescence”

Dr 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 or 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 of ‘independence versus safety’ also impinges on a number of other areas.

Adolescents do not like being told what to do. The doctor should try and avoid ‘giving advice’ but should, instead, encourage questioning and provide information, emphasising 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.
- High risk of the unsupervised bath
- The effect of irregular sleep
- Alcohol
- Driving
- Sport
- Employment
- Contraception
- Genetic implications
- Advantages / adverse effects of specific anti-epileptic 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 present also have tonic-clonic seizures and may have absence seizures. The seizures predominantly occur soon after awakening.

The 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 generally 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 relatively new drug, lamotrigine, may be effective in those subjects who do not respond adequately to monotherapy with 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. The absence

seizures, in particular, 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. In this syndrome 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 or 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 the syndrome of 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 epilepsy
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. The 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 a mean age of 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 sensations 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 seizure 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 condition, which typically follows measles infection very early in life, under two years of age, usually presents in the 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 pattern is characteristic, with a discharge in all the 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, are described above, with a single seizure or single cluster of seizures and no recurrence.

Investigation

The investigations of epilepsy in adolescence are similar to those at other ages. Basic blood test or full blood count, urea and electrolytes, calcium and liver function tests should be performed. An EEG with photic stimulation should be obtained. Neuro-imaging should be considered but will not be necessary in those conditions which are obviously benign, as described above.

Treatment

It is very important not to group the epilepsies of adolescence together as a single entity. For example, benign partial seizures in adolescence should not be treated if there is only a single episode whereas treatment of juvenile myoclonic epilepsy with sodium valproate is strongly recommended and usually needs to be continued long term.

The mainstay of treatment is with anti-epileptic medication. The first-time drugs carbamazepine and sodium valproate should be used. Sodium valproate is, as already stated, the drug of choice for juvenile myoclonic epilepsy. It is also the drug of choice for absence seizures. The role of lamortigine as a first-time drug is currently being assessed. This drug has a wide spectrum of action and has advantages over sodium valproate in being very well tolerated. It is not associated with weight gain, which is a common problem with sodium valproate.

For those adolescents with seizures of partial onset who cannot tolerate the adverse effects of anti-epileptic drugs or who refuse to take them, self-control of seizures should be offered. This method may be effective in suppressing at least a proportion of partial seizures, especially those which are heralded by a clear aura.

In treatment-resistant seizures the possibility of 'pseudoseizures' must always be considered and should be managed appropriately with a positive, non-punitive attitude. The concept of 'locus of control' is important. An approach which is often helpful is to say: 'Wouldn't it be wonderful if you were in control of the attacks instead of the attacks being in control of you?'. The adolescent should be encouraged to find a way for controlling the attacks. He or she should be reviewed after a specified period of time, for example three weeks, and if there is any reduction of the attacks at that time they should be praised for having done so well and for having begun to gain control themselves. Sometimes a change of life situation may be necessary.

Surgery may be indicated in a number of circumstances. The most obvious of these is the tumour presenting de novo in adolescence. Some teenagers may have had a history of complex partial seizures for many years and may be found to have mesial temporal sclerosis, a dysembryoplastic neuroepithelioma or a hamartoma on MRI scanning. It could be argued that these patients should have surgery earlier. If surgery is necessary, it is probably better to carry this out sooner rather than later. The longer the seizure disorder affects the subject's education, development and social situation the more difficult it will be to overcome 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 very important to consider the impact of epilepsy on the life of the adolescent and to minimise the isolation and stigmatisation that the teenage may feel at a time when being part of a approving peer group is so important. These factors, together with the issues of alcohol, driving, sport, contraception, genetic implications, and 'safety versus independence', imply that the management of epilepsy in adolescence requires skill and sensitivity.

Further reading

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Anne Philpott - 'A white coat and sensible shoes' Young Women's Sexual Health

I work for International Family Health now, which is a British based organisation (NGO) specialising in international sexual and reproductive health, but I was the co-ordinator of a young women's sexual health project in the South West of England for two years, and what I would like to talk about today is some general aspects of the project. It was funded by the health authority and managed by two voluntary sector projects NCH Action for Children and the local Well Women's Centre. I was employed for two years, from September 93 to September 95.

The aspect which I am going to talk about mainly today is the results of a participatory needs assessment that was conducted as part of the project. The project originated out of NCH Action for Children's work locally, running teenage pregnancy groups and also young women's sexual health groups, and also a need expressed by the Well Women's centre that they were not meeting the needs of local young women. A report was produced of the needs assessment and was disseminated in the area.

What I am going to talk about today is quickly outlining the methodology of the assessment and the talk about at the findings of the needs assessment and them some issues about the participatory and community development of the needs assessment.

The needs assessment aim was to identify the sexual health service needs of women aged 13 to 25. That age group was chosen because of the high rate nationally of unintended pregnancy and the high rate of abortion in women in their early 20s. Some people felt that was quite a high age for a young women's sexual health project. It was also a needs assessment to identify the needs of service users who traditionally didn't access sexual health services in the area, and there was focus on a particular geographical area. This area was a large local authority housing estate on the outskirts of a small town. They had the highest number of 10 to 17 year olds of any ward in the County, a higher pregnancy rate, there had traditionally been a lack of resources in the area, although NCH Action for Children did have a project there, this was where the young women sexual health project was based, and there was a higher rate of unemployment than in the surrounding districts.

The data was collected for the needs assessment in two stages. The first was field work with young people. There were 9 focus discussion groups held with young women. The discussion groups were sampled on age ranges and other aspects, for example, one of the focus groups was for 13 to 14 year olds, another

group was for women who had had children as teenagers, another group was of teenagers who had been pregnant themselves, there was a discussion group with young lesbians, and another discussion group with women with learning difficulties. There were also two focus discussion groups with young men, it was felt important not to miss the perspective of young men when thinking about sexual health service needs for young women.

The second stage was with service providers, where there were 19 semi-structured interviews that took place. Service providers were recruited through traditional work channels and all sexual health service providers or people who had a related interest in the area, and also some service providers were recruited through, for example I saw an advert in the local newspaper for a pregnancy help line that would offer free pregnancy testing, so they were also interviewed.

Now I am going to talk about what we found out during the needs assessment. These were the areas where the results were focused. The first two are looking at the issues raised with young women in the focus groups. The third and fourth around services are a comparison about what young women said about what they felt about sexual health services and also what service providers said, and the last one is a comparison of what young women said in the focus groups and what young men said in the focus groups about sexual behaviour.

Young women were asked what type of sexual language do they use and what sexual language do they feel comfortable with. A lot of young women said that they felt very caught between what one women called the hygienic - the big words, the medical language, and slang which they often found difficult to use as they found the words offensive, some of the words they would use to describe their own bodies. One young women said:-

> *"It's all chemical and you have to call it's proper name. I can't say I've got something wrong with my fanny doc."*

So young women often felt that they had to feel that they were speaking a foreign language when they went to see their doctor, they had to think in advance about what they wanted to say when they wanted to talk about a sexual health issue. One woman said that her doctor had explained that she was to take her contraceptive pill orally, and she didn't feel she could ask what orally was, and she didn't understand what that was, she didn't realise that it meant putting it into her mouth.

A lot of young women in the focus groups, particularly the younger women, spoke about having secret and inventive language which they used when talking amongst themselves, so that either young men or older people would not know what they were talking about. One young women talked about using words such as 'jazz' or 'opera' to describe different types of sexual activity. So they might

say *'I went to see some Jazz last night'* so that people didn't guess what she was talking about with her friends. Another young women said, *'we use totem - you know to describe time of the month - a 40 year old wouldn't understand'*.

Secondly we asked young women what they felt the determinates of trust were in a relationship with the service providers and educators. By far the biggest deterrent to trusting somebody was that that person was judgmental. For example, one young lesbian talked about her doctor assuming that she was on contraceptives, when she went to talk about her irregular periods. Also, young women talked about the assumption that they were sexually active, when they asked a question about condoms for example.

Young women talked about a need for clarity around boundaries of confidentiality. Not only in the actual face to face relationship, and how far the information would go, but also in the other aspects of confidentiality around that. Another thing that young people said that they did, was testing out. The would test someone out with a trial question, which was not about the thing they wanted to know. For example one young women said that she would pretend that she had a questionnaire from school about sexual health, and then she would ask her mum to help her out when really she was trying to find out about sexual health issues.

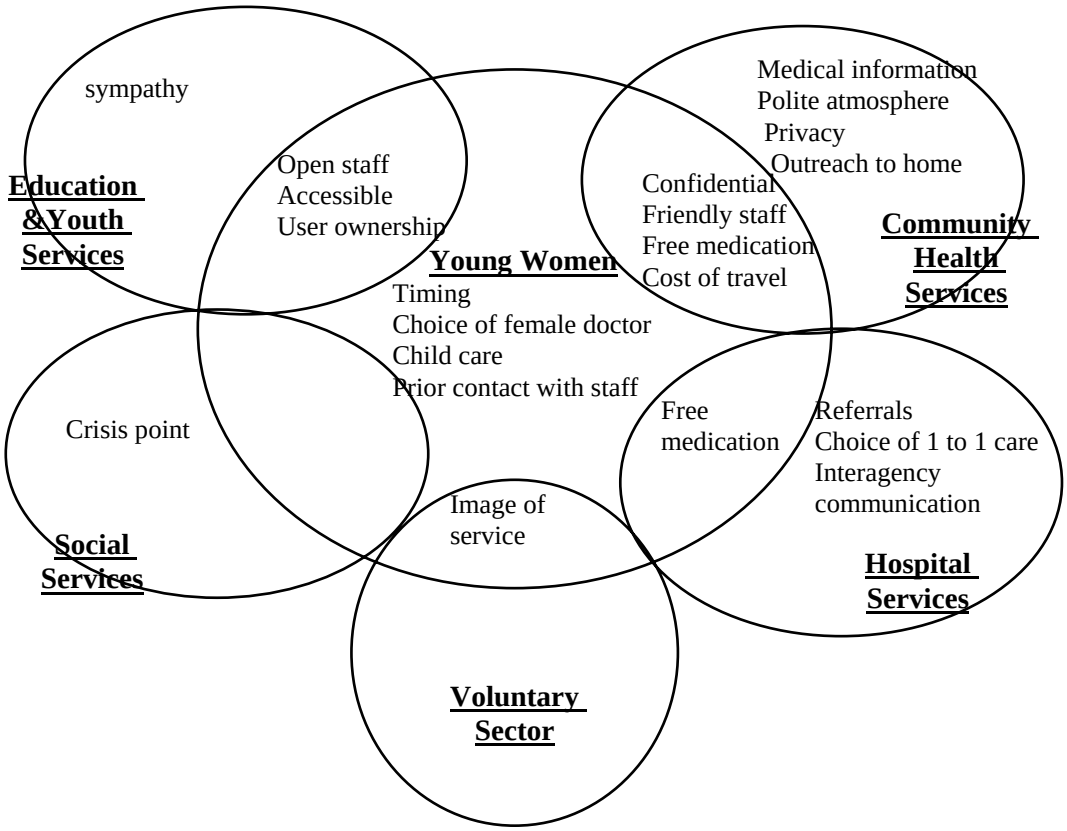
The focus groups also talked about the importance of education for the educator, especially about HIV and AIDS. A lot of people said that their parents did not know about HIV transmission as they had not been taught it themselves.

The second topic is education and information. We asked young women about the way education was delivered, topics and also sources of education. A lot of young people talked about a dislike of a biological focus in sex education rather without the social focus. One women talked about a book her mother gave her when she started her periods. *'She gave me a book about how a caterpillar turns into a butterfly. God knows what that's got to do with periods.'*

Lots of young women talked about the confusion of euphemisms in many different ways in their sex education. They also talked about disliking the use of boiling tubes to demonstrate condoms. They said that often descriptions of sex were often romantic and vague, and didn't match up how their first sexual experiences were. For example most people's mums extent of what they say was *'when you find a person that you love very much, you have a special cuddle. It's very exciting, and all sorts of wonderful things happen.'*
Young women talked about the dangers of being educated by their first sexual partner and one said she hadn't realised she had had sexual intercourse until it had been explained to her afterwards by her first boyfriend. They often felt

punished for asking about sex. They also criticised the fact that there were often hidden agendas in their sex education. For example an emphasis on having to be emotionally responsible during sex, or sex taking place within marriage. Young women talked about the surprise of actually feeling sexual pleasure which had not been explained to them in their sex education. They talked about the social or sexual reality of their educator not being the same as their own social or sexual reality. One young women said how her doctor had explained to her how to use her diaphragm:- *"The doctor said 'you just get into the habit. If you know you are going to be making love, you go into the bathroom, have a wee, brush your teeth, put your cap in and there you go' it's the way she said it, I just don't do it like that"*. She said that sex for her was more spontaneous and she also didn't talk about making love.

The next section was about sexual health services. We did a comparison between what service providers said and what young people said; why young women chose services and why service providers felt they thought young women chose services. The following diagram shows reasons why young women chose various sexual health services and those providers views showing areas of overlap.



There was often a stress on the importance welcoming of a non-judgmental receptionist by young women and also a privacy within consultations including a locking of the door when they had a smear test. Examples of recommendations that were made in the needs assessment were that they should be to set up a young persons watchdog for sexual health services that young people could go to themselves, that there should be more school counselling and that there should be a higher level of support services pre and post abortion.

Another point that was made about why women chose service was that when they were asked why they might chose services they talked about (in ascending order) the costs of getting to services, travel problems, and then they focused on their worries about the staff attitudes or the atmosphere of the project rather than talking about the timing of service. That was also specific to the area in which the assessment was done as there was a difficulty in getting to the hospital - it was two bus journeys to get there.

A comparison of the responses when young women and young men were asked about their perceptions or the reasons and motivations for different sexual behaviour. With regard to safer sex , young men talked about the difficulties of having sex outside or having sex around the back of the youth club. They said they found it difficult to focus on safe sex, on using a condom when they were already focusing on their performance and actually having sex and all the other stresses that came into the situation, and condoms came down quite low on the list of priorities. But when they knew that they were not going to be disturbed, or they knew they were going to have private environment, that priority was much higher.

When young men and women were asked about the reasons and motivations for pregnancy, young women focused more on emotional and social needs whereas young men focused on economic needs.

With regard to reasons and motivations for un-safe sex., young people seemed to find it more difficult to think of reasons for why they did something they should rather than why they did something that they shouldn't. May be they had been asked that more often or they were more likely to think about that after the event. Some of the phrases were quite shocking. Men had the final push and women had no weapon against that, discussing diseases put them off sex, quick sex outdoors, getting on with it. But there was a common agreement that women were labelled 'slags' if they carried condoms or if they suggested using condoms.

Turning to some of the participatory activities within the project; The advisory group which was set up at the start of the project was made up of both young

women's service users and also service providers. There was a recruitment of participants by young men who were involved in the project and also young women were involved in a wider range of the data collection and the data analysis of the needs assessment. For example young women generated scenes for the focus groups from a series of key words; they acted as focus facilitators, by attending focus group training. There was one focus group where we piloted the focus group questions and were given suggestions by that group of ways in which we could change the questions or the format. One thing that they said was that we had done a warm up exercise at the beginning of the session which they felt was inappropriate as it put them into a learning role in a group work sense, rather than research participants or being asked what their experiences were. Young women were also involved in analysing the transcripts of the focus groups. All the focus groups were taped and then they were typed up and they were coded by using a computer package and young women were involved in analysing the transcripts by working out code words and also doing the actual coding. The advisory group generated recommendations from the transcripts and so young women were involved in that. That itself threw up a lot of interesting discussions and showed between the service providers in the group and the service users themselves about what kind of recommendations there should be in the needs assessment. The young women were also involved in the launch, the dissemination of the needs assessment.

A group of young women from the local school wrote a play about potential service development which they acted out at the launch. They were involved in the designing the format of the report, and also the cover for the report. One of the focus groups turned into an on-going sexual health group for young women which was called the 'The Team Talk Group' which is did some peer education work and they are now running sexual health groups themselves at the well women's centre. There were young women involved as volunteers on the project as well and there were other activities along side the team talk group. The learning difficulties group which took part in the assessment are going on to take part in some peer education work themselves.

These are some of the lessons I felt I learned about participation. I think it is important to change the power structures of the project itself, and not expect young women to change to fit into those structures. For example before the first advisory group meeting, I held a pre-meeting group with the young women who were to take part in the advisory group to explain how the meeting would run (minutes, chairing), and in retrospect that was stigmatising the young women that they had not had experience of advisory groups or that type of formal environment rather than actually looking at the advisory format and working out the best format for the advisory group as a whole. And towards the end the

advisory group did tend to be more creative in the way that they discussed subjects, for example, when we were generating the recommendations.
I think it is important to validate young women's involvement in the project in a whole range of ways. Hard cash is a good example, which towards the end of the project's running did do for the advisory group members, but did not do at the beginning. The professionals who were coming to the advisory group were all being paid for their time and in retrospect the young women were coming as volunteers, although there was childminding provided and other expenses that were being paid. But this was not validating, for the expertise which they were bringing to the group.

I think it is really important to have transparency of motives. A lot of young women that I approached or spoke to were concerned that I was going to check up on their sexual behaviour or find out about the things they had been doing, such as sex under 16 which they shouldn't have. That's where the title for this presentation came from originally. When I went to the school to talk about young women and to encourage them to be in the focus groups, they were told by their teacher that someone was coming to talk to them and ask them questions about their periods, which they imagined as a question and answer session. They explained to me afterwards that they thought I was going to be wearing a white coat and sensible shoes and ask them in turn about their periods.

I think it is important to think about why you are actually involving young women and at what levels in the project. Not just getting young people to stuff envelopes or do the peer education aspects of the project, but how involved are they in the policy or structural levels of the project, and what power do they have at that level. How much is 'tokenism' them being part of the project. It is important to have a consensus of expectations in the different participatory activities. For example in the advisory group as service providers and service users were coming together there might have been traditional expectations that came into that relationship because that's how people were used to those relationships rather than looking at the fact that everybody was there to look at their own expertise for the project. Also finding out the expectations are of young people who become involved in the project - how much are they expecting that the project is going to play a support role or what kind of whilst they are being research participants or volunteers.

Small initial contacts with the project often grew into larger involvement. This again was the sort of testing out of the project by the young people. Young people would often come and ask me for a leaflet or some information or a book and later come back and ask another question and later still become a volunteer with the group or become part of the advisory group. Another role that I think is important to focus on is the gate keepers of young person's sexuality. We

focused a lot on finding out what young women's views were and their sexual health needs were, and maybe less so on the people who actually had the power to make changes about that in service provision or education. So it is important to look at how you can translate those needs that were expressed into a way which will hopefully promote change in the people who have the power.

What are the advantages of the participatory and community developmental approach to the needs assessment?. It increased the project's credibility amongst local young people involved and the way they would report back about the project to their friends. I just have just heard that someone has been employed to carry on the implementation of the work, which means that they have found further funding which is good. There is an increased relevancy of the research objectives. The areas which we saw within the needs assessment were a wider range that would traditionally be seen in the sexual health services. For example the language and trust issues, and the educational issues. I feel that we feel that we received a higher quality of information because of the participatory approach from the young people. There was also a focus on positive behaviour, for example asking questions like why people have safe sex rather than always asking why people have unsafe sex, which to me now seems logical because if you are trying to encourage more people to have safe sex you should be asking why they should have safe sex. In other ways the project provided a discussion bridge between service providers and service users for example in the advisory group where the two groups had a more equal power relationship and were able to discuss those issues. And also the research was not a kind of 'smash and grab' type research, it was ongoing and the project is still in existence in that local area.

The Young Women's Sexual Health Project is now based at the Well Women centre with a part time co-ordinator working to implement the needs assessment recommendations. This has entailed to date; the instigation of an evening drop in session at the centre, the continuation of a sexual health group for women with learning difficulties and establishment of a training scheme for service providers.

Y- Wait

Rosemary Kirkman
& Maggie Flint.

Rosemary Kirkman - *I'm really here just to introduce Maggie. I'm the doctor person and Maggie is the do-er person. I came in time to hear Mr Tonkin's opening address and he set the scene with questions 'who speaks for youth?' and 'how do we engage youth', and I think the previous speaker, Anne, has shown that girls are the same the world over. We have the same problems in North Manchester and I think Maggie has shown the way forward with the answer. So, over to you Maggie.*

This is the first time I have spoken at a conference like this so if you hear something knocking, it's my knees. My name is Maggie Flint and I am the project worker for a project based in North Manchester called Y Wait. It is a girls and young women's health project and it's based on peer education.

Y-Wait actually stands for Young Women's Advice and Information and Time to talk. We are not encouraging people not to trying things without thought. We have actually been reported in the local press as being called WHY WAIT. We are also not an eating disorders project although we do cover eating disorders in our work, as in WHY WEIGHT.
Y Wait for the last six years has been offering an alternative health service to the young women under 25 in North Manchester. The service that they offer includes a weekly drop in with a doctor and a family planning nurse who work along side the trained volunteers, and a drop-in local youth centre, and we always have a crèche. It is a comprehensive service, including emergency contraception. We do pregnancy testing and we also do referrals for termination of pregnancy. The majority of work that we do is actually around sexual health. Now that wasn't planned in the beginning. It is a general health project, what we have found is that the majority of things that the girls and young women come in for are actually related to sexual health issues. The other service that the project offers, is the trained volunteers go out and do talks and workshops in local schools and youth centres, usually on request.

The project actually started from HIV and AIDS money. It started in 1989 with two short term six month grants, and it then went on to be awarded a three year 'pump priming' grant to pilot the project and then in 1994 we were 'purchased' - which was the jargon we were given. The project was actually independent for three years, run by young women for young women, it now has funding from the local health authority.

I'll just tell you a little bit about the structure of the project. The project employs a part-time worker for 18.5 hours (which is actually me!), and I am the only worker and I am there to facilitate what the volunteers want actually happens. I have to make sure that the drop-in happens, make sure that the drop-in staff and arrange all the meetings and what the girls want to do happens. We also employ a trained doctor and a family planning trained nurse on a session basis for the drop-in and we always have a crèche worker for all the things we organise because some of the girls have their own children, or they have responsibility for younger children. At the moment we have got 10 trained volunteers who run the drop-in and they are aged between 15 and 23 and their involvement is in staffing the drop in and running workshops. They get involved in the training of the new volunteers as well.

We meet once a month so that the volunteers can decide what direction they want the project to go in, so they are actually tell me what they want me to do. Some of the things they have done in the passed - they have produced their own leaflet on young women and pregnancy, because they thought that the existing material was aimed at older women and wasn't aimed at them, they had been pregnant young and the material they had been given they didn't find was accessible to them. We also made a video two years ago with a young women's sexual health project for young women with learning difficulties which Channel 4 actually used.

So, now I will take you back to the beginning.

We actually started as the North Manchester girls and young women's health project. North Manchester health promotion actually commissioned a piece of work for six months to action research the health needs of girls and young women's needs in the area. It was part of the AIDS and HIV strategy. At the time there was the growing concern about the spread of AIDS, HIV, and the girls and young women were not presenting anywhere. North Manchester actually has an excellent family planning service and an excellent well women's service, but the girls and young women weren't showing up. So this piece of research was commissioned to found out why. A series of meetings were held across the district to reach as many girls and young women as possible. They were actually asked what they thought of existing services and what they would like to have in the future, and the findings of this consultation formed the basis of what was to become Y Wait.

Now some of this actually over-laps with what we have already heard. What we found was that the girls perceptions of the existing services were not actually from experience. What they were doing was perceiving what would happen if they used the service so some of it was not fair comment on the actually staff of

the well women's clinic, but this was how they thought they would be treated if they turned up. There was a deep mistrust of health professionals, particularly your GP - they were not to be trusted. As soon as you left the room your GP would be on the phone to your parents and told them what you had been there for. Family planning clinics were not being used as the girls were not planning families, it was as simple as that - 'I wasn't planning a family'. They didn't know about the other services which were offered at these clinics, they didn't know they could get on the spot pregnancy tests. And the well women clinics they saw definitely as a provision for older women and also they were a service their mother's used, so they wouldn't go there in case they bumped into their mum, their aunt, or their older sister.

So they were actually asked if they could change the service what they would like to have and the first thing they said was that they didn't want a receptionist. They don't like walking into a place and having to give out personal details in a public place to someone they don't know, giving details such as name, age, address and what they were there for. So, when Y Wait was set up we cut out the receptionist bit and the volunteers actually do that. When the girls arrive at the drop-in, they are greeted by a volunteer who just walks up and introduces themselves, by their first name, and asks the girl for a name to call her by - because if you are going to talk to somebody that's all you need a first name, initially you don't need to know their full name, how old they are and so on. This is to put them at their ease.

As to the setting, the girls didn't want a clinic. They felt that as soon as you walked into a clinic everybody knew what you were there for. Originally, the project was set up in a community education centre, quite anonymous, as when you arrived there you could have been there to throw a pot or learn sign language, even though we did have sole use of the building, there were no other classes going on at the time, it was known as this was a community education centre, and this was the sort of thing that happened there so that possibly you could be going there for something else.

The other thing that they wanted was a doctor and a nurse who were friendly. They felt that their GP and doctors very often talked down to them, they used language that they didn't understand, and they felt that decisions were being made for them and they weren't being given enough information to make their own informed choices. They also felt like they had to go with a problem that needed solving, and they needed to know what it was that was wrong before they went so that someone could tell them. So they wanted a nurse and a doctor who were friendly and who didn't wear the white coats and have the stethoscope round their neck, they wanted a doctor who would sit with them and take a turn at brewing up - which is what they did get.

The doctor and the family planning nurse which we have got were actually interviewed by the volunteers before they were taken on by the project. I was as well - it was gruelling!

They decided that it would be girls and young women only. This was actually their decision, they felt that the boys were less mature and they didn't actually take some of the subjects, especially sex, as seriously as they did themselves. They didn't trust the boys to use the same facility as them and to go out round the corner and say 'hey I just saw so-and-so going on their and she's on the pill'. So they wanted it for themselves.

They didn't want just a contraceptive service. They wanted a service where they go for anything. It might be that they had had a row at home, or they couldn't do their homework, or they just wanted to get out, they wanted their own space. So it was taken on as a general health project. You can actually walk through the door with anything. You don't even need to have a problem, we actually encourage it as a social situation we encourage the girls to come before they have a problem, because once they have a problem it is even harder to walk through the door. Whether you are a young person or not, one of the hardest things to do is to walk through a door and not know what was on the other side - I have done it this morning coming in here - so, if you are a young person with a problem it magnifies it. So we encourage them to come and visit us first, have a brew, have a biscuit, and find out what we are here for, so that if you need us in the future you know where we are. Or, if you have a friend who needs us you can bring her.

The thing about Y Wait is that it is based on peer education, and it is run by women for young women which means that the volunteers need training.

The training courses which we run are all different because they are based on the perception of the young women, what they define as their health needs. So both the content of the volunteer health training programme and the length differ. Now the original health training course took 8 months, but this included the planning of the drop-in, finding a location and actually setting it up. That took 8 months and included meeting weekly in the evenings, it also involved four full days training and two weekends of residential training, so it was quite intensive. The training was negotiated with the trainees and the original development worker for the project did it along with a women's health worker and two youth workers, so they did have some intensive support through this 8 month period. But it was the girls themselves who decided what their health concerns were and what might be the concerns of the users of the drop-in. There were 25 girls who actually started that training and 19 completed it. The original training group

ages ranged from 14 to 22, which is quite a large age gap when you are actually training volunteers.

The group also meet socially. This was seen as really important for the team and confidence building, because what was going to happen at the end of the training was that they were going to be handed over control of the project. So they met socially, they went ten-pin bowling, they had meals out, they went to the cinema, all that was funded by the project.

Three of the original volunteers are still with the project, but obviously as the years go on volunteers leave and the volunteer training remains on-going. The project actually aims to recruit annually, and this is done through local schools and youth centres. It is done by posters, leaflets and visits to explain what we are doing.

The content of the training does vary, but we find that much of it comes up all the time. There is always the sexual health stuff. They always want to know about contraceptives, pregnancy testing and whatever. At the moment in Manchester we have a zero tolerance campaign going on for male violence and the girls have picked up on that, the current training course have picked up on it and they have said that they want to know more about domestic violence. Others might want to know about eating disorders. Whatever is an issue to them.

Following the training it is up to the volunteers how much time they want to offer. If the volunteers do the training and then drop out, we don't see it as a failure, because what they have done is, they will still carry on with the peer education because they have got the knowledge and the confidence to talk about it they will pass it on. Even if they are not doing it through the project. So we don't say the girls when they start that they must make a commitment to this project. It is entirely up to them.

They usually staff the drop in. That is done on a rota basis and that is decided at the monthly meetings. But more often than not they all actually turn up every week. Some of the volunteers have had further training to do group work and their contraceptive workshop is very popular. They go around the local youth centres and do that. Two of the volunteers actually had babies before they were 16, and they frequently go out and talk about their experiences. I could actually go along and talk to young women about pregnancy and child birth, but when Tracy stands up and says 'I was pregnant at 13 and I had my first baby at 14' she has got a captive audience. I couldn't do that. I couldn't achieve that. And the questions they ask, like, 'what did your mum say, did she go mad?', these are the things that they actually want to know to give them an understanding of the

situation, and I couldn't do this. I mean, my mum was over the moon when I had my first baby!

The project has actually continued in this format until the beginning of this year. But at the beginning of this year we were actually forced to move premises. This was because of the change in the funding. When Y Wait was grant funded, we were actually classed as voluntary organisation although we had the support of the community services unit who provided the doctor and the nurse and all the family planning supplies. But the community education centre where we were based, because we were a voluntary organisation there was a small affiliation fee, they gave us the use of the building with no rent. So, when we were actually purchased by the Manchurian Community Trust and the 'powers that be' found out, we were classed as a statutory funded and they wanted more money and they wanted £1,000s and when the project was originally costed it wasn't costed with rent. So it was a case of 'we want the rent or you are moving out. Education is not providing what the Health should be paying for'. And then, in stepped the Youth service who said 'pick a youth centre, any youth centre you like, and move in it and tell us what you want'. The Youth service in Manchester were really keen to get involved once they given the opportunity. So in January this year we moved into a youth centre, we moved into Moston Youth Centre. And then in April of this year Manchester Youth Service actually went into partnership with us and I became full time and they also gave us two youth workers to work with the project, two sessions a week. We have just recruited - the idea is to set up two more drop-ins in two more locations - thirty-three more young women with the aim to open up these two new drops-ins and have just started the training now. So watch this space!

Dr Elizabeth Heycock - ‘A young person’s confidential health record’

Abstract

A multi-disciplinary group of local children’s doctors, nurses, and teachers, have devised a draft booklet which comprises 2 main parts’ a personal confidential health record, and an information and advice section. The purpose of this booklet is to empower young people to take more responsibility for their own health by entrusting them to keep their own health record and by providing them with up to date information and advice pertinent to adolescent health issues.

This booklet has been kept in a compact form and therefore by necessity information and advice has been kept brief. The information section takes into account local and national concerns over young peoples health, and addresses a wide range of issues (including healthy eating, exercise, hygiene, bullying, child abuse, smoking, alcohol, drugs, relationships, contraception, accidents and first aid). Key points relevant to each subject, and local and national contact numbers or organisations which can offer further advice are given, along with information about local services. Thus youngsters who are not aware of all the services available to them, or feel uneasy about consulting advice about their health particularly with regards to confidentiality have immediate access to basic information. This booklet has been circulated in a pilot study of 250 children aged 14-15 years. The children’s level of knowledge prior to obtaining the booklet and one school term later is being obtained along with their feedback on the booklet. It is anticipated that the working party comprising health and education professionals and young people themselves will modify this booklet according to feedback from all those involved. Preliminary data suggests that the majority of young people issued with the booklet have found it helpful.

Today I would like to present to you a booklet that has been devised in North Staffordshire to provide young people with their own health record along with advise and information pertinent to health issues which are prevalent in today’s adolescent population.

The background to this booklet is related to international, national and local concerns about adolescent health in the widest range. Local worries about the rates or alcohol and drug misuse among young people, along with high teenage pregnancy rates mirror national findings..

The district of North Staffordshire has a total population of just under half a million with a mix of rural, semi-rural and urban population groups. Currently the services that are available t young people, in addition to general practitioners surgeries, family planning clinics, and school health clinics, include drop-in clinics held by our school nurses held in a majority of secondary schools, and three young people's advice clinics held specifically for the under 21 age group in different parts of the district. Some health care practices also undertake a sixteen plus health review.

A study undertaken in North Staffordshire in 1994, through semi-structured interviews of over 250 14-16 year old youngsters indicated a lack of knowledge of services and service providers, along with worries over confidentiality, concerns about access and a tendency to consult the peer group at times of need. We undertook to develop this hand book as one way of tackling some of the problems fed back to us by the young people themselves.

We recognise that the problems that young people face today are complex and multi-factorial, and that health issues must be considered within the social context. So, a multi disciplinary group has met together to develop this booklet which is currently being piloted in two schools within out district.

Initial discussions between health education and health promotion include a very lively debate about the size of the booklet, the type of binding it should had, the reading age of the text, the topics we should cover, the inclusion or not of pictures, and the method of use once the young people had obtained the booklet. There were very real concerns about whether the young people would use the booklet and whether they would understand it.

The jacket of the booklet has been devised in a way to engage young people's interest. The majority of our working group felt that the booklet itself should be presented as a document of importance which could be referred to into adult life, thus enabling young people to sense that they were trusted to use the booklet in a sensible and adult manner. There was concern that the booklet needed to be hard wearing, however this had to be balanced against the possible advantages of using a loose leaf booklet which could facilitate additional pages for groups of youngsters with special needs such as children with epilepsy.

Confidentiality was considered a very important factor to the young people and therefore use of the hand book by other professionals such as general practitioners and school nurses has initially has been left open. Although our working group effectively debated many issues, and worked together the content of the booklet, we are keen to engage young people at this formative stage of the booklet in order to gain their ideas for further development and use.

The booklet itself has been presented to young people in the pilot as a confidential document which can been kept entirely private by themselves or can be shown to other people if they choose to do so. The booklet in draft stage has been introduced to pupils for their evaluation, and is currently is in a bound form and is A5 in size.

In order to obtain a representative view from the young people themselves during the pilot study we approached two mainstream schools, one situated in a semi-rural area with a population of mixed social/economic grouping, the other in a more deprived urban area where pupils are of relatively of a lower ability with the average reading age of pupils on entry to the school being two year below chronological age.

Once we had obtained consent from school governors and parents, we introduced the booklet to years 9 and 10 at these schools. All teachers involved have been very positive about the use of this booklet and very supportive of this pilot programme, as have the young people themselves. When the booklet were introduced, the young people recruited to the study were given a brief discussion about the background of the booklet and they were asked to fill in a questionnaire, in the classroom setting, under supervision, before receiving this booklet. The questionnaire had been devised using topics covered in the booklet to measure young people's knowledge on health related subjects before obtaining the booklet. The young people were then given a copy of the booklet and to consider it as their own confidential property which they might refer to when needed. We emphasised the value we placed on their opinion on the booklet, indicating that the future production and use of the booklet was largely dependant on their views. We explained that at some later stage we would want to learn their views about the booklet as well as repeat the knowledge of health questionnaire.

The first section of the booklet, which occupies one fifth of the booklet, is a health record. This has spaces for the young person to fill in his or her own details such as name, address, general practitioner, school nurse, and soon. It also has a page devoted for them to write in their own personal medical history. We hope that this will increase their interest in their own health and help facilitate them taking more responsibility for their health. We have included three pages for the young person to write in before, during or after any consultation, there are also growth charts for the child to fill in when they are measured.

The second and larger section of the booklet is an information and advise section, which is divided into four parts, which are colour coded, for ease of

recognition by the young people. The broad issues covered are: General Advice on health - including areas on immunisation, healthy eating, exercise and areas which cause young people very much concern such as depression and eating disorders. There is a section of advice on pubity, and a section on how to protect yourself, which contains information on stress, anxiety, bullying, and on child abuse as well as action protection as well as a section on first aid. This slide shows one of the texts, this one in relation to accidents, particularly with relation to road traffic accidents. For each topic the advice is given in this text form, which is by necessity compact, focusing on key points and there are a list of local and national telephone numbers at the end of each topic section for the young person to refer to and use, and we have also put all the telephone numbers contained in the book in a rear index section of the booklet.

This is another slide of text, in this case giving advice about alcohol. Again it emphasises key points, and again providing information which is immediately relevant to the young person as well as information of later consequences.

There was much discussion in the early stages of forming this booklet as to whether the text should be accompanied by pictorial representations either in cartoon form or diagrams. We felt that for the pilot study we would have a blank page following each topic, allowing youngsters to develop any thoughts they might have about diagrams, cartoons or other pictures which might push home any definite messages to them.

We are now in a position to revisit the pupils with the repeat knowledge of health questionnaire and also a questionnaire that we are using to evaluate the booklet. There has been an enormous amount of interest in the booklet on the young peoples behalf, and they have come up to me with individual comments and this is just one example of something a group of six youngsters initiated themselves, they gave me a series of papers about what they thought of each stage of the booklet.

At present I can only give very preliminary results on the evaluation of the booklet. But these results do indicate that our early concerns about whether the children would use the booklet, and whether they would understand them, were probably wrong.

In this pilot study of 155 young people aged 13 to 16, the results to a question as to whether they felt the booklets were helpful or not, indicated that 82% of the young people did feel that they were helpful. And 72% of the young people indicated that they understood the advice within the booklet. The category of ‘don’t know’ to the second question is interesting. It became very evident when we went into the classes of the schools, that because we were serving pupils of

very mixed ability, some of the young people had difficulty in understanding some very simple questions that were set, so that the answer ‘don’t know’ really contains a heterogeneous group of opinions, and I think we need to look into this in more detail.

136 of the young people that we asked felt that the booklet should contain pictures. Interestingly 63% of them favoured photographs rather than cartoons, again perhaps suggesting that they want a more adult representation of the facts, rather than a less adult one.

Currently in this pilot stage, the booklet has been introduced into schools with no re-enforcement. We believe that this positive response rate would be increased if the booklet was referred to in personal health and education sessions and in other health related contact points. Including sessions that the police hold in relation to drug abuse and accident prevention.

In terms of exploring the value of the booklet further, to young people themselves and to their health related behaviour, we do recognise that knowledge is only one fact in the equation and we are currently exploring other avenues in which we can use we can measure the impact of the booklet on young peoples use of services. This will require co-operation of all the agencies involved with young people.

In conclusion, as this booklet develops, we are keen to take on board the views of the young people themselves and to develop their ideas further, both through focus groups and through their participation in our working group. Preliminary discussions with teachers and health education leaders have indicated that they would be very keen to use much of the information in the booklet in their sessions at school. This would help to reaffirm key messages contained in the booklet and to remind the youngsters to use them when they need to. We are also keen to explore other ways in which the booklet might be used, for instance in peer group teaching and in regular debate in schools and youth groups. We hope that by adopting this collaborative approach, we will provide some improvement in health indices in our young adult population.

Teenage pregnancy and sexuality

Chaired by Pramilla Senenayake

Dr Diana Birch "Are you my sister, Mummy?" - The Youth Support Experience.
Introduced by Dr Fay Hutchinson

Dr Fay Hutchinson - Contraception and Sexual Education in the Nineties.

Dr Pamela Gilles - Young People's sexuality ; Promises and prospects.

Dr Nona Dawson - The Education needs of young mothers.

Diana Noble and Dr Gillian Vanhegan - What young people want.

Dr Chris Wilkinson - Providing an STD service for Youth

Muriel O'Driscoll - Psychosexual Counselling - Sexual Orientation.

Teenage pregnancy and sexuality

‘The Youth Support Experience’ - Dr Diana Birch

Teenage Sexuality - Schoolage pregnancies

“My mum sent me to the doctors when I was about four months because I hadn’t been on the periods. The doctor said it was just puppy fat, then she sent me back when I was seven and a half months and he said it was just wind. “ (Kirsty - 14. schoolgirl mum).

Such a quote is all too common. ... and unfortunately just as common now as when I first recorded those words ten years ago... A sad illustration of how out of touch we can be with the teenager’s view of sexuality and thus fail to provide adequate services , whether it be for guidance, education , practical or medical help for youth.

Each year in England and Wales approximately 10,000 schoolgirls become pregnant. Many of these girls will do well with their babies as evidenced in our fifteen year follow up data - nevertheless for those who experience difficulties, it can be depressing to see the cycle repeated in future generations - ‘old girls’ returning to a residential unit to visit their daughters and nieces in the next loop of the spiral. Conception rates have altered disproportionately so that the youngest girls now constitute a higher proportion of the number of school age births than previously indicating that the very young, most vulnerable, girls needing most support are being failed by preventive and educational programmes.

Why is this? Why do so many young girls become pregnant and so many young boys become baby fathers? An adult professional stance can lead us to fail to understand the difficulty that our teenage patients are confronted with in growing up; attempting to look at some of the conflicts from the young person’s point of view we are more able to act practically and effectively to help our young patients avoid making the same mistakes that we did at their age. By understanding the belief systems of the adolescent and his or her peer group we can interact with that young person in a way which has relevance and meaning.

It is for this reason that the emphasis of work at Youth support is on emotional and motivational aspects of sexuality - beliefs, self concepts and most particularly self worth. We must be forgiven some element of repetitiveness in

describing these concepts and their significance since the same basic principles influence so much of the adolescent's behaviour and thinking patterns.

Peer group beliefs "You can't get pregnant standing up" can be confronted with factual knowledge -sperm can swim uphill! But at a deeper level are what I would describe as magical beliefs. Intrinsic ideas with high emotional content a feeling of instinct and intuition which may have no perceivable basis in current reality. Magical beliefs centre on fundamental concepts; feelings about self, body,control - the nature of life itself.

The adolescent is much preoccupied with the question "Who am I?" Confusion arises when "Who am I?" becomes "Who are we?" Acquiring a personal identity becomes a monumental task for a pregnant girl whose identity changes beyond her control; no longer a little girl, but a fertile woman. The role of mother is thrust upon her before she establishes her own identity, hence the belief that she cannot get pregnant and denial of pregnancy. *"I knew how girls get pregnant, but never thought it could happen to me"*

Girls deny that they can become pregnant. They believe they are too young. Belief in the impossibility of pregnancy tends to become almost a magical protection like a lucky charm "It won't happen to me". These teenagers are at the stage of concrete reasoning unable to identify with the experiences of others. This explains why health education methods based on shock tactics do not work with this age group.

Teenage sexuality is profoundly affected by beliefs about control. Emotional development involves internalising the "locus of control", assuming responsibility for one's actions and one's body. Those maintaining an external locus of control are not in control of when they have sex or whether they get pregnant, are not responsible for their actions or their bodies - pregnancy is something that *happens* to them. It is a matter of fate. An unplanned pregnancy represents the ultimate loss of control. Even their bodies are acting independently with their wishes. Belief in the autonomous womb explains why teenagers do not believe sex will result in pregnancy. It also explains some of the denial.

Belief systems interact in limiting contraceptive use. Hence for young teenagers under the age of 16, it is not so much a matter of availability of contraceptive services which affects sexual practices and conception rates. Much more important is the social situation and life experiences which affect their emotional maturity, motivation and their value systems. A self esteem measure of pregnant schoolgirls and a comparable group of schoolgirl mothers indicated that while painful life experiences and deprivation resulted in an expected fall in

self esteem scores, the girls who were pregnant at the time of the testing felt much more positive about themselves than the schoolgirl mothers. Pregnancy seemed to have protective value in conserving self-worth. Girls were finding an alternative value system by which to judge their lives.

Seen from a young girl's viewpoint, pregnancy may not be so undesirable; motherhood is a fulfilment; she takes on a valued role and out of her loveless world creates a baby who will love her. Pregnancy is thus used as a source of self-worth and a false solution to problems. That being so, an alternative solution must be offered. These young people need an alternative source of self-worth in order to ensure that when they become parents this is because they desire parenthood, with all its responsibilities, hardships and joys, not merely as the only perceived escape from a catalogue of problems.

Dr Fay Hutchinson - 'Contraception and Sexual Education in the 90s'

I have worked in the field of contraception and young people for the past 30 years. I have been asked to talk about contraception and sex education in the 1990s and we are now half way through the 1990s, so we can look both back and forward.

I want to begin by asking you a couple of questions. Young people are very much targeted now as a cause of a lot of our social ills - the single parent, the break-up of the families, the cost of the Social Services, and they do seem to be getting a lot of bad publicity - particularly from the media and our very virtuous parliamentarians. Can I as you all if you think there are more pregnancies in the 15 to 19 age group in 1970, 1983 or 1993 (which is probably the last year we have figures for)? Yes, 1970s is correct. Conception rates for young women. 84.4 per 1,000 in 1970 and went down in 1980s and up again in 1990s but not to the rate of 1970s.

What about teenage mothers - cause of so much expenditure and fury? Were there more teenage mothers in the 70s, 80s or 90s? 1970s - more than double than we have now. To listen to the media you would think it was the reverse. We have made some advances.

What about teenage sexual activity. What do you think the average age of the start of sexual activity is now? Most young people have their first intercourse at the age of 17, but about 20% of them have intercourse before their 16 birthday, and with Diana's talk and others we have already had today it is clear the really vulnerable ones are the ones who have sex really early - and this is usually because they are no 'super-sexy', but because they have been brought up disadvantaged emotionally, physically abused, sexually abused or are very sexualising upbringing, or they are very alone and sex is their only way of seeing that they are of any use to people.

Why do they do it? These were some of the reasons they were giving: - 'a natural follow on' - a follow on from what do you ask - physical contact, being in love, peer pressure. Young men seem to be more open to peer pressure than young women. Often trying to prove themselves, show that it does work. When you are asking youngsters why they have sex that first time, the usual answer is 'well it just happened, I got carries away'. In this young group, about 30% will say they had sex unexpectedly, when in some groups it is 50% say the same time. This accounts for a lot of the unprotected first sex, people getting

caught out when they first have sex, they are not prepared, they are not looking ahead.

What has happened in the 1990s in particular is, there was a document called 'Health of the Nation' which the department of health published and everyone got rather excited about, and two of the targets which are relevant to us was that we should reduce the teenage pregnancy rate for the under 16s by 50% by the year 2000. And we have figures and figures... basically the rate when the document came out in 1990 was 10.1 per 1,000 girls under 15 who became pregnant in a year, and there has been a drop until the last year we have figures for which has got down to 8.4 in 1994, but there has been a drop and a more noticeable drop in the under 20s. But in the discussion group I was working with earlier today, they seemed to be saying that in their areas they seem to be doubling the rate, and I wonder if it is anything to do with the last pill scare when a lot of young people seemed anxious about going on the pill.

The other consequences of the 'Health of the Nation' target has been more designated young people centres opened. Sometimes this was a way of not closing family planning clinics and re-naming them young people's clinics, but not making much difference to the atmosphere or the way in which they were run. Gillian Vanhegan and Diane Noble will be talking much more about what we thinks works to make people feel happy about coming to a centre. So increasing the number of centres that were available locally for them is one thing.

We have done a lot of work through Brook in unison with other organisations to establish the confidentiality of consultations for under 16 years old. And this has certainly been valuable as far as a lot of general practitioners go, were there had been much more resistance to seeing under 16 year olds without a parent. And I think that method has just come through and there are a lot of questions about confidentiality, but certainly this is the prime concern of young people that come to us - is it confidential, do you have to tell anyone, and if you say yes, unless you give them the assurance that it is confidential they are not prepared to tell you what is going on. But having said that we respect their confidentiality, that doesn't mean that we will just say 'there, there, of course we won't tell anyone', if they are in a situation that is harmful to them or dangerous to them, or we feel that they will get parental support, we help counsel them and help them to see that they may need support form elsewhere, or that it wouldn't be so bad to share the information, but I think one would only do this, one would only bread confidentiality, in very exceptional circumstances and with their knowledge.

I think another factor that has come about in the 90s is the increased awareness and availability of emergency contraception. Strangely it seems that those who are against abortion who are also against emergency contraception, which they seem to confuse with a sort of abortion. One would think that they would be relieved that it reduces the number of unwanted pregnancies. But the use of emergency contraception, has really reduced the number of unwanted pregnancies, considerably, but also it has by coming in and asking for emergency contraception that has got young people who are sexually active, or intend to be in the future, coming in to see their doctors or their clinic. It is a time when you can discuss what is going on in their lives, what is happening, what they want. So that is something else which is improved.

But I think the most significant thing as far as I am concerned, in the 90s, is that we have become much more aware of the sexual health of young people, and I see this as a positive thing rather than a negative thing. I have tried to find a definition of sexual health which I though would be useful to me in the kind of work which we are doing and would define what I meant by it, and I came up with something like this....

Our aim should be that we enable young people to remain sexually healthy, so that they can have children, when and if they want them. When and if they chose to have an active sex life, help them to minimise the risks of an unwanted pregnancy or sexually transmitted disease. When we are talking of sexually transmitted disease everyone thinks of AIDS and HIV, but in fact the less dramatic diseases, gonorrhoea and chlamydia are more significant if looking at future infertility and ill health. So with that, not only are you wanting young people to take responsibility for their sexual health not only as to whether they will be become pregnant, but also protecting themselves from sexually transmitted diseases.

This goes for boys as well as for girls, and is very much influencing what we want, which is to see a wider use of condoms, and what we are certainly advocating to the youngsters who come to see us at the Brook, is that if they are on the pill they should use a condom as well to protect them selves - that you double up. The double up method is taken up quite enthusiastically by the youngsters who are starting their sexual lives, but, as it has been observed before, as they get a bit older and they can see the disadvantages and think they can get away with it, the condom use does tend to be reduced.

So, youngsters can develop an experience of enjoyable and rewarding sexual relationships without harming themselves or their partner. Some people get a bit worried by the word ‘relationships’ and think that I am encouraging promiscuity, but practically the majority of people will not be monogamous

throughout their sexual life and I am not in the business of helping people to have un-rewarding, un-happy relationships, and I think that people are confident in what they are doing and are not being pressurised, their chances of making a good and enjoyable relationship are much higher.

So, sexual health, I think, is a really vital part of the services which we are providing now and should be included. I think we have got to get into a position where we can do more screening in contraceptive clinics, more treatment, to help youngsters keep themselves healthy.

One of the things that has interested me over the years, is that we have the pill, we are providing the services, we are all ready and willing to be helpful, we love to see them and it is all confidential.... Why don't they come?! And there are a whole lot of reasons why youngsters don't use contraception. Particularly early on in a relationship. And one of the series of reasons is the myths about it. I am just going to run through a number of the ones which I have heard countless times, usually when someone is pregnant. Perhaps this is where sex education might help I suppose.

'It can't happen the first time' - A strongly held belief that you cannot get pregnant the first time you have sex.

'I thought I was too young' - Too young for what? I ask.

'We did it standing up' - The gravity theory!

'I went for a wee straight afterwards' - The flushing theory

'We only did it once' - once is enough

And then there are a whole of 'he said myths'

'He said he would be careful', 'He said not to worry', 'He said he would take care of me', 'He said "I thought you were on the pill"'.

Another one that I realise that I heard 'He said he would marry me'.

Another common myth is the safe period. I was looking at a book that had been written - was the whole issue of a practitioner magazine which was issued in 1923, and was all about birth control and it said there about the fact that they weren't quite certain when ovulation occurred, but it did seem that the most likely time to become pregnant was just before or just after a period. And that

sort of mythery is still around, and a lot of youngsters who said that they thought they were in the safe period, ask them what the safe period was.

The other reason for a failure to use contraception is a fear of the side effects, and I could give a whole talk about that! Side effects of all the contraceptives, but particularly the pill.

There is also the denial of sexuality - 'I didn't think it was going to happen'. First sexual intercourse, not being prepared. There is a great difference between the youngsters who are using contraception at the time they have their first intercourse who tend to have been in the relationship for some time, it has come about gradually, have talked about it, and the youngsters where it just happened, it was unexpected and they were not prepared.

There is also irregular sexual intercourse. I think women particularly are rather economical about contraception - they only believe in using it if they are going to get their moneys worth! So if you are only having sex once every six weeks, is it worth it?! But not just with young people, difficulty of communicating with sexual partners, difficulty at actually saying to them 'are you all right, are you using contraception', 'well no I'm not - have you got a condom?'. Reunions, regular use of birth control, difficulties that sort of thing, there are a whole lot of reasons why not only youngsters have difficulty in using birth control. And so I think this is something which can be tackled partly with sex education, but in the clinic practices this is something which we are having to deal with.

So what are the changes since the 70s?

I think one big change is that there is an increasing choice of places to go to. General practitioners are seeing more young people, and I have some evidence of some interesting work being done in practices, where a doctor is particularly interested in seeing young people. They set up a special time, a special session to see youngsters, you make it known in the practice that one is willing to see people of any age about contraceptives, in confidence. But one of the most interesting developments, which is particularly happening in the North West of England where they are rather advanced in some ways, I have known some practices where doctors have sent letters to youngsters who have been coming up to the age of 16 (now perhaps even 15 or 14), inviting them to come in for a medical consultation, not just about contraception but for a who lot of reasons, but basically to establish a relationship between the doctor and the young person, because this is one of the reasons why young people don't go to general practitioners - 'they are too much a friend of my mother', or they don't think it is confidential. This establishes the relationship between the doctor and the young person, but where they have had an even higher rate of people coming in

for consultations, is where the letters come from the practice nurse. The practice nurse has then been the person who has seen the youngster and given them advice on diet, emotional health, skin conditions, the need for contraception and the practices confidentiality. And I think that it is a really good way of seeing youngsters, because let's face it they should have a choice where they go for advice and there are not young people's centres around the country.

What about the boys? We haven't mentioned them much have we?

At Brook and at other centres we encourage young men to come in with their partners and take part in the consultation, and that is always a pretty good sign that they are taking some responsibility, that they are trying to help out. But also what about seeing boys for themselves. Where do they get their sex education, where do they get their anxieties dealt with? And with the HIV scare and the sudden promotion with condoms this is become a way of them coming in, but you just don't hand them the condoms. I think some of our most successful centres, some of our centres in London, are where we have had young male outreach workers, going into schools or youth clubs to do health promotion, and will be available at a drop in centre for young men, so that when the come it seems to diffuse a lot of the excitement or aggression that they sometimes generate which is a reflection of their own anxiety when the sometimes come into what looks like a female centre. At the clinics they are not just taught how to use a condom and when, they are taught about emergency contraception, looking after themselves, about testicular examination so that they can know when their testicles are normal and when they are not, because cancer of the testicle is becoming more common in the younger age group. So, being treated with a respect and in confidence, a number of them will then want to go on and want to talk about their own particular anxieties, often about their sexual performance, their normality or their sexual identity. I think this is an example that would be of great value if we could have more drop-in centres for young men.

What about the methods?

I don't think there is anything really new on the horizon. One of the things I would like to see coming in a bit more quickly, there has been talk for sometime about a plastic condom that is not so 'splitable' and is warmer and doesn't reduce sensitivity. We have been promised this for some time but I have not yet seen it. But you know, it seems to be more of the usual refinements at the moment, there doesn't seem to be anything really new coming in.

So I think as much as anything we should be giving youngsters access to contraception when they need it, before they need it and we will use this opportunity to help them with any areas of their sexual health.

What about sex education?

Well, there have been some improvements in some schools. It has been very much a political football as well hasn't it? But talking to the youngsters I see, I still get the impression in many schools it is still a question of too little and too late. Also that it is mainly factual information and it doesn't relate much to the situations that youngsters find themselves in. And this rather saddens me, because I know that from 20 years ago with the FPA Sex Education Unit, we were trying to pursued teacher training colleges to include sex education in their curricular so that teachers would have some background that they could feel a bit more confident a) about their own sexuality perhaps, their own information and b) helping youngsters with sex education. But the answer was 'the curriculum is over full and we can't fit this in'. So, it does concern me that a lot of the sex education has been given to people who have not had necessarily the training in it. Because, although the factual information is useful, there is much more value if people can be trained to work in small groups where people can actually discuss issues, they can discuss choices and options, they can look at hypothetical situations - what to do in these situations, what choices are there, they can role play. One of the most interesting things I have seen is doing role plays with young people where you actually change the genders - and you get all the old stereotypes coming out where the girls all say what they think the boys say and visa versa. But to be able to conduct this with a class requires special skills and teachers may not necessarily have this, or they may feel that this is too intimate work. Therefore some schools have used outsiders who are trained to come in and do some sex education, but this is an area which I see a great role for school nurses. They are already in the schools and working partly with the young people. They do need training as well, but they have quite a bit of background that makes them perhaps able to do sex education more easily. So, school nurses are a valuable asset. I think however, that the media have a tendency to polarise views about sex education.

So, what does it come down to? I think what strikes me more and more as the years go by is that there is still a great deal of adult anxiety about teenage sexuality. It is seen as threatening, out of control, challenging, destructive, and there seems to be a great need to control it by various means. By limiting information, hoping that by telling them in sex education all the terrible things that might happen, that they won't do it. But there is no evidence that this works, and we are much better advised to follow a positive policy. Which is really something of the ethos of being able to say to young people quite honestly

- ‘We hope that as you grow up you will have an enjoyable and rewarding sexual life, but this doesn’t come easily. It needs thought and consideration to get it right. You don’t get it right by rushing in, being available, hoping for the best, not talking about it with your partner. Because sex can be a wonderful experience or it can be a disaster, and it is up to you to get it right.’

It is really a question of being able to accept that teenagers have a very strong sexual feelings, that they are at their most aroused and most attractive at this stage, and instead of asking them to deny it and control it, help them to give them the choices and the options so that they can develop at their own pace and make their own choices, but without too much damage.

Question from the floor - as a school nurse working in mid-Essex, I would like to reinforce the fact that school nurses do a lot with the teenagers, and the majority of school nurses also have drop-ins whereby the students can drop-in and talk in confidentiality with the nurses. We are also doing quite a lot of health promotion with the sexual health team. We are trying to start it as early as we can, currently years 8 or 9 and upwards as it is difficult to get in earlier than this. But I don’t think people realise that school nurses are doing as much as they are in schools.

.....No, I think this has been a great development in the last 10 years, I think they are a valuable resource, when they are trained and if they are happy to do the work. I don’t think that school nurses should automatically be the person to do it - has she the personality, has she the knowledge, or the willingness to do it. But where they are prepared to, I can see the difference in some areas I have worked.... I can almost tell what school someone comes from by their confidence in asking for what they want, coming earlier for contraception, because they have had reasonable sex education and have been treated with respect.

Young People and sexuality: Promises and Prospects for Education

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Introduction

This paper aims to provide a brief overview of the available evidence on sexual health and sexual behaviour of young people with a view to informing the debate on the provision of sex education for primary and secondary school aged children.

The paper begins by reviewing available findings from studies of the sexual health of young people. It outlines the UK response in terms of improving access to family planing services for young peoples' sexual behaviour and what we know about the nature of young peoples' sexual relationships. It concludes with some observations pertaining to sex education.

1 Teenage Sexuality: Is there a problem?

1.1 Pregnancy, conception and abortion

The United Kingdom has one of the highest rates of teenage pregnancy in Europe. Each year there are approximately 70,000 births to teenage girls under the age of twenty. There are 8,000 births every ear to girls under the age of sixteen (Hunt, 1994) and just under one in five young women aged 15 - 19 years have every been married (IPPF, 1994).

IN the last ten years there has been a slight increase in the conception rate in the under 20 age group. Whilst over three quarters of all conceptions for all ages lead to births of babies, only two thirds of all those to under twenty year olds do so and just under half of those to under sixteen years olds do so.

The difference between conception and birth represents abortions. Between 1972 and 1990, the abortion rate increased in all women. However, the largest proportionally increase in this rate was in young women aged 16 to 19 year old. In the under 15 year age group the rate increased from 1.6 per 1,000 women of this age in 1970 to 3.1 per 1,000 women in 1990 (OPCS, 1991). In 1992 it had risen to 5.14per 1,000 women in the under 15 year olds (OPCS, 1992).

Recent data from a study of teenage pregnancy in Scotland have revealed strong relationships between deprivation, conception and the outcome of pregnancy

(Boulton-James it al 1995). In the 13-19 year age group, rates of pregnancy increase with increasing levels of deprivation. Young women in the most affluent grouping to have become pregnant. In addition, fewer women in the most affluent category (36%) than the most deprived (73%) went on to give birth. Conversely, 50% of the most affluent women compared with only 14% of the poorest women had their pregnancies terminated. Do we know why? Some have argued that in times of high unemployment young girls are having babies to enjoy the benefits of welfare provision. The available data do not however support this contention (Marsh et al 1996). It has also been suggested that poor access to family planning services may contribute to the problem (IPPF, 1994) but as yet this differential in conception and birth rates is incompletely understood.

There is little doubt that unplanned and unwanted pregnancy in young girls is an issue of considerable concern. The government White Paper, Health of the Nation (DOH, 1992), identified sexually transmitted diseases, the transmission of human immuno-deficiency virus (HIV)and sexual health of young people as key areas for the improvement and promotion of the public's health.

The Health of the Nation includes a target of halving conception in young women under 16 years thereby reducing pregnancies from approximately 9.5 per 1,000 reported in 1989 (OCPS, 1993) to 4.8 per 1,000 women aged 16 years by the turn of the century (DOH, 1992). Some limited progress towards achieving this target has been made with rates falling from 9.3 in 1991 to 8.5 in 1992, 8.1 in 1993, but rising again to 8.3 in 1994 (ONS, 1996).

1.2 Sexually transmitted disease, including HIV

Because of the way sexually transmitted disease is recorded in genitourinary medicine clinics, there is little data available on cases of STD by age in the younger age groups. The good quality data that does exist is somewhat 'out of date'! The data available on cases of STD by age in the younger age groups. The good quality data that does exist is somewhat 'out of date'! The data which is however available for 1988 (DOH, 1993) suggest that not inconsiderable numbers of young people aged 16 to 19 years present with infections. Genital warts and Chlamydia appear to be a particular problem for young women. Although in absolute terms, the numbers of young people under the age of 19 years who had presented with HIV infection in 1988 was small, the situation is of concern given the prognosis of the condition. Self-reported data indicate that 5% of 16 - 24 year olds may have every attended GUM clinics (Johnson et al 1994).

Is there cause for panic? Is teenage sexuality a problem? The data shows there is indeed cause for concern about young people having unprotected sexual

intercourse. How should we tackle the problem? Three complementary approaches are considered:

* To improve sexual health services for young people and access to them.
* To improve our understanding of young peoples' sexuality
* To continue to promote sex education in the wider context of social relationships

2 Services: the solution

The Department of Health has long recognised the need for specific guidelines regarding the provision of contraceptive and family planning services for young people. The 1989-91 health planning guidelines pointed to the need for separate less formal arrangements for young people building upon the good practice model provided by the Brook Advisory Centres (Wilson et al 1994). By 1994 almost half of the health authorities in the UK were running family planning services for teenagers (IPPF, 1994). A recent review by Aggelton et al (1996) for the HEA suggested that family planning service provision could be improved by being offered in an integrated way, readily accessible, in locations with a young atmosphere, by sympathetic staff and subjected to regular monitoring. This review has been complemented by new Guidelines for Promoting Services (HEA et al, 1996). The encouraging largely downward trend in conception rates may in part be due to improvements in service provision, but further substantial improvements are only likely to occur if continued service developments are supported by other approaches and interventions. Educational provision may be an imprint element of an integrated approach but to devise appropriate programmes we must first understand young peoples' sexual behaviour.

3 Young peoples' sexual behaviour and the social context in which it takes place

3.1 Sexual behaviour and condom use

Studies from around the UK consistently report that between one third and one half of young people aged 16 years say that they have engaged in penetrative sexual intercourse (eg. Clift et al 1989; Breakwell and Fife-Schaw, 1992a; Currie and Todd, 1993). The average age at first intercourse is 15.2 years for young men and 15.5 years for women (Malbon et al, 1996). The younger the person is when first sexually active, the more likely they are to have sex without contraception and to know a close friend who has had a sexually transmitted disease (Mellanby et al 1993). Young people report that sexual intercourse is more likely to occur if they are drinking alcohol (Robert et al 1994).

Contraception usually occurs after first intercourse (Bar-Cohen et al 1990) and the first sexual experience in a relationship is usually mute, with the encounter proceeding through coded physical messages (ingham et al 1991). Girls tend to believe that boys are more knowledgeable sexually therefore wait for them to take the lead in talking about sexual matters (Kent et al 1990; Holland et al 1991).

Among those who are sexually active in the 16 - 24 age range, condom use on the last occasion of sex has been reported to range from one in four (Galt et al 1989) to half of those asked (Breakwell and Fife-Schaw, 1992b). A recent survey by the HEA indicates that one third of young women aged 16 to 24 years and just over one half of men reported using a condom on the last occasion of sex (Malbon et al, 1996).

Although three quarters of sexually active 16 -21 year olds in one survey reported ever having used condoms (Bowie and ford, 1989) data on consistent use of condoms is scant.

Those least likely to report having used a condom on the last occasion of intercourse are those most likely to have had four or more sexual partners in the last year (Bowie and Ford, 1989, HEA, 1993). Lack of condom use is associated with alcohol consumption in young people.

Similarly, those young people least likely to perceive themselves to be at risk from STD/HIV infection are those most likely to have two or more sexual partners in the previous year (Galt et al, 1989). Thus it could be argued that those young people with a higher chance of STD infection or unwanted pregnancy due to higher partner change rates are also those least likely to use condoms or contraception or even to perceive themselves at some kind or ‘risk’.

Why don’t young people use condoms?

Reasons given by young people for mot using contraceptives in first sexual encounters or early on in new sexual relationships include the following (see e.g. Wellings, 1984; Holland et al, 1990; Abrams et al, 1990).

* They have poor access to condoms
* They think conception is not possible
* They did not expect to have sex
* They believe it is wrong to use contraceptives
* They think their partners won’t like it
* Their relationship was not ‘serious’

* Reluctance on the part of young women to accept and express their sexual feelings.

Most young people say they use condoms to prevent pregnancy. Some youngsters think teenage pregnancies happen partly because of a failure of use of contraception but also because of carelessness in use, lack of belief that they will get pregnant and pressure from boys on girls to have sex (Roberts et al, 1994).

Young people do identify problems in using condoms:

* Embarrassment of buying condoms
* Condoms are mostly available in daytime hours
* Fear of being caught carrying condoms
* Practical difficulty in putting them on
* Contravenes the romantic codes of sexual interaction
* Women fear the impact condom use might have on their reputation

Attitudes to condoms among young people of both sexes are however generally positive, (HEA, 1993). In 16 - 19 year olds 38% of men and 23% of women thought it was the mans responsibility to carry condoms and 76% of both sexes believed that is was sensible for women to carry condoms (HEA, 1993).

3.2 Young people's sexual relationships

Young people's sexual relationships are characterised by serial monogamy. 'Steady relationships' may be of short duration and paradoxically, condoms are less likely to be used in a relationship which is, however short in length, regarded as 'steady'. Trust, with the implicit agreement of fidelity is a key feature in young people's relationships and penetrative sex occupies an important role since it is perceived as 'real or 'grown up' sex. This has important implications for STD and HIV preventive education programmes. MacIntyre and West (1993) have noted that only 2% of a sample of 18 year olds in Glasgow felt that abstinence from penetrative sex was a form of 'safer sex'. If the only 'real' sex is penetrative then abstinence from that particular activity is never even conceived of as a possibility.

Explorations of the nature and meaning of sexual relationships in young people are rare. Holland et al (1990), have found that young women's sexual behaviour was governed primarily by their concerns about pregnancy and the risk that engaging in sex might damage their personal reputation. ON the other hand they were aware of the social potency of 'having a boyfriend' and were strongly attracted to romantic notions of relationships. Thus they tended not to resist male pressure to have penetrative sex because of love, trust and fear of losing

their boyfriends. They 'did' sex to keep their boyfriends happy but also to keep their boyfriends. The 'relationship' aspect of the sexual contact was vital for women. This finding is supported by other work.

In reporting their worries about the future, one in three fourteen year old girls in one study mentioned their concern about having an unhappy marriage and about fidelity in relationships (Gillies, 1989). Boys of the same age seemed, however, to lack the imagination to envisage marriage as potentially problematic, since none of them considered it worthy of concern. It could however be argued that perhaps boys have an over-optimistic vision of their future, lack the language in which to discuss such issues or are too shy to discuss them in interview. Holland's initial exploratory work on the meaning of sex and relationships in young men did not reveal many surprises. Young men appear to define their sexuality in terms of masculinity, use social 'techniques' to dominate women who appear to collude in the process (Holland, 1996). Perhaps we need further in-depth work to explore beneath the stereotypes. However, the limitations of available data notwithstanding, the social context of sex appears to be of major importance in shaping and maintaining sexual activity in young people. This needs to be explored further if we are to produce sexual education materials of value. We should not presume that the range of materials currently available to schools are sufficient to the task. In a recent review of the outcome of sexual health education interventions, Oakley et al (1995) stated that future educational interventions should be designed using evidence based reviews of the literature; should have content based on what young people say they want and focus on changing behaviours rather than simply on altering attitudes or improving knowledge. Few could disagree with such statements. I would however argue that preparation and testing of additional sexual education materials based on our current level of understanding of the meaning of sexuality and relationships in young people, will do little to enrich the educational process. In other words our evidence is as yet incomplete, our perspective is limited and our prospects are not promising unless we grasp the nettle and seek to advance a new agenda.

4 Advancing a new agenda for sex education

The implications of the above findings for the design of sexual and personal relationship education programmes for young people are clear. If social influences are so important in the development of sexual interactions, behaviours and responses, then sex education must feature early in a young person's development, properly located in the social context of family, school and leisure activities in which is occurs. Such education must address the meaning of sex for young people as well as the mechanics of sex.
'Sex drives' and desires are rarely discussed and often represented as somehow immutable and not open to the influence of cultural cues or stimuli in our

everyday social environments. These 'signs' can include advertisements for almost anything from alcohol to sports wear, images from the television or the cinema, literature and even the beat of disco music. Young people, very young people, live in a social world. The challenge for sex education for young people is to unpack the social norms and values surrounding adult sexuality and sexual behaviour in contemporary society and to allow discussions to evolve which place sex firmly within a range of diverse social contexts.

Vague 'fears' about tackling sex education and thereby 'promoting' sexual activity in the school years appear to be unfounded.

A World Health Organisation review of existing evidence noted that sex education in schools leads to a delay in the onset of sexual activity and a reduction in overall levels of intercourse among teenagers (Baldo et al 1993). In addition, the national sexual lifestyle survey in the UK noted that pupils who report schools as their main source of sex education were less likely to have sex before the age of 16 years and more likely to have used contraception (Wellings et al, 1994).

Pupils themselves are supportive of sex education in schools. A survey in Salisbury Secondary Schools found that pupils were particularly keen to discuss the emotional and social aspects of sex with teachers (Evans et al, 1994). A survey by the Health Education Authority found that school pupils welcome the opportunity to talk to teachers about sexual matters and contraception (Meikle, 1994). Whilst, on the whole, more 13 - 15 year olds (65%) are prepared to talk to their teachers about contraception if parents are not informed, almost one in three (31%) would talk to teachers even if their parents were informed. Thus many young people see parents and teachers as partners in the process of sex education rather than opponents. What of parents?

Contrary to the generally held beliefs of policy makers in the field of sex education, school-based efforts are likely to find favour with the majority of parents (Kirby, 1992; Went, 1992).

The recent National Foundation for Education Research (NFER) Survey of the issue included parent perspectives from a national sample of schools. In this survey, 94% parents reported that schools should play a part in educating children about human sexuality, sexual development and relationships (NFER, 1994). The HEA's sex education alliance project is currently at the forefront of developing new resources with local schools support and involving parents (HEA, 1994; 1995).

The task today therefore is to challenge prevailing assumptions and fashion sensitive ways of integrating sexual and health-related social education into the everyday life and culture of our young. I would argue that school has a pivotal role to play in what must be a cross-sectoral pragmatic approach which traverses lay, professional and disciplinary boundaries.

Dr Nona Dawson - University of Bristol

The Educational Needs of Young Mothers

The UK is presented as having the highest teenage pregnancy rate, including the highest rate of pregnancy to under 16 year olds, in the European Union. This statistic is rather misleading because in fact it is England and Wales that have the highest rate, Scotland is consistently lower, and Northern Ireland, although not producing accurate conception rates on account of that province's abortion legislation, is lower still.
Whether these differences are a result of education, moral climate or the weather we do not yet know. This paper is presented on the basis of research that the University of Bristol has completed on the provision of education for pregnant schoolgirls and schoolgirl mothers in all the national regions of the UK.

For the purposes of today I shall mainly be using the position of school-aged mothers in England and Wales. In this case I mean young women who are still of statutory school-age i.e. up to 16 years. How many people are we exactly talking about? Comparatively a very small number. Indeed since 1990, a bumper year for young women's conception, the absolute number of young women in England and Wales who have become pregnant has been consistently under 8,000; of that group under 4,000 girls have become a mother since 1991 to 1994 (latest figures). To help put these figures in context, in academic year 92/93 there were 1,434,000 school girls in secondary school. 7,243 schoolgirls became pregnant, 3,287 had a termination and 3,757 had a baby. We really must keep all this in proportion. The image I would like to give you is from my own town of Bristol, where we have the lovely Avon Gorge, on which cliff face we have a number of climbing accidents each year. Proper education and training helps to reduce the accidents on the cliff however we still need to provide an ambulance service for the few who experience accidents. PSE can be a fence at the top of a cliff but surely we much also make provision for when accidents do happen.

More usefully we can consider rates of conception and the rates of termination and maternity. Although it is of course a concern that the rate for 1994 has gone up a little, particularly in terms of the target in 'Health of the Nation', nevertheless when we look at the rate for young women who deliver babies - that still is on a downward trend.

It is this group of very young mothers who have been receiving adverse criticism in the past year or so on account of being 'drains on the state' and for

producing problem children. This notion needs to be severely knocked on the head. If it is the case that we wish the young mothers to have an opportunity to come off state benefit, to become taxpayers, then access to education and vocational training is paramount. Research based both here and in the States tells us that this is precisely what young mothers want. Indeed a mature State would be working towards exactly that position. Any simple cost benefit analysis would indicate that it would make economic sense if not moral sense.

If it is the case that the children of young mothers are disadvantaged (as noted by the literature and current research with which I am involved investigating a large cohort of teenage mothers and their children) then concurrent support with parenting is also essential. However, it really must be emphasised here - we are not talking about an homogenous group although we describe general trends. As with any group, young mothers are an heterogeneous group and when you examine any group individual differences are clear. Like Ann Phoenix, I support an non-pathological view of teenage pregnancy and parenthood.

It is the case that all young people up to the age of 16 should be receiving some sort of schooling. During adolescence the vast bulk of young people are attending main stream schools however small groups are not, for a variety of reasons - including pregnancy and motherhood. The first major study into this type of provision for these young women in the whole of the UK was completed by the University of Bristol in 1994 and 1995. Today we shall talk about what is happening here, in England and Wales.

It is certainly the case that recognition of the educational and social needs of this type of school student has been an increasing concern for local education authorities. This has resulted in an increase in special centre provision for pregnant girls and young mothers, with some including child-care facilities. Although the main form of education supplied to young mothers in England and Wales is an average of five hours home tuition per week. (for further discovery of the position read the reports). The meaty question that is raised here is not whether LEAs are fulfilling their statutory duty by supplying some form of education for these young women, but how would one begin to describe the **quality** of such education. This is an absolutely fundamental question.

Home Tuition

While taking into account the undoubtedly committed work supplied by home tutors, nevertheless receiving on average only 5 hours of tuition in your own home, with only one tutor, will mean that the curriculum open to you is severely limited. Indeed the DFEE recognises this and recommends home tuition only for a short time - towards the end or pregnancy and only during a very short time

in motherhood, before the girl returns to school. Except, in England and Wales she does not return to school (like her sisters in Scotland).

Mainstream school

Some girls do of course return to school and continue to have access to the full curriculum. However, many more do not for a range of reasons. These include primarily lack of child-care. the Grandmother will probably be working as well and will be unable to care for her grandchild while her daughter is at school, and there is no statutory provision of other types of child-care for schoolgirl mothers. The only way that a girl could get help with child-care, apart from paying for it, would be to be deemed a 'problem' by social services. Another reason some young women give for not wanting to go back is not that the school itself is unwelcoming but that there can be a lot of unwelcome peer attention, particularly from boys.

Special Centres

Special centres are no longer called 'special centres'. The name of the off-site that houses pupils who are being educated otherwise than in mainstream school is Pupil Referral Unit or PRU. No doubt you have heard mention of them in the news in relation to the education of disruptive children. The same term now applies in England and Wales to units for pregnant schools girls and schoolgirl mothers. What is significant about this is that for the first time PRUs are open to inspection by OFSTEAD along with mainstream provision. Also there are clear guidelines laid down for the type of curriculum that should be provided. The SFEE recognise that the full National Curriculum is not possible in most PRUs, however it requires PRUs to supply a core curriculum which includes English, maths, science, IT and modern languages. This is laudable however it has caused an economic headache for LEAs.

My own view is that the educational side has not been emphasised enough by many off-site units for pregnant schoolgirls and schoolgirl mothers. There is absolutely no doubt that social, emotional, physical and psychological support is very important but I believe we do the girls and their children a disservice if we do not give them every opportunity to gain further knowledge and skills to enable them to be productive workers and good parents.

What I want to do here is raise a number of points for consideration:

* Should better attempts be made to educate young mothers in main stream school? Although English and Welsh LEAs agree with the DFEE that that is where young mothers should complete their schooling, they identify lack of child-care facilities as a major problem. The underlying view at the DFEE is that all school students should have an **equal opportunity** to experience the

National Curriculum: and indeed that they have an **entitlement** to it and LEAs should be looking towards supplying the **access.**

* Should clearer routes to part-time accredited courses be made available for young mothers of very young children? Some view this as a start in taking into account the huge demands of babies and would allow the young mother more family time as well as giving her an opportunity to increase her knowledge and skills.

* Following on from this, should we, like a very small number of LEAs, allow access to further education colleges for young mothers aged between 14 and 16? We saw in the press not long ago the case of a young mother, aged just under 16, being refused permission by her LEA to attend an accredited hair-dressing course at her local FE college, which also had child-care facilities. The alternative for her was going to be home tuition. Those who feel that FE colleges would be appropriate for educating young mothers put forward the following reasons:

1. the students range in age and are therefore more suitable as learning companions to the young mother who feels herself as older than her peers on account of her responsibilities
2. there are part-time accredited courses available that will allow a young mother both to experience more of her little child and to gain a qualification
3. many of the courses are vocational and will have a better chance of helping a girl on the job market than a limited number of GCSEs
4. many FE colleges have crèche facilities.

* Should more emphasis on supporting her parenting be given in the early years of motherhood, and opportunities for further education be offered at a later stage? Working mothers, at whatever age, face the tension between the needs of their children and their own needs. It is certainly the case, generally speaking, that the position of the child of young parents is not terribly good. Much qualitative research indicates differences between how young mothers and older mothers relate to their children to the detriment of the children of the younger mothers. And much quantitative research indicates a gap downwards on literacy scores, emotional well-being scores etc. for the children of the younger mothers. And much quantitative research indicates a gap downwards on the literacy scores, emotional well-being scores etc. for the children of very young mothers. However other work, particularly in the States, has shown effectiveness in enhancing mother-child relationships through parenting programs.

* What support should be given to young women post school-leaving age? It is certainly the case that the education and training position for young mothers aged 16 and over has had minimal research attention in the UK. The well-

known American study of the Baltimore cohort indicates quite clearly that most young women will attempt if not succeed to gain additional qualifications and jobs. In this country a small number of groups are working to provide vocational training for this particular group of young women. For example, at the Bournemouth and Poole College of Further Education Project MATERNAL is now well under way. (this project has received major funding from the European Union).

* What are the structures that we ascribe to school-aged mother that gives it its particular characteristics here? How would viewing young motherhood differently change how it is seen as a problem or not? We will have read Diana Birch's first study of young motherhood in which she clearly describes how points in history make a difference, for example, she tells us that Henry VII's mother was 14. We know that in 1973, when the raising of the school-leaving age from 15 to 16 took place, all of a sudden there were a group of pupils whom we had never to consider in a special and different way. We can also look to our European neighbours for contrasting structures which will have an affect on how dependent or independent you view these young people. (We have a research bid in with 4 other partners from Europe to investigate educational and training opportunities for very young mothers in Europe). For example we may look at age of consent as it applies to heterosexual women. We will see that it ranges from 14 to 17, and indeed within our own state there are differences - in Britain it is 16 and in Northern Ireland it is 17. What does this lead us to ask about how we view young mothers.

* This leads us to question whether a young mother is a child and therefore dependent on the adult world, or whether she should be view as a young adult who in any case is seen as responsible for a child no matter her age. How would our view of her affect how we see her development into an adult with adult responsibilities including a job and the fact of being responsible for a growing child? Taking that any society should be examining credible measures to prevent early unplanned pregnancy in the first place, what should a mature society do for that increasingly contrasting group who have a baby while still very young? (the average age of first childbirth is now 28)

I wish to end by quoting one LEA's summary comment to our 1994 Survey of educational provision for pregnant schoolgirls and schoolgirl mothers in the LEAs of England and Wales:

There are difficulties for some girls when the time comes to return to school - some are virtually unable to do so. This could be overcome if tuition could be provided with Crèche facilities. Present tuition arrangements provide for at least some of the girls' educational needs but their very specific needs (on a

personal and parental level) would be better met if they could work together in a group where their social and emotional needs could be professionally addressed. Many girls are isolated in overcrowded homes with only tacit support from the child's father. Group tuition would provide mutual ('hands on') support and ante-natal care and counselling could be part of the routine.

Diana Noble and Dr Gillian Vanhegan -
'What young people want'

Diana Noble is the General Manger at the London Brook Advisory Centres - Talking first about what young people have indicated they want from sexual health services from some recent research work.

The first bit of research that I would like to talk about is a bit of research commissioned by Avon Health Authority and carried out by the department of sociology at the University of Bristol. They did some in depth interviews with 147 14 to 21 year olds and they did a survey of 403 questionnaires over 8 young people's clinic sessions in the Bristol area. The findings were quite similar from both of the methods used, so the researchers were quite confident about what was said.

The first thing that I thought was quite interesting was that young people were saying in terms of family planning clinics that they were rarely perceived as appropriate places to get advice on sex and related matters. One wonders whether that has something to do with the term 'Family Planning Clinic' and how well young people relate to that. Are young people planning families at 13, 14 and 15? The sort of family planning idea is also very off putting for gay young men and lesbian young women. Two thirds of those interviewed that were sexually active, only 50% knew where their local service was. I think that if we think we are very good at are getting away from the term 'family planning' by using the term 'sexual health', it was all quite interesting that the term 'sexual health' was totally meaningless to the young people.

So a number of factors emerged which constrain young people from making more use of services that are available. The fear of anonymity and confidentiality is obviously key. Young people looking for advice on sexual matters don't particularly want that to be public knowledge. The importance of clinic location, which links with the previous concern of anonymity and also important issues about location and travelling to local centres. Waiting times and conditions - the sort of physical environment, and particularly the reception and waiting room area are thought to be really important, and certainly young people use the term welcoming an awful a lot. And very important is the anticipation of judgmental attitudes. I think that it is quite fair that for a lot of young people their experience of adults is of disapproval and it is of lack of respect, and they are going into a clinic were they actually don't know what those adults are actually going to be like. So, if your experience is of not

receiving respect, then one can understand how you might anticipate that it might be judgmental.

So specifically in this particular piece of research work, what young people said they wanted from clinic services:-

Ease of access. The service being near was seen as essential and again this is often linked to travel - particularly with regard to the cost of travel, but also that they might have quite limited geographical knowledge outside their immediate home and school area.

Anonymity - again linked to access. 50% of young people said they did or would feel embarrassed about going near a clinic.

Offering a wide range of service - that helps with the anonymity and ease of access. Young people also say that they want particularly the services of counselling and someone to talk to.

Appropriate publicity - frequent, casually and anonymously available are what young people are asking for.

Open every day or/and at least once over weekends. This was in particular linked with emergency contraception and that fact that unplanned sexual activity is often at weekends, and one doesn't want to wait for a one session per week clinic which does not open until next Wednesday.

Able to drop in - being able to drop in was particularly important to under 17s, and there was a general feeling that appointments can be a hassle, so being able to just drop in was very important.

A telephone help line - especially important that if there is only a one or two day per week clinic in their area that there is some back-up in-between.

The comfortable and welcoming reception and the confidentiality issues were impressed more strongly by young people. What happens at the reception area was is definitely seen as vital.

I think that there is one very clear message to remember from that work it is that if young people feel that there is confidentiality and that this isn't disapproval, what you will get is trust, and when there is trust, then young people will be open to the services on offer. That particular report makes 22 specific recommendations around clinic services for young people, which I clearly do

not have time to go through, but I would be happy to let people know where to get hold of the report.

The second piece of research I want to talk about is something that we did at London Brook Advisory Centres as part of a service review, where we commissioned some independent research to run a series of focus groups. These focus groups were not with current Brook Service users and they took place in schools and youth centres in North, South and East London. We were particularly interested in the specific views of different groups of young people and from that work today I am looking specifically at aspects which effect access to clinic services.

So, first of all a group of young heterosexual women under 25. In terms of factors effecting access, the travel issue comes up again - not prepared to travel. Also apprehensive about staff attitudes and embarrassment. So already we are starting to hear the same words, and this is continue because this work reflects the work of the Avon report. What they wanted was a more personal image from services. Discretion and integration, again anonymity by integration with other services. They wanted a balance between something that is discrete, but also they wanted to avoid the kind of back street dingy image that some services have. The under 16 showed always the main point as confidentiality, trust. The focus group there was pretty split about services being available to young men at the same time. They again wanted integration, with a particular emphasis on a need for the opportunity to discuss emotional family issues, and they wanted anonymity.

Two groups of men. Under 25s said that there was some embarrassment which made accessing services difficult, but generally speaking they didn't see themselves having problems as such, and saw that services were really more for women and very much related the idea of a clinic service to a problem - and I think this is an issue worth much more exploring. Having said that however, they did want more publicity. Under 16 young heterosexual men, again apprehensive, embarrassment, fear of disapproval, they wanted more publicity, they wanted longer opening times. Also, I think was particularly interesting, they wanted a specific area in reception for drop-in, so they could actually prepare themselves before approaching the service, and I think some of that is the kind of the sussing out, to see what it looks like, what's happening etc. which is part of the finding out if there is a non-judgmental attitude.

We had a focus group with young lesbians, and again factors effecting access included the fact that clinic services have a very strong heterosexual image. Again needing to travel was an issue. What they said they wanted was sex

education, and what they really needed to talk about the specific risks attached to lesbian sex, to talk about the developments of smears to lesbians, and there was a very strong feeling from this group that what they wanted was a service and that their needs were not being met by anybody.

There was another focus group with young gay men and young men unsure of their sexuality. Access issues here were for safety, really on two levels, one of the kind of physical safety of using services and being out on the street, but also safety in terms of being able to explore the issues around their sexuality. Confidentiality was very important. In terms of image they felt that services had both a strong female and a strong heterosexual image. There was a keenness to have general services for gay teenagers, because not all felt that they may be wanted to identify with a gay men's service at that stage. Peer support was very important here, good publicity, extra strength condoms, and this raises the question of what services we are offering in some clinics for some groups of people. They wanted to be able to identify that there were gay staff, and counselling was also seen as being very important.

We ran other focus groups with young people - young people with learning difficulties, young people who's family language wasn't English and young physically disabled people. There isn't time really to get into the detail that I could with the work with all the groups, but what I wanted to end by saying was that having a young people's clinic is just the start, and it is issues such as confidentiality, and attitude and trust that really make the service accessible to young people.

Gillian Vanheagan is the senior doctor at London Brook - translating Diana Noble's research in terms of service delivery and in particular what is staff are doing at London Brook Advisory Centres.

I would like to describe for you the London Brook. There is a waiting area that young people really wanted to be welcoming and hospitable. Normally this area is fairly jam-packed with young people sitting on the floor cushions. We also have all the coffee making facilities for them, the radio that they can play and of course leaflets and posters. Most importantly is the suggestions box, because we feel that we need a lot of feed-back from young people about the sort of service that they need, and over the last week I have been dipping my hand into the suggestions boxes as I go around the clinics.

They have all been very positive about the service that we give, but there have been requests for very material necessities. Such as wanting a pay-phone in the waiting area so that they can contact their friends and tell them how long they

will be, and perhaps that is because they sometimes have to wait a little while before they can be seen. Also they wanted snack machines so that they could supplement the coffee. But all very reasonable requests I think.

Brixton is very much one of those local centres where young people wanted to go locally, so that they didn't have to travel, they didn't have to explain why they were away from home for a certain length of time. A very large number of the young people using the Brixton centre, black British, west-Indian, mix-race, African, adds up to about almost half the number of clients that we see that the local population are very much using Brixton as their local centre. And at Hayes and Redbridge on the outskirts of London where there is a very high Indian, Pakistani and Bangladeshi population there are using the centres there. When young people come in they did ask for welcoming, non-judgmental staff, and obviously the first person that they see as they come into the clinic is the reception worker, and I know that all our reception workers are well trained to be non-judgmental and to be welcoming, as you can see, to the young people as they enter the service. They are also able in most cases to take the young person into a room at the side to register them at the centre, so that they don't have to stand in a big reception area with other people around, and talk about why they have come to use the service. I think one of the things I would say is that as well as being non-judgmental is treating the young people with respect. And that is what young people wanted. They felt they had been criticised, they had been judged by parents, by teachers and so on, but when they came to use our service they really wanted not to be criticised but to be treated with respect.

After being registered, they then use the centre, and we work in teams of nurses, doctors and counsellors. Counselling is very important to the Brook service and because people come with a multitude of problems, it is important that they have access to all members of the team. In this case you see one of our doctors working with our 'posed client'. Obviously here she is talking about contraception, but what we hope is that during a young persons travels through the centre, they are going to be well informed, to be given plenty of information about whatever they have come about, so that they are able to at the end of their visit make whatever choices they need to make around their sexual health, as Fay and Diane were saying 'sexual health' doesn't mean much to young people, but we know what we mean by it, and we know that's what we are helping them with and whatever they bring to us, we hope to be able to advise and inform so that the young person is able to understand when they leave the centre.

I have mentioned the counsellor as well, and the counsellor has a very important part in the team. She will generally see all under 16s when they first come along to the centre, and will see all the girls who are pregnant, and she will also talk to anyone who has relationship, emotional, or family difficulties, and anything else

that may be worrying the individual. So that at the end of the visit they may be able to make their choice. As Fay was saying it may be 'double dutch' she may be using the pill but wanting to use some condoms as well and these will be given to her in a bag so that she can leave the clinic without everybody knowing exactly where she has been and what she has been there for.

Diane was saying that young men felt that Youth Services had very specific female/heterosexual angle to them. We have tried to develop (and quite successfully) in the London Brook Centres, young men's drop-ins, and I could give a whole talk about how we have gone about developing a service for young men, we did try giving them their own separate centre at one stage, but that wasn't what they wanted. They wanted to come along as partners to young women, but they also wanted their own space within the clinic, and over the last week since these photos we have actually now got a completely separate area for them within the centre, and this is the major touch-screen system which breaks the ice. They can come in, they can use this, they can access information and they can talk to members of the male team. They get the idea about all the different things they can talk to our members of staff about, I don't know whether you can see this, on the screen it says 'safe sex', 'keeping safe', 'contraception', 'conception and pregnancy', 'HIV', 'AIDS', 'Confidentiality', they can tap into information on any of those aspects of sexual health. Most importantly, contraception, because contraception does involve young men. It is extremely important if his girlfriend happens to be on the pill, that he knows simple things like anti-biotic stopping the pill working, if she forgets the pill it's not going to work, so he knows he has to use his condoms. Contraception is not just the domain of young women.

We developed a special consultation card for young men because like in most clinics, we had a very specific gynaecological card about periods and so on, so we now have this card for young men, because it is more suitable to be talking to them about lifestyle, about drugs, about diet, and as Fay was saying, the very important advice which must be given around testicular self-examination. To talk to them about AIDS, HIV, and STDs.

So that is what we have achieved in our local centres. This is how we publicise them, this is our map of where they all are. We do have a central city centre which is in Tottenham Court Road, because although most people want to go to their local centres, some of them want to come to Tottenham Court Road for anonymity. I come from West Wales and I was sitting at work in Tottenham Court Road one day when a young girl came trough the door, and she had travelled 220 miles to seek anonymity, and you have probably guess it, our parents live in the same street back home! But some people really will travel a long way.

As well as our local centres, we go out to young people. When Diane was presenting her information, she was saying how people wanted very easy access, they didn't want to travel far, so the best thing we can do is go to them, and this is one of our newest outreaches in West London - Brook Out West. As you can see we are there at weekends for them. There are 14 youth workers in the team and three administrating nurses. Administrating nurses may be a term you are not aquatinted with. We have trained this nurses so that, working to a specific protocol, they can give emergency contraception, they can give the contraceptive pill, to a young person who comes to these outreach projects and then within a few days and then have the prescription countersigned by a doctor. This increases access to emergency contraception and contraception for young people.

Another terrific outreach project, is going into inner city, into Islington College, where once a week we go in and have a very devoted clientele who just don't have to travel because we are there on the spot, which is just what young people wanted.

I have been saying for some years that we really needed to go to the young people, and my favourite outreach project is Camden and Islington Health Bus, which we use this bus for three hours every Monday afternoon from 3 to 6pm. We take the Health Bus and we park it near to one of the big North London Schools, Parliament Hill Fields or Highbury Fields. And when I was working on the health bus a few Monday's ago we had 50 young people who came in to access the information that we were giving in the three hours. It is hard work, but extremely valuable work.

Young people didn't see themselves as actually knowing what information they needed to access. This came out of the Bristol survey. So on the Health Bus we have all the information about alcohol abuse, about drugs, about diet, we get asked all kinds of questions about acne, about smoking, and also at the back of the bus, is a small room, a medical room, so that if somebody needs emergency contraception, or the pill or condoms, we can take them in there and the doctor or administering nurse can talk to them absolutely privately. It was interesting the other Monday as well, I was working with a male outreach worker, and when the boys came onto the bus they tended to gravitate towards him and the girls gravitated towards me, and we did see really quite young 11 or 12 year olds, which as Fay was saying, before they are sexually active when so much good work can be done with young people at that stage.
In all surveys what young people want when they come to services is confidentiality. We know that the duty of confidentiality owed to a person under 16 is as great as that to any other person. I was absolutely horrified in the

group I was in at lunchtime today to hear somebody say they had actually seen on the wall of a waiting room of a general practice a notice which said ‘no 16 year old will be seen without their parents’. I hope that that is a very rare event. Doctors are bound by the General Medical Council, and we know that patients are entitled to confidentiality, but that runs through all workers with young people in Brook. And it is no good just us knowing it is a confidential service, we have to let the young people know it is a confidential service, and this is a very useful leaflet for any of you who have contact with young people, and I will be putting them out on the table in a moment.

And so to finish up on a lighter note. These are some of our members of our outreach team demonstrating just how much a condom will stretch and if you don’t put a condom on the right way you put your foot in it..... Thank you.

Dr Chris Wilkinson -

'Providing an STD (Sexually Transmitted Disease) service for youth'

As with any service for young people, the a sexual health service should fulfil accepted basic minimum standards with regard to timing, accessibility, confidentiality and the attitudes of staff.

One definition of sexual health and it's main component parts are on this slide and I will state here that I am of the belief that such services should be along an integrated line, that is with facilities for both men and women, and facilities to get contraceptive care as well as care STDs, all at the same consultation. My reasons for this is that not only do the clients not recognise the divide between family planning and genital medicine, but it is also difficult in practical terms to manage one without the other.

At present although there are many community based young people's services, there are few true sexual health services for young people. This is in part because young people's clinics have developed out of community family planning clinics which are not equipped or serviced adequately to carry out full STD testing. Even now, because of the limitations available in technology, and difficulties in transportation of specimens to laboratories, a full community based sexual health service, meeting the standards of genitory medicine is not easily achieved. This is further compromised by the lack of doctors and nurses who are trained in across both specialities, who are able to work sessionally.

I have been involved with two integrating sexual health clinics for young people. The Open Doors in Hackney, and the Brook Clinic at St Thomas' Hospital in London. The former is community based and is fully integrated sexual health service for young men and women, and the latter is a similar set up, but is actually based in a hospital GUM clinic. These like others could be regarded as prototypes or models of service provision. Both of the reasons I have outlined, as well as for cost, it is difficult to set up such clinics nationally that are accessible to all.

I would like to concentrate really on why we need STD services accessible to all young people and what we can do to develop existing services by outlining the epidemiology of common STDs, by looking at why STDs are important, and just to look at whether we are looking at STDs as a nation well, and finally to consider what we can do in the future.

Data from the KC60 returns, which were collected from all GU clinics and is Department of Health data demonstrates the number of STD cases in England. As virtually all cases of gonorrhoea pass through GU clinics, this is actually a reasonable estimate of the amount of the disease in the country as a whole. And whilst this trend in the 80s was increasingly downward, there has been in the last two years, an increase of about 5% per annum. Data on Chlamydia, was only started in 1989 when testing became the norm, have shown a rise in the last two years of 7% per annum. But in fact for a number of reasons the number of cases of Chlamydia are probably a gross under-estimate of the true number within the country as a whole. and this is for two reasons,. firstly the test which we have available to us for routine testing does not detect all cases, and secondly a large number of family planning clinics and general practitioners are also testing and treating Chlamydia. Just to put other STDs in perspective, wart infection, herpes are relatively common but when we consider HIV and syphilis for all intent and purposes these two infections are rare, especially in teenagers. This gives us some idea of the number of cases and trends, but does not actually tell us about the prevalence or proportions of the population infected, and as Chlamydia is one of the most important STDs in the UK, I shall refer to this predominately from now on.

So just how common is Chlamydia? That is just how many of our friends, and how many of us in this hall actually have it at this very moment. A number of studies have looked at Chlamydia rates in varying clinic populations. Genitary medicine clinics, the STD clinics obviously seem to have the higher proportion, but even in family planning clinics, gynaecology outpatient clinics, termination of pregnancy clinics and antenatal clinics some studies have shown quite high percentages, and indeed a number of studies also looking at young people specifically have shown very high prevalence, and in the first 6 months of the St Thomas' Brook Clinic the rate of positive Chlamydia infection was 25%. And as a proportion of all those attending was 13%, which is still a high percent. There was also geographical variations in the prevalence of STDs and I think it is reasonable to say, that inner cities the rates of Chlamydia and gonorrhoea are both higher with approx. 10 to 15 percent of all the countries of all the cases of gonorrhoea going through two of the large clinics in South London, whereas some of the other 200 GU clinics across the country, many of which are outside cities, hardly ever see a case at all.

So who gets STDs? In 1995 - 60% of these cases, were under 25. 90% were under 35. The other interesting thing is that if you look at the difference between male and female, in younger age groups, far more women are being tested and found to be positive, than the male in the equivalent age group. Young women are more likely to have an infection diagnosed that young men. This may be as a result of behavioural differences, but also physiological

differences such as in differences in the reproductive tract in young women making them more liable to infection with Chlamydia than either young men or older women.

Just turning to HIV, the number of young people being diagnosed as being HIV positive is small but one thing to note is that over half of all cases in this age group were people who were symptomatic or actually had Aids, and they are very likely to have caught their infections when they were in this age group. So the safer sex message has undoubtedly played a part here, but the slow spread of HIV is also in part to being confined predominately to certain groups in the population.

As the majority of people infected with Chlamydia are without symptoms, it has important adverse consequences if untreated. A way of identifying those who might be infected, and therefore need to be tested, needs to be sought. A number of studies have addressed the risk factor for Chlamydia infection. There is in fact no one discriminator, but young age, short duration of sexual partner, poor condom use, and being of black ethnic origin, seem to be the best indicators. There is agreement between studies that these factors will screen out the majority of people with Chlamydia, but the specificity is poor and many people without infection would also be identified. But if you just take the first three risk groups here, that actually includes the majority of sexually active young people. So, that begs the question of are they all at risk and should they all be tested?

So we know that STDs are common, and we know that they affect the young and especially women, but are they important?

The reason that STDs are important is because they cause morbidity. And that is the damage that such an infection does both in the short term, associated with the initial infection, and also in the long term as a result of ongoing chronic infection such as can occur such as in the case of HIV, or untreated syphilis. These effects can be physical or psychological. And at this point I would just like to say that we, as health care professionals can also cause serious morbidity if we are not precise in our diagnosis. If we are going to diagnose an STD in an individual we have to be sure about that diagnosis, because the personal consequences for that person and their partner can be enormous.

But obviously it is the nature of STDs that infection is not always limited to the individual, and some STDs are very infectious between sexual partners, and many of them can even infect the foetus resulting in foetal death, and congenital abnormality (such as in the case of syphilis), or infection of the new born, such

as can occur with Chlamydia, gonorrhoea, syphilis, HIV and herpes. In short they are a major public health problem.

To exemplify morbidity, I have chosen two examples. These are Chlamydial infection and wart virus infection, both of which are common in young people. Whilst the list of complications is not comprehensive, they are the most important, and it is of note that they mainly infect women.

Pelvic inflammatory disease, or PID, is a common diagnosis, and about 60% is caused by Chlamydia and about 20% of untreated cases of Chlamydia will go on to develop into PID. The main long term complications are sub-fatality which occurs in about 9% of cases, atopic pregnancy - which although to die from atopic pregnancy is now rare, it is still a major cause of maternal mortality and morbidity. And chronic pelvic pain which will reduce the quality of life considerably and may require major surgery as part of its management.

Moving on to wart virus, although the wart viruses, or human papilloma viruses do not actually cause cervical cancer, of the 70 of the viruses types identified, three are closely implicated with its aetiology. They can be transmitted sexually, and cervical cancer is related to first intercourse at a young age and a high number of sexual partners. Just having said that, almost all women who have had warts will not ever go on to have pre-cancer, or overt cancer.

So STDs do not only lead to considerable cost to the individual, but also to the country. And it is estimated that the treatment of PID and its consequences comes to around £50m per year. I am not actually aware of the costs of the cervical screening programme of the costs of treating cervical cancer, but I suspect that it is a large figure.

We have really dealt with these first three points here, but the other point that is not commonly realised about many STDs is that they are without symptoms. The implications of this is that many men and women, and especially the young, are entering into relationships ignorantly blind to the fact that they are either infected or can be infected. And although many people realise that HIV has a non-symptomatic phase, they do not seem to apply that knowledge to other sexually transmitted diseases. The lack of symptoms of others. That means that we have either go out and look for cases, or we have to educate people to recognise when they are at risk. We cannot expect an individual with no symptoms or information about his or her risk, to attend an STD clinic spontaneously.

It is also important to offer benefit from testing, and treatment of most STDs , curable ones such as Chlamydia and also chronic ones such as HIV, can offer

benefits. Notification of partner enables those who may have been in contact with an infection, but are a-symptomatic, to benefit from testing and treatment, preferably before any complications occur.

Another important issue that is that STDs are potentially preventable.

So are we succeeding in the management of STDs? I will just start with the information that in this country we have one of the most comprehensive and developed STD services in the world, and we are very lucky to have that. But at the same time, we have rising instances of Chlamydia and gonorrhoea, the rate of re-infection of Chlamydia is probably is high - and is estimated to be around 19% in teenagers. PID increased dramatically in the 70s and 80s and doesn't appear to have declined. Tubal factor sub-fertility which is related to PID is common and etopic pregnancy rate is reported to be increasing.

This is in sharp contrast to the situation in Sweden where in the early 1980s when faced with a 20% of young people attending clinics having Chlamydia, they targeted the rising unplanned pregnancy rates by aiming to change the attitudes and knowledge of young people by open rather than hiding issues, they introduced screening programmes, and they made partner notification or contact tracing a legal requirement. Perhaps also very importantly they allocated resources to do this. Chlamydia rates in Sweden is now down to 5% in the young people's clinics and PID is also less common and they are expecting to see a change in the etopic pregnancy rate and sub-fertility rate. But it is accepted that most of this probably resulted as a consequence of improved protection and treatment, rather than prevention through changes in behaviour. They have also seen at the same time a drop in their un-planned pregnancy rate.

So, why are we not managing to deal with this major health problem optimally? I think the main reasons are listed on this slide supplemented by the points raised previously. And I think that nationally, and I am not pointing at any one part of the health service, we may not being actually achieving the quality of STD control available to us, especially in the case of young people. And with the exception of some GU services, there is no standardised process of testing, that includes what test you use, how to test and when to test, and this leads to inconsistent management which varies, depending on where the client accesses health services.

Often this is because inadequate funding - for instance those working in general practice would find it difficult to carry out contact tracing, whereas in the hospital set up we have got health advisors who are funded specifically to do this. Just an example of the variation of care that can occur, is an audit that was carried out in my own hospital that found that women attending the emergency

or gynaecology departments with PID were in general were inadequately investigated, they were treated with either inappropriate doses or types of antibiotics, and they received little or no advice with regard to partner notification and were therefore put at risk of re-infection. I am glad to say that we have now introduced a trust -wide protocol and training for all relevant staff, and the situation has been totally reversed and the standards are now high and more or less uniform irrelevant of which service a women accesses.

And finally, dispute the acknowledged benefit from antibiotic prophylaxis prior to procedures such as abortion, which has an increased complication rate in the presence of STDs, many centres still fail to offer either prophylaxis, that is antibiotics, with the procedure or screening for STDs at same time as the procedure or just before.

So really what do I feel we can do to improve the sexual health of young people, even if they don't actually recognise the term? I think education about STDs to broaden their understanding. We need to raise awareness to help young people recognise when they have been at risk, and may need to seek further advice with regard to STDs, and I think specific attention should be made to meet the needs of young men who are poorly catered for in these services. On-going training and updating of healthcare workers is vital, and as primary care takes on a bigger role in the health provision of this country, practice nurses need have a central role here. We should encourage new tests to be introduced for STDs, such as the chain reaction for the testing of Chlamydia that can be carried out on a urine sample and does not require a genital examination to be performed, which would be of great benefit to managing young people, although one has to bear in mind that there may be other reasons to examine a client. Consideration should be made to the national standards for testing and also the cost benefits for the screening programme of Chlamydia for young people should receive public debate.

And finally, I would just like to say that someway ahead, or possibly around the corner, are a number of vaccines against STDs. And there are trials undergoing for vaccines against HIV, herpes viruses, wart viruses and Chlamydia, and I await their introduction eagerly.

Muriel O'Driscoll

Psychosexual Counselling - Sexual Orientation.

I am a midwife and family planning nurse who is also a qualified psycho-sexual therapist and at present I am employed as the Senior Nurse at Wirral Brook advisory Centre for young people where their problems with relationships, health and sexuality are able to be discussed.

I have recently been working with young people, and in some cases their families, who have dilemmas and worries about their sexual orientation. this is hardly ever a major problem for the individual concerned who, although being worried about his/her future and support from the family, has usually been convinced from a very early age of the 'difference'. Their family or careers from Social Services, however have many problems of attitude, acceptance and ignorance and need education and support to enable them to accept and continue loving and caring and coming to terms with the loss of their expectations.

I feel that this topic is rarely given enough space for discussion. It crosses every division in society of race, social class and geography and needs airing at conferences such as this. I would be happy to present the topic, using care histories in order to stimulate discussion and awareness.

I do not intend to set myself up as an expert on any-thing, least of all on gay and lesbian issues. My reason for wanting to bring this subject to the conference and give it an airing is mainly due to the fact that not enough is known or written about homosexual young people. This is rather like the paucity of information available at the beginning of this century about all things sexual!

Homosexuality was redefined in 1974 as 'Sexual Orientation Disturbance' which implies that gay and lesbian youth are disturbed, or in conflict. Being gay is not a psychiatric problem or disorder and as such cannot be 'cured', however well-meaning the efforts of doctors, psychiatrists and therapists. Psycho-analysts still see it as an anal fixation problem. One of the few booklets on this topic is produced by MIND, the leading mental health charity for England and Wales that seems to re-affirm that this 'condition' is wrong and can be cured.

I do not want to get into the medical or psychiatric discussion on the reasons for being gay but rather to focus on the dilemmas in a family for community when

being gay can no longer be kept in a confused inner part of the individual concerned.

According to researchers from Kinsey in 1953 to Brechner in 1984 between 4% and 13% of the population as admitted some homosexual experience with greater numbers having some thoughts about their sexual preferences or come curiosity. Looking at the lonely hearts columns in any local paper would give a biased view of the local community with many adverts for 'BI-curious' contacts as well as lesbian and gay requests for introductions. Homosexual issues are quite rightly discussed openly in most media venues and the power of the media and popular culture should not be under-estimated. Looking through recent issues of teen-age magazines like 'Sugar' and 'Just 17' can reveal letters and articles on this topic, so it must be something that young adults are concerned with.

In this climate many of our young people are confused about their sexuality and sexual curiosity and many feel that parents, teachers and other carers would not understand their confusion.

In Liverpool a few years ago a self help group was set up for young adults who saw themselves as gay or lesbian. It was called 'Phase' n response to the adult view that their interest was 'just a phase they were going through'. Adult experts and agony aunts tend to minimise this sexual exploration and interest by re-calling their own experiences of a crush on the teachers or older pupils or out of reach pop stars or footballers. this however is quite different as these icons are usually remote and completely unavailable and equates to the dream of owning/driving a Mercedes or playing the lead in a film! Young people who are gay tell me that they do not have any more or less of these feelings for the unattainable than any one else. What they do have is a very strong feeling that they are different from their friends and family from as far back as they can remember.

Perhaps I can illustrate this with a case study of a family who consulted me last year.

Darren was the middle child of Dave and Anne, with an older sister and a younger brother. They were quite comfortable due to the hard work and ambition of Dave who now ran is own joinery company. Darren was 16 when he was brought to see me with instructions for me to 'cure' him. He was working part-time in the local McDonalds whilst studying at a local drama school where he was already making an impact in television small parts. HE had recently come out to his family and they were distraught and demanded that

he gave up is course immediately. Darren could not leave home as he was financially dependent on his parents.

Darren had no problem with being gay, he had always felt different from his friends and brother, he had friends who were boys and girls and was a popular if somewhat solitary young man. His main worries were not hurting his family, wanting to continue his education and being accepted as he was. I had some sessions with his mother and other members of his family. Like most mothers Anne was willing to stand by Darren and love him, but she was worried about all the negative publicity around gay issues. In her mind Darren was already dying of AIDS and was more than likely being exploited by the Drama school. She was grieving for her loss of *her expected futures* as she expected marriage, grandchildren and happiness for her son.

Dave could not bring himself to talk about the problem or to talk to Darren. He wanted to remove Darren from the unsavoury influences and not let him out to go to drama school or any of the clubs where he may be influenced. This was a natural reaction to protect his son but underlying this was his anti-gay upbringing and evident homophobia.

His siblings had great difficulty initially with the younger brother no longer wanting to share a bedroom with Darren or being seen in public with him, almost as though being gay was infectious!

His elder sister was initially shocked but then accepting as she had always been in tune with Darren and confronted him when younger when he exhibited his reluctance for aggression and rough and tumble games.

Grandma was expected to be shocked but was found in therapy that she was the turning point and the most influential person in the family. Her acceptance and love for Darren was unconditional and proved to be pivotal in allowing Darren to express his feelings and future wishes.

Eventually this family came to terms with this perceived disaster in their lives and accepted the special gifts that Darren brought to the family and learnt together to look at themselves.

Just to prove that homosexuality crosses all races and cultures another client was Shumila, and eighteen year old student from a Hindu Indian family. She had ‘come out’ at university and needed help in telling her family. Shumila wore typical student uniform of Doc Martins and dungarees, with silver body piercing of nose and eye-brow. Her head was shaved and her make-up quite startling. As can be imagined there was a lot of reaction to Shumila’s announcement, but

eventually there was understanding and compromise, as Shumila agreed to grow her hair again!

The main points that these cases brought to me were as follows:-

It can happen to us - Being gay can occur in any race, class, religion, culture, nationality, etc. There is nothing that predisposes to being gay nor can anyone be influenced by another to be gay, although being or acting 'camp' may be an act used to entertain, to fit in or to avoid certain issues.

Individuals usually know from a very early age that they are different - even if they do not have the words to describe their feelings. This may be exhibited in behaviours that are different from their peers or in feelings that may or may not be verbalised.

Families especially mothers feel a sense of loss for their preferred futures that usually include weddings and grandchildren and a sense of continuity.

Those who are closest may be the last to recognise the pain as excuses are made for behaviours such as 'he's always been sensitive/solitary/a show off/aggressive/ etc. It comes as a shock when outsiders appear to know your son/daughter more intimately than you do.

Negative images in the media influence acceptance Gay people are frequently portrayed as sad, disturbed, promiscuous, child molesters, over the top personalities, outside of acceptable society. This is despite the efforts of soap operas and films and specialist programmes that of course are not usually watched by the straight population.

Absence of a family role model. As children we learn most of our living and social skills from our family or carers. For the gay young person there is a need to look further afield for role models. Because of the widespread homophobia there may be a reluctance to air their fears, hopes and feelings with those closest to them and then it is much more difficult and shocking when the individual 'comes out'.

So far this has all sounded depressing as far as families and individuals are concerned. Although as I said before I am no expert, just a listener and supporter of young people, I have been looking at some areas where we as carers, parents and concerned adults may make some improvements.

More discussion about sexuality in general and homosexuality as part of this. Homophobia and not wanting to be different is rife amongst the young and

is influenced by what they hear from those adults closest to them. We must take as much care to avoid homophobic language, jokes and references as we would with racist or sexist comments.

Unconditional love and support made evident by all who care for young people. This is usually implied by parents and carers but needs spelling out and stating frequently. Parents and carers still love and support their children who may be or become disabled, dependent, criminals and even drug addicts but have more of a problem with those who are gay or lesbian. Even if they could accept, they may give the impression that they would not and so cut off the supportive lifeline to their children through fear of their reaction.

Education and awareness for carers, teachers, social workers and Doctors surrounding homosexuality in order for *facts* or *myths* to be discussed with young people.

Positive images of gay and lesbian people to be celebrated e.g. Chris Smith labour Member of Parliament made his homosexuality known before standing as an MP so removing the treat of exposure and sensation by the media, as well as being accepted as a person first and a gay MP second.

Bringing gay and lesbian issues into mainstream education and discussion so that they are not always identified with the 'abnormal' or deviant areas of society.

Celebrating difference and accepting diversity The world would be a very monochrome place if we were all the same. People are not better of higher than others, just *different* and that diversity makes life great.

Finally the most important thing that we can give to any one is the gift of respect for self in order that respect can be given to others.

I would like to thank the organisers of this conference for giving me the opportunity to air this subject and I hope that you will all consider your own attitudes and actions in your work with young people.

Muriel O'Driscoll, 62 Canning Street, Liverpool, L8 7NR 0151 709 1505
October 1996

Social and Behavioural Challenges in Adolescence -

Chaired by Ann Sutton

Paul Griffiths - ‘Needs of young people - the role of voluntary agencies’

Dr Leon Polnay - ‘Needs of Young People in Residential Care’

Laura Gamble - Recreational Drug Use

Christine Ferron - School Drop Outs

Dr Aggrey Burke - ‘The challenge of race - the outcome of teenage pregnancies’

Keith Drinkwater - Young People Running Away.

Paul Griffiths -

'Needs of young people - the role of voluntary agencies'

First I would like to congratulate Youth Support - .. happy 10th birthday to you. I think you started, on the same year as Childline, it's Childlines' 10th birthday too this year, so … happy birthday Youth Support.

Now, in letters to Judy Blume, who was an American agony aunt, who wrote a book called 'what kids wish they could tell you', amongst the examples of correspondence, one stands out:-

'Dear Judy, my mum's so scared to tell me anything, so could you write a book called "How to tell my daughter" so I can give it to her, yours Karen, aged 12'

One call I remember taking in Childline all those years ago, was a young women who said:-

'Please help, my mum says she is going to leave my dad, and I am going to stay with him. My daddy says mummy is going to run off with another man, and I am going to go with her. What can I do?'

Think about it.

Why do young people need voluntary agencies, and what can they do to achieve and reach out and begin to work with young people, who come to them for help?

Some of you may remember a children's society campaign a few years ago which featured a boy against a yellow background and it said 'I need a good listening to'. Well that is our motto, that is what we should all work from.

I am going to talk a bit about what the Children's Society has done in recent years, to listen to listen to the needs to young people, and structure it's work and activities in such a way that they are child involving, child friendly, child empowering, and while it is very depressing to hear of adult's criticism of, say, the recent NSPCC commission of an inquiry report into child abuse, had anyone actually asked the children about what their experience was of being a child was in the UK today. At least the NSPCC did that, and if their projection of 1 million children who are unhappy, were listened to in some way, rather than the adult view, which I heard predominately on the radio, may be we would actually learn from that.

I think that rather like Youth Support, when I launched Childline, this was against Department of Health advice and almost every director of social services in the country. It was irresponsible, we were giving children analgesics, the social service departments were going to be overwhelmed, and well, you know, 'please don't do it', to the point that my own professional credibility was questioned and threatened on many, many occasions. Well, it was launched and in the first ten minutes of it's work it was swamped with over 50,000 calls, we know that from the figures BT actually gave us. Calls that did get through were disembodied voices, rather like the young women I have just talked about, and which we as adults never really stop to listen to. Now, why is that? And what have we at the Children's Society done as a voluntary agency, to attempt to address this balance, and become what I would term a Real Children's Society?

So, what do we know about young people's needs already?

Well, in asking them, we find that their only certainty is change. That the proportion of children living outside the two parent family is almost the same today, as it was in 1851, that there are decreases in family sizes, postponement of parenthood, increase in child-baring outside marriage, and there is a frailty and discontinuity in relationships. The proportion of children under 16 living with both natural parents was 83% in 1979 and in 1991 it was just 68%. Nearly one in five of households in London has just one adult. Children are less likely to share the companionship as they used to with siblings or wider kinship, and in London in 1991 43% or households with children had only one child. In 1979 10% of all children were living in poverty - that's defined as people living below 50% of the average income after housing costs. In 1992/93 33% of all children were living in poverty. And 14 of the most deprived local authorities (of the first 20) were here in London, whereas within 20 of the 40 postal districts within London there is the highest income in the country. So hence this huge contrast twixt poverty and affluence. In 1971 80% of 7 and 8 year olds went to school unaccompanied by an adult - you probably remember going to school without anyone coming with you, we now know that only 9% are allowed to go to school on their own (1995). So we have this contract between what I call the free-range environment that many of us grew up in, and the battery reared conditions that most of today's children grow up with.

When we turn to special schools, we find that an decreasing proportion of children were placed in special schools in the 80s but between 1991 and 1992 this trend was reversed, and between 1991 and 1994 there has been a threefold increase in the number of pupils who have been permanently excluded from school. 1985 37% 16 and 17 year olds were in full time education and 29% had a full time job. In 1995, 69% of 16 and 17 year olds were in full time education

and only 8% had a full time job. And so it goes on, 90% of all young people leaving care are unemployed. Benefit rates, we know about the removal of benefits from 16 and 17 year olds. And the removal of benefit entitlement for asylum seekers. Housing stocks have reduced very considerably, in 1994 345 households applied for re-housing under homelessness legislation and were refused assistance on the basis that they were asylum seekers. So it is against that backdrop, and there many more statistics which you could take which would demonstrate the considerable pressures upon children and young people today. There are a few upon which we actually based, what we call, our justice objectives, and ways of working within London, and helped resource some of our new projects which I am briefly going to talk to you about.

We were largely lead by the UN convention on Rights of the Child, to which this Government, fully signed up member, ascribed to at the summit in New York just a few years ago. Yet we have a justice system that still locks up children. And 8 times as many black children as white children. I was in Feltham the other day and that was very, very clearly demonstrated. The Governor told me he had to resist three judges that this 14 year old should come to prison, should come to Feltham Young Offenders Institution. It is illegal, but the judges were insisting on that, but he successfully resisted. Yet, we still have 15 and 16 year olds locked up in this country.

So, we determined to organise our work in to six justice objectives upon which we would actually carry out our work, and we called them our action plans.

1) We felt that all children, and we had to be idealistic and envisualising about this, all children should have a good start and have access to positive childcare experiences in their homes and communities - this concerns children under the age of 8.

2) We felt that all children should be protected from all forms of violence and abuse.

3) All children should experience just processess and retain their liberty, unless containment is necessary to protect themselves or others from serious harm. We also wanted in that context to adopt an object that anyone under the age of 18 should not be in prison custody.

4) We felt all children should have access to sufficient income, and the number of households with children and young people where income was below half the average should be reduced.

5) All children and young people should have somewhere to live, and no-one under the age of 21 should be homeless. This is not the case in London today.

6) And finally that all children should be listened to, and be able to participate in their neighbourhood, and in services which effect their lives. And also that their thoughts and wishes were taken into account and they were able to make informed decisions about their lives.

So on the basis of those justice objectives, what I want to do now is to talk to you very briefly about the process as we, at the Children's Society have made here in London in the last three years.

Well, we are setting up two new projects under the object of 'have a good start'. One is a project in Dagenham and that is about listening to children under the age of 5 and asking them what services, what play groups, what facilities they would actually like. If you listen to them, carefully, they have a lot to say, particularly at that age, I can remember that just about - and being a grandfather now I am living all that again. They have a lot to say about the places that they go to and what's good and what isn't good. We need to listen to them and value them. The setting of a project where we are helping parents learn how to play. I was looking at the swiggle diagrams on display, and that is particularly going back to my childhood too, and I was very much a follower of Winnicott. And in terms of looking of parents who were themselves as children were deprived of play, or don't know how to play and they now have children of their own. The setting of a project will help them play, to help them in what understanding play needs actually are. We did this by talking to children under the age of 5 and watching them and looking at their degree of depravation and withdrawal, and how we are going to get that turned around so that they become healthy young people.

We are going to set up a project under our objective which reaches out to homeless young people. There are about 400 homeless young people under the age of 21 in Central London with a number of serious mental health problems in some cases, it is really touch and go as to whether they get into the justice system or the criminal system. Their life expectations may not be any longer in some cases than 24 years. We really have to start to work with them, however resistant and angry they may be, and that is often based on past experiences of abuse in care and so on.

Under our treated fairly objective we are having a rights and participation project which looks at young people who are in local authority care and how they are actually going to change that for themselves, in Hackney, Lewisham, Newham and Southwark.

We have a project which is called ‘Schools Inclusion’ (not exclusion but inclusion) where children are actually earmarked, or identified as being for their behaviour excluded from school, we want to turn that round to a positive way and call it schools inclusion, and that project is now taking off, and is very valued by the schools concerned, in Lambeth and Wandsworth.

We are setting up a project which is also about rescuing, I had to use that word even though I don’t actually like it, rescuing those young people inappropriately committed to prison. Like the children I was just talking about. We are working very closely with the prison in Feltham on that.

Under sufficient income, we are setting up a project which is about helping young people tackle their poverty, the fact of their poverty within the anti-poverty strategy which exists in the London borough of Greenwich. We are involving them in that, and a way of involving industry and business to take an interest in young people and their special skills and talents, and how they can develop and feel more valuable and not unemployed, and lacking any value

We have a project in East London which is looking at the social exclusion of young Bangladeshi women. Also about young people with disabilities. This is tied up with poverty as well within Tower Hamlets.

We have another project which is going to look particularly at asylum seekers, who are particularly discriminated against in UK today. There is a lot going on about that at the moment. And refugees in Newham and very possibly in Hillingdon.

We are working with young tenants who are largely excluded from housing associations and so on. We are setting up a project to support young homeless in gaining tenancies in housing associations. We have already secured a very large contract with a very large housing association in Brixton and we are going to back them up and support them and demonstrate that they can be reliable and vulnerable, and not stereotyped as unreliable and noisy and rowdy as people often do. We believe, we trust in young people, and that project is going to demonstrate that very conclusively. We also want to develop with those young people the concept or notion of self build. They have talents, they have skills, there are modern apprenticeships and so on. Why can’t the build their own houses? And we want to try and help them do that. A lot of that is visualising, which is what we are doing. And if we have that belief we can work with young people, because this is what they want, we have consulted them, and we want to take them along with us.

We have a project with in Battersea and in Wandsworth which is about preparing young people for independence - that is those young people leaving care.

We have another project under our listen to objective which is about looking to children in neighbourhoods, about how children at all ages, can influence the development their own neighbourhood and turn it around from being not the safe place that we parents think it is at the moment but into the safe place, which is it clean, where they can go out and play football in the street, where they can feel as free as perhaps we did - although perhaps I have a rosy memory as a child growing up in Liverpool. So that is about involving children in community decision making processes, it is about influencing counsellors - in my other life I am a counsellor in Bedfordshire and I would welcome young people coming to see me and persuading me that the village green should be used for something else, or that a youth club ought to be build. We have problems too, not only in London, but also in the so called leafy places, in terms of the intolerance which there is of young people and where they can go and play and feel valued and wanted. That is working across the London Boroughs of Hammersmith and Fulham, Hackney, Enfield, Camden, Bexley and Lewisham. So a pretty wide spread cutting across London.

And finally we have two projects, one is called 'Baseline' (not too far from Wimbledon hence the name I think), working in Mitcham, London Borough of Merton, which is about providing information and advice of all kinds based on what young people want - if you like a kind of walk in child line can listen to young people on the phone, but in some cases children need to work face to face. Now in Mitcham particularly what we actually did was that the young people actually designed the centre themselves, and with us they demonstrated where they would like it to be, they were involved in the appointment of the staff and the also involved in the appointment of the management committee. Now, that is not patronising, that is what is actually happening, if you were to go to our Mitcham project you would actually see the young people running it, with us and the London Borough of Merton, and they are involved in making management decisions about the running of an agency in collaboration, as partners, genuine partners, with us. I think that is one of the few projects in the country where I think that that has actually happened. We have another project on similar lines set up, called Genesis, which works inside a school in South East London, two thirds of the young people there are black and our whole team is black working with these young people and facing some of the problems of growing up in Peckham with them.

There are some of the examples of the projects which the Children's Society have, in the last two or three years, developed. So, I think that when you can

see, as a voluntary agency in London, where you actually get a group of people working with young people, as partners and so on, that is a very powerful mechanism. We have certainly found that. Children are very demanding, they want something done like yesterday, and we try to do it like yesterday, because that is the way it works and what we want to do with them. We can look at the social policy issues which are around, their therapeutic needs, their health needs, their family problems, but we look at that very much from a young person's perspective - with them as partners.

So, looking ahead - yes, we want to work with young asylum seekers. 53% of all young people looked after in the London Borough of Hillingdon are children who have on their own, not with adults, have fled from oppression and very possibly torture in other countries. We also want to work with young people who abuse other young people, who may well themselves have a history of discontinuity in care, poor bonding in early childhood and so on. Now, I know that list can actually go on, but I think voluntary agencies like ours, and we are not the only one, Youth Support certainly and many, many of the others, could stand here where I am and really claim that we are in the forefront really of developing young people centred services today, and this is against the backcloth of declining resources from statutory agencies, wide spread public disaffection and often anger and apathy towards young people, increasing needs, highly competitive market place which we are in which makes young people much more vulnerable and at risk.

Tallulah Bankhead once said 'I wish I had children, beautiful children, well, I wouldn't care for the other kind'. Well, we have to trust (that is a word which I have picked up today), and care for every child beautiful or otherwise.

Dr Leon Polnay -

'Needs of Young People in Residential Care'

I have amended a few of these notes as I have gone along, as I have seen there has been quite a bit of repetition of various themes and points during the day. And I think that this is good, it indicates that there is a high level of agreement among the speakers at this meeting, but I think also, when you look at who comes to a meeting, perhaps the people who we most need to influence are not here and we agree amongst ourselves but we perhaps need to get our hands on other people.

First of all some statistics. Currently about 50,000 children are looked after altogether, with about 20,000 in residential care. The numbers in residential care are dropping and now mainly represent those children and young people with the most severe difficulties (about 20%). The routes into residential care are generally neglect, abuse, offending, 'difficult to place' and behaviour problems. But in general we are talking about combinations and thinking about many of the young people I am working for or with nearly all of these apply - so it is multiple difficulties rather than single problems we are dealing with.

In terms of a policy that we are supposed to be pursuing in health, in terms of the 'Health of a Nation' targets, I think I would challenge anyone to identify any group of young people where the 'Health of a Nation' targets are perhaps least met. So, if we look at teenage pregnancy, or smoking - certainly with the first group of twelve we worked with, we found one non smoker amongst the 12. In terms of sexually transmitted diseases and in terms of self harm these are a group of young people who we should really strongly targeting, that is if we believe in 'Health of the Nation' targets.

But it is not just the health service which ought to be targeting these children, because clearly there are major problems in other areas. Many have learning difficulties, some simply because they have not attended school, and certainly over all may be 60% or 70% are not attending school, or certainly in the past have missed large amounts of school, or where there has been incredible discontinuity in their education. I would have brought some notes along, but I have trouble carrying heavy weights at the moment, but you read a huge pile of notes, and you read the changes in school. Enormous number of schools, 6 or 8 primary schools, or more secondary schools, with very large gaps. So, no wonder there are learning difficulties, which I think is perhaps to some extent an understatement.

Many are excluded from school, or when they are in school they have problems or behaviour in school, and if we turn to behaviour, prostitution is certainly in our district a major problem. Boys and girls as young as 12 are involved in child prostitution, and many of those children were abused in the home before coming into care. We see that community homes are targeted by people who wish to recruit them into prostitution, and certainly the offer of drugs and other substances may well be a factor in that as well. But prostitution is a major factor, and actually trying to prevent children going into prostitution is also an important area. In our district we have prostitute outreach workers, who are ex-prostitutes, who are involved with the community homes talking with the young people.

In terms of substance abuse, we actually think that perhaps there is a great deal of knowledge about that, but we also see another side of it, that people will experiment with almost any substance, to see what would happen. And we are regularly seeing children being admitted to hospital - we had a group who broke into an elderly couple's house, found some pills, took them away, and the pills were 'frusemide' a powerful diuretic, and 'digoxin', but they were sick kids, they had to be monitored, it could have been potential lethal, and some children will actually try virtually any substance that may or may not give them some pleasant effect, and certainly there are major concerns about that. We have had one or two children in intensive care recently, but no fatalities.

What about health, what problems do we have there? Well, start with diet, because when we looked at what children in residential care were eating, not what they were offered, I may add, none of the children were eating fruit and vegetables. Well you might say does it matter, they have bigger problems than whether they eat their greens or not! But having said that, they were following very unhealthy and restricted diets. Continence was a problem. Problems of wetting, or soiling, smearing faeces, common problems which we encounter.

Discontinuity, I think is one of the areas which make work so difficult. The children move from one area to another, and to build up a programme of health care which can actually be delivered is very difficult. What happens is that we are frequently going back to the beginning and starting again, and not really delivering a proper continuous programme of health care. Lack of information, is very much a problem. What happens to the children's medical records, do they follow them, do we have the information we should have? Do we have proper information about family history, do we know what treatment the children have been on or should be on? And very often we have to be a fairly good detective at milking records and other systems to get this information.

There might be poor compliance. We may get there, we have the medical records, we know what treatment the child should have, how well, how effectively is that treatment being complied with? And what level of organisation do you actually need, to ensure that children get repeat prescriptions, that they attend appointments, that they actually get connected with the service.

Fear and mistrust was one of our major problems. When we asked the children what it was like, what they felt like, when they had their routine health check examinations and reports, we found that there was one person who felt it was a good idea, everyone else was very critical about it. Imagine what it is like to be taken to see a doctor who you have never met, to not know what is going to happen, and to be in fact the object of that consultation, rather than a person who is centrally involved, who's views, who's worries about their health are being looked at. And I think many young people feel very negative, they don't want to go, and there is a great deal of fear and mistrust about that whole process And I think we should be doing something to address that.

Choice - who do you want to go with you? And major issue, was whether they were accompanied by a male or female person, and also whether they saw a male or female doctor. It is a major issue for most young people, but again, we found that most were not asked and didn't get a choice. And often were reassured that 'yes it will be a lady doctor' or 'yes it will be a male doctor', would actually make a big difference about how the children would feel about the medical consultations. And when we think of what is involved in those reports, I think that too many are confined to physical health, height and weight, and not very much if anything about health promotion or mental health. So I think we can do a lot to improve the quality of health interviews for this group of young people.

What do we need? We certainly need a better access to existing programmes of care. If children are not in school, they probably don't have access to the school health care service, and to health promotion in schools. What access do they have to primary health care teams? How easy is it to get an appointment? What are the problems with access? Do we need on top of that a separate tailor made programme, which is actually made to meet these young people's needs? We often talk about 'comprehensive' or 'seamless', but quite often it seems to me that rather than seamless it is a whole pile of rags. We do need to provide continuity within that service, and I hope that one of the messages that we are putting forward in our programme is that we are here to stay. I think now, we are two years into our programme for young people in residential care, I think the fact that the same people keep coming to community homes is beginning to be realised, that we are providing continuity. Not only over time, but in the

various places where they might be seen. We need proper information and records which not only we have, but the young person has, not us being the only custodians of that. And above all we need collaboration - we need to be working together.

Aims - What are the aims of the service? in fact, that's probably the aims of service for any children in the community. All we are doing is restating it and saying that we have the same aims as any service which is dealing with children.

What are the objectives of the service? We do want to have an overview of children in residential care, their health needs. Identify gaps and attempt to meet those. We need to provide a source of advice to staff in community homes on health care. And for individuals we need to provide health care advice - to young children who are looked after. So we are really working at three levels, at the population, at the level of the community home, and knowledge about child health, and at the individual.

In our approach these are the various levels we are trying to work at:-

* Health Promotion programme which is taking place in community homes.
* Individual assessment of health needs.
* The young person is actually in control of the process - which is very important - rather than the object of it.
* Provision of support and training for residential social workers.

So, who is in our team?

* The most important person, the only full time member, a research school nurse.
* An administrator to keep records and to provide information about where children are coming from and going to.
* Paediatricians, three part-time people who are seeing individual children - I am the only one which is permanent, but we can give children the option of seeing either a male or female doctor.
* A part-time clinical psychologist who is part of the core team, who will see individual young people
* And a child and adolescent psychiatrist who is part time.

We have a broader range of people, and the extended team is just as important:-

* Social services policy officer, without whom none of the work in community homes could actually happen.

* We have the involvement of training officers from both health and social services in supporting the educational programme for residential social workers.
* We have a named educational psychologist working with us in order to try and look at the educational needs of each individual young person.
* And we have a dietician because we are obsessed with what people eat!

Interestingly we are hoping to get funding to run a programme where we will try to improve diets and also self knowledge about food and independence. One of those lovely things which happen by chance - the cook left from one of the community homes and an unemployed chef applied for the post to work on a temporary basis, and people were sampling mushroom and oregano soup and all sorts of lovely things and because the meals were absolutely super, restaurant food, rather than sitting down to the minimum time to eat the meal, everyone sat down and talked, communicated and it was absolutely wonderful. It was orderly, and it made a very big difference. And we are now trying to see if we can actually extend that, recognising that a good meal and actually sitting down and eating together is very important process.

How do we assess the needs of individual children?

We have a questionnaire pack, which they in fact complete themselves. It consists of a number of different questionnaires. There is the Trent lifestyle questionnaire which looks at areas such as food, injuries, out of school activities, feelings, drugs, alcohol and sexual health - we have added an extra couple of pages to cover sexual health and self-harm. And we have other questionnaires which cover depression, fears which children may have in ordinary situations, and a locus of control questionnaire, and a quality of life questionnaire. And the children can complete them in one go or in several steps.

The next stage, we have actually got these questionnaires now onto the computer and having done that we provide feed back to the young person themselves on the results of the questionnaire and we produce an agreed health care plan on the areas which they actually want to work on which arise from the questionnaire and that is actually agreed. But what we think is very important is that the recommendations are actually implemented. So the core team have a monthly meeting at which we have a review of every young person and the progress of implementing their recommendations. We have to deliver. We can't just make assessments, raise hopes and then not deliver. And I think that the implementation is very important and must be seen to be successful.

The health promotion work in community homes is done is six-week blocks by two team members. It usually consists of an introductory session, and then

chosen topics by the young people and sexual health and drug miss-use are the most often chosen topics by the young people. There are also individual health promotion and staff support as well within that element of the programme.

We started at the beginning by establishing a one week course on health for residential social workers. We have ten or twelve people on each course and these are the areas which we cover:-

* Growth
* Development
* Child health surveillance programme
* Common illness and their management
* Mental health
* Substance miss-use and drugs
* Sexual health
* Child protection

And we have a follow-up day in sex weeks time. And we have had very positive feedback from that and we would want to in the future extend that and do some advanced training related to health.

Where might we be going for the future? I hope that the project for children in community homes is permanent, it's got secure funding so what is it's future?

* I think developing the **trust** of individual young people is very important
* **Communication of health information** which has been very poor, to young person and to others about the young person.
* **Continuity** within the programme, with who is seeing an individual.
* **Choice** for them in terms as where they are seen - in the community home, in school, we also meet in Macdonalds which is quite popular (back to food). The young person is actually in **control** of the programme rather than being the object of it and we would like to end up with **meaningful medical appointments** - which the young person is taking a full part in and which actually achieves some objective, because I think currently we have poor attendances, and we are not really achieving what is required. And by medical appointments I mean with the paediatrician, with the clinical psychologist, or with the child psychiatrist or with the school nurse who are involved in the project.

Recreational Drug Use

Laura Gamble

Really Useful Knowledge

This paper is a brief summary of an ongoing piece of research which explores the mix of knowledge, folklore, tribal customs and boundaries which together shape the strategies used by young people to control their recreational drug use.

Young people may begin experimenting with a particular drug for its specific effects - or they may try several drugs and even mix them. As well as the pleasurable effects for which they are taken, most drugs can produce unwanted effects and carry the risk of a range of problems.

In addition to the risks off increased tolerance and physical or psychological dependence, there can be unpleasant symptoms such as nausea, vomiting or tiredness; some types of drug use can cause depression and feelings of panic.

Broadly, there are four types of potential risks:

To mental health (for example, a drug can trigger mental health disorders which have never surfaced before)
To physical health (some drugs can be especially harmful to people with conditions such as heart disease, diabetes or epilepsy)
To psychological well-being (effects can range from mild anxiety to panic attacks and even paranoia)
Situational risks (driving, riding a motorbike or working with machinery can all be dangerous)

With <u>any</u> drug, legal or illegal, zero risk from potential harm can only be achieved by not taking it. Most professionals working with young people have now adopted an approach which acknowledges that a proportion of young drug users will know about risks but will continue to use their chosen drug, or drugs.

So, what can we learn about this successful controlled recreational drug use? How is this recreational relationship with drugs generated and how is it maintained? What do we know about these young people who do not describe their drug use as problematic and who rarely approach drug services for help or advice.

In 1993/4, my colleague and I studied in-depth interviews conducted with 26 respondents, all recreational drug users with several years' experience of a wide range of drugs. The results of this study established some significant factors which enable young users to maintain control:

* There are certain drugs which appear 'protective' of control, because of their particular effects, low prices and context of social use. CANNABIS, EXSTASY, AMPHETAMINE and LSD are amongst these.

  By contrast the 'antagonistic' group of drugs (notably HEROIN, COCAINE and CRACK COCAINE) are seen as those to be avoided, because of their ability to cause dependence, high cost and more isolated context of use.

* Users seem able to learn strategies which avoid, or reduce, damage to their health. They are cautious about where they buy drugs, control intake to avoid becoming dependent and understand adverse reactions and how to cope with them.

* The Social group also acts in ways which monitor lapses in control and seems to have a role in moderating drug choices, methods of use and even behaviour. Within these unwritten 'rules', support and reassurances are given to friends who need them.

  All of these boundaries, combined with the fact that almost always this recreational drug use is funded from disposable income, enable controlled drug use to continue successfully.

In the second part of our research, we have attempted to identify the factors which distinguish successful controlled drug users from dependent drug users. We developed a questionnaire to try to define the contrasts in lifestyle and behaviour between a group of recreational drug users, who had never sought hel from any drug services, and a parallel group of young clients of my service (DAIS) and my colleague's agency (OPTIONS in Worthing). The two groups were in the same age-band (under 30) and as far as possible there was an equal gender balance. There were 68 respondents in each group.

The questionnaire attempted to identify a variety of issues relevant to maintaining control over drug use and reducing problematic outcomes. These included: knowledge about drugs used; boundaries and taboos about particular drugs; methods of administration; attitudes towards caution and fear of consequences; and learning from mistakes or bad experiences.

Our work in part one of the research suggested that the 'recreational' group would typically be socially-integrated, fun-loving people, though relatively cautious and controlled; whilst the profile of the 'treatment' group would be more socially isolated, impulsive and uncontrolled.

In terms of lifestyle, we were attempting to measure the degree to which members of both groups take part in social activity, enjoy the company of other people, use drugs in a social context and choose to spend time on other recreational activities.

Other sections provided data on drug choices, initial drug use and spending on drugs (and alcohol); the influence of friends and the importance of the social group; the valued sources of knowledge about drugs and their effects, as well as 'boundaries' concerning drugs to be avoided; and the extent to which issues such as fear of negative consequences or learning from mistakes have a role in shaping behaviour.

What follows is a brief resume of the main findings of this second study.

* The recreational group are more likely to be employed or students, more socially integrated and feel more in control of their lives than the treatment group.

	Employed	Unemployed	Student	Employed in the home
Recreational	39	11	14	4
Treatment	19	36	7	6

Chi Square = 22.92 Significance = $p<0.01$

These figures lend weight to the idea that internal 'lifestyle' factors impose a protective effect on the control of drug use.

This is also supported by the data on spending:

INCOME SPENT ON DRUGS/ALCOHOL BY GROUP

	Some	Most	All	Total
Recreational Group	54 (79%)	14 (21%)	0	68
Treatment Group	37 (34%)	14 (21%)	17 (25%)	68
Total	91 (67%)	28 (20%)	13 (13%)	136

From this it is clear that the treatment group spend significantly more of their 'available' income on drugs and alcohol than the recreational group. A quarter of the treatment group reported spending all of their income on drugs.

* The treatment group are far more likely to use opiate drugs, cocaine and benzodiazepines while alcohol, cannabis, amphetamine, LSD,and magic mustrooms were more likely to be used by the recreational group.

Which drugs have you used in the last three months including alcohol, (both groups)

Type of Drug	Recreational		Treatment	
	Number	*%*	Number	*%*
Methadone	0	*0*	20	*29*
DF118	0	*0*	5	*7*
Diconal	0	*0*	5	*7*
Heroin	0	*0*	22	*32*
Opium	0	*0*	2	*3*
Palfium	0	*0*	2	*3*
Hypnotics/Benzo's	0	*0*	4	*6*
Alcohol	64	*94*	39	*57*
Cannabis	64	*94*	48	*71*
Barbiturates	0	*0*	1	*1*
Amphetamines	29	*43*	20	*29*
Neuroleptics	0	*0*	4	*6*
Anziolytics/Benzo's	0	*0*	15	*22*
LSD	18	*26*	9	*13*
Ecstasy	25	*37*	14	*21*
Magic Mushrooms	2	*3*	0	*0*
Solvents	0	*0*	1	*1*
Cocaine	*7*	*10*	17	*25*
TOTAL	68	*100*	68	*100*

* Most people in both groups reported that worries about breaking the law did not affect their drug use - over three quarters of the combined groups agreed on this.

This is an interesting finding because the responses from both groups were so similar.

However, the reports of drug-related problems reveal a quite different picture:

Numbers of respondents reporting drug related problems in differing life areas, by group

	Recreational Group	Treatment Group
Legal Problems	8	45
Family Problems	20	46
School Problems	8	23
Employment Problems	7	29
Relationship Problems	9	49

* The treatment group revealed significantly higher levels of drug-related problems and they were six times more likely to feel that their drug use was 'out of control'.

* The influence of friends on patterns of drug use showed some interesting results, including the finding that friends of the treatment group were significantly more likely to worry about their drug use than those of the recreational group. So, whilst problematic drug users may lead more chaotic lives, this challenges the idea that they exist in an uncaring community in which no-one is concerned about them.

* Most drug users acquire knowledge about drugs either by finding information for themselves, or they learn by experience, first-hand or from friends. The study findings showed that successful recreational users are more likely to find out about a particular drug before trying it - whilst those in the treatment group are more likely to find out about it by trying it.

The findings from this research offer potential new directions for health promotion/risk reduction campaigns, both in terms of content and style of delivery. There would clearly be value in a focus on ranking drugs and behaviour in a 'hierarchy of dangerousness' and in making available accurate, reliable information. If these messages could be delivered directly to the peer group, they would be in tune with the attitudes, beliefs and experiences already well understood by young people.

In acknowledging that all drugs are not the same, and that each carries specific risks, public health campaigns will need to avoid the accusation that we are condoning some forms of drug use. We are all familiar with messages about 'safe' levels of alcohol use, which promote protective strategies whilst warning against antagonistic behaviours - are we ready to accept the same approach for recreational drug use?

REALLY USEFUL KNOWLEDGE is a research project which began in 1993. The authors are **Michael George**, Director of Drug & Alcohol Services, Worthing Priority Healthcare Trust; and **Laura Gamble**, Acting Director of the Drug Advice and Information Service, Brighton, South Downs Health NHS Trust.

Christine Ferron -

School Drop Outs

Despite a long term decrease in global drop out rates, the status and evolution of young school drop outs has generated increased interest among health professionals in recent years. Leaving school prior to completion definitely limits most young people educational and professional perspectives and also severely impairs their economic and social well-being throughout their adult life. It is virtually impossible to obtain a precise assessment of the extent of this issue, because accurate rates for school drop outs remain difficult to determine. Several factors contribute to this basic uncertainty, but the most critical one is how to determine whether or not a person is a school drop-out. The variety of the definitions seems virtually unlimited.

In an attempt to standardise this notion, we decided to consider that the term 'drop-out' would stand for adolescents who left any kind of educational system without any useable degree and without getting involved in any professional training or qualified job. This term includes adolescents who decided to drop out from school and students who were excluded from the educational system as well.

In Switzerland 5% to 8% of 15 to 20 year olds drop out from school or training programmes without any title of education. Two years ago we conducted a study designed in order to assess the health attitudes, behaviour and needs of 15 to 20 year old school drop outs in French speaking Switzerland. The data was collected by means of an anonymous self assessment questionnaire, distributed by health professionals or educators in different settings. We compared this data to similar ones which were collected in schools among adolescents within the same age range. I will show some of our results to illustrate my presentation.

Transversal studies conducted in the area of health status and health behaviour, overwhelmingly agreed about the existence of a poor health status among adolescents who drop out from school. Besides basic health problem they present a lower level of concern about their body and themselves, a lower level of physical activity, more nutritional problems, and a higher frequency of accidents. They are earlier initiated into the use of licit or illicit drugs. Their consumption appears more important and more frequent.

With regard to the behaviour of youngsters in their sexual life - here is what we found about the frequency of sexual intercourse, which is higher among drop-outs. The number of sexual partners is also higher amongst drop outs especially among boys. Contraception use is more often occasionally or not at all among

drop outs. This behaviour is translated into a higher level of sexually transmitted disease, abortion and pregnancy - the latter being a possible direct cause for dropping out. Drop out may also be victims of violent acts, including sexual abuse or injuries arising from violent circumstances. Here you can see that unplanned pregnancies and sexual abuse are much more frequent in drop-outs than in adolescents in schools.

Families of drop-out adolescents show a number of characteristics which were highlighted by a number of studies. A larger proportion of father and mothers who are non working, unemployed or retired, do not get any direct income from a professional activity, a lower level of education, a high proportion of parents without a qualified degree, an important of non-qualified labourers among fathers. Financial sources more often average or below average. A head of family more frequently from a foreign country. The most salient research findings tend to describe family contacts which fails to provide adolescents with a basic security which thus gives them feelings of self-doubt and unfulfilment, a lower level of cohesion, a lack of emotional bonding, closeness, loyalty and empathy, an inflexible structure, an extreme rigidity of internal rules, definition of roles and strategies for problem solving. A limited ability to adjust to changes. Parents indifferent or negative attitudes towards education may also be highly influential factors.

Drop out youth tend to present more frequent feelings of personal failure, ruthlessness and hopelessness. They have lost the notion of professional and life choice, they have more negative perception of society as being violent, rejected, unfair and contemptuous. They more frequently express hostility or anti-social tendencies. They have little hope of attaining a secure and challenging job which would provide them with some sort of economic security and a social status in the average. They have more frequent perspectives that they find depressing, becoming blue collar workers or employees without the hope of being promoted and they have projects far away from the job market. Creation of their own business or dream job. They have a low level of knowledge concerning the school and professional choices available to them and the necessary steps to go back to school or to find a job.

Regarding their psychological adjustment, drop-out youth are more often inhibited by the perception of their inability to accomplish personal goals. They have a deficient self-image and a non-valued body image, a higher psychological vulnerability and an emotional instability, a more external locus of control, a higher anxiety level, more depressive symptoms and suicidal thoughts. Here is what we found regarding these tendencies. Much more drop outs felt depressed, wanted to kill themselves, or attempted suicide.

Drop out youth are also more worried about their future, they have a lower level of life satisfaction. They more often express the need for a personal help and feel more lonely. Here is what we found among girls, the percentage of respondents saying they need help in various areas. All the percentages are higher in drop-outs, but the sharpest differences concern depression, sentimental life, professional future, difficulties with parents, tobacco use and drug use. Among boys the most important differences also concern depression, professional future, difficulties with parents, tobacco use and drug use, but school and work, sleep, and alcohol use are added to the list of problematic areas. There is also a higher incidence of undesirable events in these adolescent's lives.

Finally adolescents who have left school are also different from their peers who have remained in school as far as their attitudes towards the school system are concerned. For instance, in their opinion, school is not helpful when it comes to the decisions regarding their future professional life. There is also a higher frequency of school phobia and academic failure amongst these adolescents.

Thus, as you can see most research on school related factors as focused on student behaviours and performance on school, little attention has been given to the influences of schools themselves, their organisation, teachers and leadership, on students decisions to drop out. Yet, many drop outs attended schools where they found conditions that could affect their performance at school and ultimately their decision to leave.

The results of longitudinal studies show that in fact dropping out can be beneficial to some kids - as well as for the schools they attend. Some students choose other alternatives over than going to school - alternatives which in some cases can be more fulfilling and rewarding. A study of high-school graduates and drop-outs found, for example, that some drop-outs showed equal or greater improvements in self-esteem and a sense of control than high school graduates. Overall, however, most findings support the notion that dropping out has negated individual and social consequences. A few of them also suggest that overall poor adjustment pre-existed in these adolescents.

The most immediate individual consequence of leaving school without any qualification is a low level of academic skills, which makes it difficult for them to secure a steady employment or an adequate income and limits their access to additional education. The absence of education activity also has negative effects on their personal and relational adjustment. Inactivity and lack of stimulating perspectives can entail a tendency to become depressed, a lack of self confidence and a feeling of guilt, related to the belief of lacking the necessary abilities to be fully accepted as adults. All these negative feelings favour the

adoption of life habits which can possibly have harmful effects. That might be an increase in meditation or drug use, symptoms of stress or psychosomatic symptoms are more frequent than among adolescents in school. On a relational level there is a dismantlement of their social network and a progressive decrease in their contact with their friends who stay in school.

Out of school young people also seem to have a greater tendency to become delinquents. Here is what we found regarding divine behaviour. Drop out girls and boys are more likely to have run away from home, spray painted the walls, stolen in a public place, beaten up someone or intentionally broken something.

Family relationships are not spared in this progressive degradation of the quality of social life. In some cases conflicts appear in family circles which used to function successfully before, in other cases pre-existing difficulties are increased by the presence inside the family of a inactive adolescent who has more and more difficulty in accepting parental authority and to submit to him or herself to the rules of family life. Here we can see that drop-out adolescents are much more often afraid of having conflicts with their parents, or being beaten by their parents (although those percentages are also quite large for adolescents in school).

Not all students can or should be expected to finish high school or college, but all of them should be considered as our resource for the future, and should be given the chance to be properly trained, to acquire some professional skills or to learn a job in an appropriate setting.

Here are some of the elements that may be needed to develop a successful strategy of drop-out prevention.

Different programmes aimed and designed for different types drop-outs. Different kinds of students drop out for different reasons. Some are related to problems at school, others are related to factors outside the school. A comprehensive strategy will need to address all these factors.

An appropriate mix of educational and non-educational services in each programme. Effective programmes must first address the particular academic needs of the students, by providing the appropriate kind of curriculum, mixing academic and vocational studies, constituting equal ability groups of students. A sensitive and responsive teaching staff. Individualised instructional progress, and even a adapted schedule and location.

Secondly, these programmes need to address other needs of students, and perhaps the most important is their psychological need for someone to care

about them individually. A need for connectedness which can be met through thorough guidance of counselling.

Our team is currently conducting a research and an action among young school drop-outs, which consists of supporting a group of 100 of these kids during one year. A first assessment of their situation was made one year ago and a second one after one year. This group will be compared to another group of 100 drop-outs who have not been supported by us during the same year. We hope to be able to show that even a light support, if personalised, has a significant and positive impact on their psycho-social adjustment and school re-integration. Accurate and timely identification of students with a high risk of dropping out. A study found that half of the drop outs interviewed did not discuss their decision with anyone at school before they left. Another research that some drop outs begin showing signs of academic failure and disengagement in school in the early elementary grades. Particular attention should be given to the support which is provided to the adolescents immediately after their first failure during the educational classes, or immediately after their first expression of their desire to give up school. These appear to be key moments for the future of these adolescent's education.

As regards to drop out youth's social integration many results of enquiries emphasise the superior value of broad multi-competant community wide programmes, aimed at changing the social environment in which adolescents are reared and educated. Interventions which are supposed to be the most effective are associate community education, intensive dialogue with policy makers, participation of the media, interventions in and out of school, and relation groups including different complementary partners interacting inside a network.

Some measures were also proposed within a smaller scale. The essentially include the creation of appropriate types of curriculum and the possibility of offering a second chance to recent immigrants. The school integration to these young people, may also imply their easy access to local and national information about the nature of the jobs that are available without any degree and the material conditions of unemployment.

As far as health is concerned, the improvement of drops outs access to information principles as an inventory and a presentation of the existing resources in health care and in health promotion. The useful places, organisations, persons and financial support. Several authors emphasise the benefits of individual attention and recommend personal counselling. This type of approach does not exclude the occasional participation of some members of the adolescents parents, teachers or other educators. Others have noticed the efficiency of group work and suggest setting up therapeutic groups, this

methodological choice is generally related to the trend that consists in the increasing the adolescents participation in initialising and developing the social adjustment process. This increased participation may have a positive influence on their level of motivation and it may also help school leavers maintain a sense of identity and feel like fully active social members.

Whatever the method, the therapeutic objective generally remain the same. School drop outs need to establish a life project, to improve their relationship skills, their ability to communicate and to co-operate. Some authors emphasise the objective of empowerment or self esteem and self confidence improvement, but on the condition that underlying issues are also addressed. On a cognitive level there is frequently mentioned their need for a better self knowledge and an improvement of their ability to solve problems or to reach logical solutions.

On the more particular level of the relationship of the adolescent to the school, the work and the environment, it seems that one of the principal objectives of the therapy is to carefully analyse and deeply understand the reasons for the lack of expressed motivation, accepting young people as they are at the start rather than immediately requiring the adoption of so called realistic attitudes. Another fundamental objective is to favour the emergence of a dynamic perception of school and education as crucial components of a balanced existence.

All the conditions preceding and accompanying dropping out are so closely related that it remains difficult to determine with any certainty whether school leavers problems are symptoms or causes of their failure to complete a school programme. Indeed personal vulnerabilities function as part of constellation of contributing factors that precedes dropping out of school and drop out status itself may play a closer role in fostering a depreciation of self perceptions and social group contacts conducive of development of problematic behaviour or patterns. The identification of the various indicators which predict the likelihood of dropping out could be positively completed with research studies designed to explore the possible influence of resiliency factors. Indeed the reasons why some students with an unfavourable background manage to stay involved in an educational environment and why others with comparable underlying difficulties decide to drop out of school are still unclear.

The main findings of one research on this subject found that scholastic competence is positively linked with the number of sources of help and a higher sense of self esteem. A better knowledge of the school related factors which are associated with dropping out may provide some interesting explanations regarding this issue. Indeed we need thorough studies focused on school processes involving institutional forces, internal organisation, explicit and implicit rules, types of leadership, teaching methods, staff training and modes of

assessment. We also need to uncover the processes that underlie and lead to dropping out.

Many of the factors that are known to be associated with this problem are structural in nature and reveal little of the underlying processes. For example why to young migrants of the second generation have higher drop out rates? Some possible explanations include the use of language in the home, the pressure that parents place on youngsters to learn and use English, the values they transmit regarding education and work, the circumstances surrounding the families immigration, the social status of the family and so on.

As it appears clearly the needs of school drop outs are multi-dimensional. Primarily social, academic and vocational, the difficulties of school leavers are also salient in areas of psychology and health. In Europe, in countries where access to free health care is made relatively easy, several studies have shown that unemployed school leavers consult health professionals more frequently than their peers who stay in school, both before and after they decide to drop out. This higher number of meetings with various health professionals underlies the higher level of health needs in this population of young people, who may actually have a tendency to convert their psycho-social concerns into actual physical symptoms. The role and involvement of health professionals in the field of drop out prevention and recovery needs to be more accurately defined in order to favour the adjustment of their actions to the diversity of types of school leavers. In particular improving the efficiency of their action on the double level of early detection of dropping out and the comprehensive charge of school drop out implies health professionals implement and use a multi-disciplinary network which would more likely to address the whole structure of drop out's adjustment issue.

Dr Aggrey Burke -

'The challenge of race - the outcome of teenage pregnancies'

What I want to talk about today in the limited time is really teenage pregnancy among dysfunctional mothers, and the sample is drawn from among a group of persons who presented with child care concerns and there selected by attending school in Britain. The reason is quite straight forward, those who don't attend schools in Britain do a bit better, and I am not making any..... the department of education is doing a good job! But there we are.

Now the population of these persons is very much an abusive one, a half come from inter-parentally violent homes, a half have been sexually abused, more suffered from other forms of abuse, and two thirds of them feel rejected in their homes.

The sample is a sample that is personal to me, about 250 persons, and about a third of them were adolescent at the birth of their first child. Whether that is an increase or not is up for grabs. It is not the middle classes, it is the population of people who have a difficult life experience as indicated here. Two thirds ran away from home. Two out of five had an in care experience. Quite a lot attended psychiatric clinics in adolescents and one in ten went to a secure home.

Now, you can ask why are we concerned with this? And we are concerned because of the issues which confront us here in London, in terms of half the children, we believe, in the care system may be black. And I mean by black, no Asian, but looking like me or something like that! This population of dysfunctional mums are also very unhappy in adolescence. They feel unwanted and unloved, they take overdoses, they abuse alcohol and drugs and they sell themselves in one way or another. So, this is a very sad group, and I was very interested to hear about the drug users, and how one might start looking at the whole issue. But in adulthood this population which have come to me as mums, remain suicidal continue to get in trouble with the law, they abuse alcohol and drugs, they are violent and they present a serious risk of child abuse. And adolescent mums and adult mums are very similar in this regard.

So, one might want to know then why we should be interested in the adolescent mum as compared to the adult mum. Well, the adolescent mum is far more likely to be disturbed, and by disturbed I mean disturbed. And they are far less likely to be psychotic, and I mean by psychotic - mad, for those of you who don't practice the same trade. The adolescent mums, when the come to

adulthood, are more likely to abuse drugs, and choose partners who abuse drugs. And that is a critical issue - they need soul-mates, and the soul-mates do the same things as themselves, that's a worry.

Now, the fact of the matter concerning this population is that they live on income support - they are an underclass, to be absolutely clear, they are an underclass. They live on income support, and in dependency housing, and we have here the high court and the other courts spending a great deal of time talking about this down in our group. Most of whom, or at least half of whom will be black. And why look at the race dimension. Well, the first reason is that that is what I work in, and the second reason is that most of the people who work in it are white, and maybe interested in some theoretical constructs, though for us it is like practical constructs in that when we look at the prisons and other places like that, we find the population of dysfunctional mums, and dysfunctional children, and dysfunctional dads ending up there as well. So we are very concerned about that.

Now, there are three ethnic groups which I describe here. One is black with two parents black, one is mixed race with one parent black and one parent white, and one is white. I don't know what white means these days, but anyway, they don't look black! What we find when we look at these three groups, which is the point of the discussion today, that there are excesses found among mix races and white mums in my sample according to their experiences in their childhood. The mix race and white, often the mix race had a white mum so you could say that they are not dissimilar from the whites in terms of who there mums were, but they come from families that are often inhabited by an alcoholic mum or dad, and the parents are more likely to be violent to each other than the black mums. And it is interesting too that this dysfunctional family of the mix race and white group seems to have more forensic problems among their dads. So we have a sense that this underclass of mix race and whites if rather different from the underclass of black, and that what makes sense to us. We believe that they get into the underclass not simply to do with black, where the blacks get into the underclass for reasons for mainly to do with black - that is what we believe.

Now, the mix race and white mum, suffer more physical illness in childhood. That is very interesting when thinking about the last speaker talking about drop-outs, similar problems of physical illness and this is something we should think about when trying to understand adolescent mums. The mix-race mums are in fact different to the white mums and the black mums in so far as they are more likely to be suicidal. Exactly why this is the case is interesting to speculate, but they have racial identity confusion in 70%.

Now, it is all very good for white workers to say that they can undo and work with racial identity confusion, we believe they are mainly escape from it, and simply don't deal with it, and when a mix-race mum is working with a white worker, it is more likely than not, that the white worker will skip that issue. But it is common in terms of the dysfunctional mum that comes into the services. It is interesting too that 20% of the black mums also had racial identity confusions. the reasons for that are worth debating, but I won't get into that today.

The black mums are different from the other groups in so far as they were more likely to have been brought up in an maternal extended family setting, and that makes sense from African, Caribbean and black American populations. Now, there are no differences in the childhood experiences in these three groups, in terms of sexual abuse. Which as you will see is very common in this sample and there is no difference in other abuse and about half were in care at some time. It is very interesting that the dysfunctional mum presenting might have very powerful similarities in how they present. There is no ethnic difference either in terms of violence from the mum to other persons or in terms of recent forensic problems, problems with the law.

Neither do we find ethnic differences in the numbers who are disturbed. We find three in five are disturbed, two in five abusing alcohol or drugs, and two in five being suicidal. And the three groups are very similar in that regard as well. This here puts us in a frame in terms of how and what has happened to this population. We find here that the mix race group tends to be black, a non white call here, whereas the white group seems to be different. There is more sexual abuse in the white group, there is more neglect in the white group, physical abuse to a child is more commonly found among black groups in this sample. And this leads to the work that is being done in America, which is finding similar distributions to the presentation of persons with these difficulties.

So where does this take us?

It takes us into the problem of how these groups then start to model their lives. And we see that the white groups and black groups here seem to be rather different in how they do their business. White groups are more messed up and personality disordered, and disturbed. Black groups are less likely to be so, even though the popular thing here is that us blacks are taking a lot of drugs in a big way.

What are the implications of this work?

Well, it is really about the population of people. That is what they do at Youth Support, the look at this kind of population. They started 10 years ago in order

to try and make sense of this population and there are many in London here, and in the rest of the country and perhaps in Europe too, who are struggling with is. Has Europe got a race problem? I say they do. Are they spending money on it? I say they are not. Is there a way forward? Well, here we have a situation as to the way backward or forward, I don't know. In this sample of adolescent mums, of dysfunctional kind, presenting with child care difficulties, coming through the courts, only 25% of their children will go home.

The rest will go to nice children's homes, will be exposed to abuse, not only sexual and physical, but racial abuse, we believe, in such facilities. And we make no apologies, because we work in those children's homes ourselves, and yet we know that if only three quarters of dysfunctional mums, can be worked with, if that three quarters are loosing their children can be worked with at a very early stage, then they would not have been dysfunctional. Can they be worked with later on? I cannot answer you that. What we know in terms of working with this population, is that we have real difficulties. Most workers are white, most training is done in a framework as though the race perspective is now irrelevant. Most of the dysfunctional mums which we find in London here, and in Britain, are likely to be exposed to some of the realities of race and otherwise, that are presented today. I haven't given you any answers, I know that, but I have, I hope, opened your mind to possibilities.

Keith Drinkwater -

Research on running away and street children.

In 1985 following 4 years of consultation and research the first Safe House Refuge was opened in London. This was followed by two further Residential Refuges (Leeds & Bournemouth), 1 family based in Newport, S. Wales and Street work was carried out - without a refuge - in Manchester & Birmingham.

Five pieces of research were carried out and published:

- 1988 London Safe House The Children's Society (TCS)
- 1992 Runaways NCH Action for Children
- 1993 Survey of our 1200 young people. 13 - 16 in Leeds TCS
- 1994 TCS work with children/y.p. who run away or are on the street
- 1996 The Centrepoint/NSPCC Refuge in London

Newman, C. Young Runaways: findings from Britain's first safe house. The Children's Society, 1988. - A study of young people at Britain's first refuge for young runaways, plus a nation-wide survey of police missing person statistics. Key findings:

* Incidence of abuse amongst young people who run away;

* Over-representation of young people from residential care amongst young people on the streets in London;

* Estimated 98,000 missing person incidents (under 18 years old) each year in the UK.

Abrahams, C and Mungall, R. Runaways: Exploding the Myths. NCH Action for Children, 1992. A study of police missing person statistics in five areas of England and Scotland.
Key findings:

* Estimated 102,000 missing person incidents (under 18 years old) involving 43,000 young people each year in England and Scotland;

* Young people generally do not run away to the 'bright lights' but stay in their local area;

* Over-representation of young people from residential care amongst young people who are reported missing.

Rees, G. Hidden Truths: young people's experiences of running away. The Children's Society, 1993. A survey of young people in Leeds, plus interviews with young people with recent running away experience.
Key findings:

* Estimated 1 in 7 young people in Leeds have run away and stayed away overnight before the age of 16;

* Very high incidence of running away amongst young people in residential care, but also a higher incidence of running away from family than had been previously estimated from missing person statistics;

* Running away usually starts within the family, even amongst young people who later run away from substitute care.

THE YOUNG PEOPLE WITH WHOM THE PROJECTS WORK

The young people have generally had a high level of disruption in their lives. Within the family there was a high incidence of relationship breakdown, conflict and violence. Most of the young people had spent periods in substitute care and often had had a number of different placements. A significant minority of the young people had spent extended continuous periods away from both family and substitute care before the age of 16. Amongst the over 16 year olds, frequent changes of accommodation and periods of homelessness were common. Most of the young people lacked support networks (apart from the streetwork projects). There was a high level of detachment from family and (where relevant) social services. There was also a high level of detachment from the education system. Many young people had a distrust of adults and relied on peers for support. There were significant levels of substance use, self-harm, depression and criminal offending amongst the young people interviewed.

The large majority of the young people had run away before the age of 16. Most of the young people had first run away from family, usually remaining in their local area, and only staying away for a short time. Many of the young people who had run away from family were subsequently placed in substitute care.

Most of the young people had run away many times and later running way incidents were on the whole more extensive and wide-ranging than first incidents.

Young people identified a number of positives to being away from where they lived, including relief from pressure and making new friends, but the majority felt that being away had not helped to sort out their problems. There were also a number of negative experiences including fear, loneliness, and physical and sexual assaults. A majority of the young people had resorted to strategies such as stealing, begging or providing sex for money in order to survive.

IMPLICATIONS OF THE FINDINGS

Drawing on the research data, a model of intervention has been developed. This suggest that future work with young people could develop along broader lines to incorporate:

* Primary prevention (e.g. education in schools);
* Secondary prevention (e.g. mediation between parents and young people);
* tertiary prevention (e.g. street-based outreach work and refuge-based work).

There are a number of areas for consideration by other agencies including:

* The need for a co-ordinatoed response to working with young people who run away;
* The need for a response to the issue of young people running from residential care, and in particular to the issue of bullying;
* Education support for this group of young people.

The research has also highlighted a number of social policy issues including:

* Young people's legal position under the age of 16;
* Support for young people leaving care;
* The impact of family breakdown on young people.

Keynote Lecture - Richard MacKenzie

Usually the keynote speaker sets the tone for the conference - but as the last speaker on the schedule I wondered the wisdom of having the keynote speaker last - but as I sat here and dealt with my jet-lag I realised that as you people are falling asleep, I'm waking up - so the wisdom is really there, but it was also the wisdom of having the keynote speaker last because certainly we who come from different environments and different backgrounds come in with a lot of assumptions as to what exists and what does not exist, and I must say that the time I've spent listening today and the wonderful session that we had over lunch has certainly brought me up to date with where you people are and I'm very impressed with what has been accomplished in the UK. It allows me to take off from what I've learned about what you've learned, to share perhaps in some of the things that have been talked about today by the various speakers and perhaps place them in a context which is a little different from that which has been spoken about today.

I always say that if we had all the answers to the questions we raise in adolescent health, we would have no problems and part of not having the answer is often how we look at things. And I would like to suggest different ways of looking at the adolescent and their problems. I'm going to jump about seventeen pages in my talk, because I'm not going to get through them all and I promise I'll end on time if not before time, but I'd like to put forth something for you all to think about as I'm talking and that is - a lot of problems that we see in adolescents - a lot of what we call problems in adolescence - are really their solutions.

Their solutions to what? - their solutions to growing up. Their solutions to attaining their development - to getting out of their transitional period called adolescence - the best they know how - so what become problems for us, become solutions for them.

Let me elaborate a bit more before I build up my case. I look at adolescents giong through the supermarket of life. They are pushing their baskets down the aisle and they can't afford once in a while, because of their socio-economic status, because of lack of family support, certain kinds of growth experiences which we feel would be healthy for them so they end up in an aisle called drugs - suddenly they are reaching out for peer group acceptance, that's what their need is, that's what their hunger is and they're in the aisle called drugs - so they reach up and take the drugs and that's the way the accomplish that transitional event which is so necessary for growth. And you could think the same way about their sexual behaviour how they choose to do those things because they are in that aisle when that need comes about. They don't have people with whom

they can sit down and talk about what's going on They don't have models of healthy roles of what you do in relationships, they don't have places to go and release their stress over what they are experiencing because of the demands imposed upon them by the adult or the conventional society. So they reach out and they reach out into the aisle of the market that they happen to be in.

I would now like to go back a little bit and talk about Diana - she said something about me and I would like to say something about her and what she's doing - because there is a tremendous wisdom in what she's doing. Fifteen years ago, ten years ago, the technology of working with adolescents was very primitive. We had basically psychiatric technology - of sitting down, hands on our chins saying 'Aha' .. 'Hmm, aha' .. 'Well that's because when you were two years old …'

It doesn't work. And so what we had to do ten years ago was to sort through what we were doing and what was going on with adolescents in those days and see what was best going to help them. Adolescents became our teachers, adolescents became our resource and we began to develop the technology of working with adolescents.

The second issue that came up in Diana's work is that she named her programme 'Youth Support' in other words, within that terminology, there is an inherent belief in the goodness of Youth. We are to support that natural process which is going to go on in young people. It is not 'Youth Guiding' - it is 'Youth Support' and that is one of the basic assumptions which has served me well in working with adolescents over the past twenty five years - it is that within the individual there is a good which is attempting to be expressed in the best way that it knows how from the environment that it is allowed to express itself in - with a thrust from that individual to become the best person that they can be.

Now put that back into the context of problems and solutions - you begin to get that dynamic view of an adolescent - not going out trying to do things bad, but trying to do things well. I have not met an adolescent yet who is there trying to do things 'unwell' - they are out there to do things in the best way that they know how, but perhaps it is in a way that is going to be problematic to them as individuals. Adolescence then becomes a time of change a time of transition, another way to look at adolescence is to look at it as a time of crisis because I am told that in Chinese the character for crisis also means change and also means opportunity. And anybody who has worked with young people, who has worked with families or has worked with adults - you know that the more settled they are, the more difficult it is to create change in them - it is when they are in chaos, when they are unsettled, they are uncomfortable, when they are going through a process of change that you can now effect some kind of input into a

healthier position for them to be. Adolescence then as a crisis is opportunity to change so it provides a great opportunity for us as providers, as health supporters, as health promoters to help that individual to become a better person , for themselves and for the people around them.

One of the things that was mentioned earlier, which I wrote down - because anyone who works with adolescents will realise that there is a tremendous meaning that young people give to words - and one thing I always say to our people in training - pardon my vernacular - is what is the difference between making love and fucking - is there a difference? But when we couch the terms with adolescents and we use the phrase 'making love' is it really making love? After all when they ran the surveys finding out why people had sexual intercourse no-one answered 'it felt good'. But isn't that why a lot of people have sexual intercourse? It feels good - it's a recreational experience - put a hyphen between the E and the C - it's a re-creational experience - it allows you to have this intense feeling of pleasure and to move on from that. It's an 'in body' experience - something which is often deprived in adolescence - and if you look at what adolescents do, they seek out 'in body' experiences because they have this intense accentuation of their ability to appreciate pleasure, something not talked about as a developmental task - they have this increased appreciation of pleasure.

So another thing that I have learned in talking to adolescents is that you have to choose your words. The term juvenile delinquency has no meaning any more - a delinquent was seen as someone who drifted away from the fold of adult value therefore had to move into some kind of corrective action because of age and back into the value of the dominant culture - it's not to approve juvenile delinquency or what has been referred to as juvenile delinquency - in today's environment Juvenile delinquency really does not have any meaning - you could make every kid over twelve a delinquent by imposing a seven o'clock curfew on every child over twelve years of age. You suddenly become a juvenile delinquent, you report to the delinquency court for that, so really as was well pointed out it's an administrative term, so we have to watch the words we use, we cannot say I understand that you're a juvenile delinquent and that's why you're here today, or you've been involved in delinquent acts and that's why you're here today - choose your words carefully when you talk to adolescents and listen carefully as to how they choose their words in response.

Let's look at adolescence as a resource. I've been sitting out there all day looking up at this picture (of a group of happy young people on a 'Youth Support' trip to the Russia) - they are not youth as a problem - they are youth as a resource. Resources not only for things they can do to help themselves, but a resource to us in general as professionals. I can say that I have learned more

about adolescents from adolescents than I have from all the reading and all the lectures and of the teachings that I have had from all the experts around me - but you have to listen - and you do not only listen with your ears, you listen with your eyes. You see what they are doing, you see how they are behaving, how they are responding - listen to everything and not just to their body language , but to their group dynamic because they are doing what they are doing for a reason, they are doing it to resolve some issues, some driving forces within themselves, they are attempting to accomplish their tasks of adolescence.

I always say , we must catch our young people in doing something right - we spend so much time in catching them doing something wrong - why didn't you put the garbage out? , why didn't you get a better mark in your exam? Why are you going dressed like that? Why did you put that ear-ring through your nose? It's all these judgmental views and we really must in our interaction with young people, separate the action from the individual. Again focus on the goodness of the resource within the individualo because that is what will guide their way down through the supermarket of life to attain their adolescence. I'm frightened now because I think the supermarket has become quite complex for the adolescent - I would not want to be an adolescent today. I think there is a miraculous process going on within each individual as they negotiate those teenage years. Because just look at the supermarket around them. The facility which they have to adopt, what we know as health compromising behaviours.

They are really there - they have to circumvent those things - and again we have to remind ourselves that the majority of young people do. The majority of young people negotiate those adolescent years with no problem. Or maybe with a few little crises here and there a few problems, maybe some intra-familial kind of conflict that goes on as they begin to shake away the dependance that they have on some kind of family structure. We are biased because we see the problems, that's kind of obvious because we see the kids who are not doing it well. But the majority do do it well and those that do not do it 'unwell' are not in any one socio-economic groups. I can tell you that being in Hollywood I see a lot of kids who come from very affluent families - they call it the poverty of affluence - by giving you are taking away. By constantly giving to young people you take away from them that opportunity or that ability to do it for themselves. And by doing it for themselves they attain some measure of competence, self esteem and confidence.

But if every time someone says well I think I would like … someone hands them money or the response is well here have a car or an apartment - I have seen fourteen year olds living in apartments on their own because they wanted it .. and the family could afford it. But of course those pathologies do not come to our attention, because those pathologies do not come to anyone's attention they

are often hidden or seen very privately and taken care of in ways so that we don't really realise what the depths of the problems are.

The other thing that I have been taught by adolescents is that youth is not really a time of life. Many people have got up here today and I've watched them, that there is a youthfulness in the people that are working with youth. Youth is not a time of life, it is really a frame of mind. It is how you think about yourself in relationship to the world around you and we tend to think about the world around us by being influenced by the people around us - if we spend a lot of time with young people we keep that sort of questioning value about what is going on around us. Questioning view about - why are we doing things this way? So youth is not a time of life it is a frame of mind and we grow old but we grow old by deserting our ideals. Young people carry their ideals with them - not by expressing them clearly but expressing them in the best way they know how.

A little on adolescent development - let me reframe that for you. An exciting way to think about adolescents - G Stanley Hall in 1904 conceptualised adolescence as that storm and stress of transition. I think that is an over simplistic view, a superficial impression of behaviour. It does not take into account the dynamic event that young person is experiencing. I have a much more dramatic view and I take my view of it from Clouseau who said 'We are born twice over , once into existence ..' - we never existed and now we exist - '… and once into life' - and the birth into life was adolescence in his mind. Now isn't that a fascinating way to think about that process that we are seeing before us, that storm of Stanley Hall now becomes the pangs of birth and we become the obstetricians. We guide this birth, we do not create this process, and what is going on before your eyes is not a product of the moment but is a product of the incubation period that this individual has been since their moment of existence. So we see the pain of labour as this individual moves out into the peri-adolescent toxicity, the perinatal toxicities that we care so much about in the new born but the peri-adolescent toxicities of the environment and society around them. That can influence not only their biological growth but can influence their psycho-social growth - their ability to function within their environment into which they are being born. So here we have a new dynamic view and we know that organisms under going change at rapid rates are most susceptible to negative influences - when we expose the human body to negative influences it is those parts of the body that are going through rapid change that are most at risk . So we see the adolescents reflecting back to us as their 'obstetricians' the difficulties and stresses in the society - and we blame them. It's like blaming the child for the perinatal mortalities, for the obstetric mortalities - 'it's your fault .. sorry kid, you can't live .. it's your fault'.

With this view we can now invest ourselves in a partnership with young people, a partnership in which they are moving through this period of change, they are moving through this period of crisis, and the problems they bring to us we must aptly see as being their solution. What it has done, interestingly enough, is that we have developed a whole new what I call adjectival palate - a palate of words to describe what we are seeing. For example if you are a wine taster, you can't be a wine taster without learning a whole new vocabulary - what the nose is, the taste is, the finish is - you have to learn that palette of words to be able to be a wine taster. And to work with adolescents we have to learn to develop a palette of adjectives or words to describe what we are seeing - and not only that but also to talk about what we are describing scientifically. And many new words have come into the vocabulary since I started to work with adolescents in 1970. The concept of 'at risk' and 'high risk' was not around - it existed for heart disease. But not for behaviour. Now more and more we are looking at kids who have behaviours that are high risk and placing them at risk for negative outcomes to their health. But these are behaviours and not physiological phenomena, these are not blood lipids, these are not uric acids, these are behaviours - and modern medicine does not have ways to measure behaviours, so it pooh poohs it - although it accepts it for heart disease lack of exercise, or smoking, but for adolescence it is difficult to get this total biosocial approach into the modern medical jargon - to have it accepted on a co-equal basis with a lot of the other issues that are goig on in medicine today because working with adolescents today is not high tech - it's high touch. It's high touch - it's touching them with your words, touching them with your person, touching them with your understanding.

Touching them with your caring - not high tech - we don't need a Cat scan to diagnose substance abuse. We have also come to hear the words like 'co-morbidity' substance abuse and sexually transmitted diseases have a co-morbidity, substance abuse and underlying psychiatric disorder have a co-morbidity - they exist together, as a balance for each other or as a consequence of each other. We hear things like 'sentinel behaviours' What are sentinal behaviours when we read the adolescent literature? Sentinel behaviours are behaviours which put them at risk, or may be describing a process or natural progression of events which put them at risk . We know that kids drop out of school - the main activity of adolescents, is a sentinel behaviour, to put them at risk because they are integrated into a peer group which is already at risk because they are not involved in the dominant culture. Why do they not get a job you ask? Did you know that those who have a job are more at risk from drug abuse than those who do not? Why ? - They are exposed to adult society and now have the money to buy the behaviours of the adults. So employment is not the answer - much better for self esteem, and sense of value and self , but it does not solve the problem of substance abuse.

We hear terms such as surrogate symptoms or problems such as with HIV disease we measure a lot of surrogate markers which tell us about the progress of the disease. It is not the disease we measure, it is the marker of the disease. A surrogate for what we are trying to follow. Why am I talking about these things? Because a lot of times we cannot prove the value of what we do unless we look at the outcome or consequences of our intervention. To do that we need to look at surrogates, sentinels, markers of charge. I cannot go around checking if kids are putting condoms on - I do not want that job! So we have to develop surrogates for that. Surrogate markers to see if kids really use condoms - so all this language becomes important. I talked about l5 years ago saying that you cannot counsel kids in the rain - kids who are greatly disturbed, or uncomfortable; having just broken an arm in an athletic event for example you cannot sit down asking him to tell you about his family. The kid will say Come on, Doc! I'm in pain. Many things we cannot do until we wrap around the individual their immediate needs, short of an Abraham Masell concept - the hierarchy of needs. You can't do therapy in the rain - give them some shelter first. You cannot talk about security to someone who does not have a place to hang their hat or sleep. They cannot sit and talk about any period of time. And they are not going to talk to you about sensitive issues unless you can assure them confidence - and you mean it . You are not going to break that confidence - and you mean it - you are not going to break that confidential relationship by some kind of behaviour which is non verbally going to communicate a reason why they come to you. If you send them out to your waiting room with a drug test urine bottle to send off to the lab Mum and Dad waiting are going to wonder why - you are breaking your confidential relationship. So these are things you must wrap around your relationship with an adolescent in which you couch, in which you carry your expertise, your special knowledge and commitment and your caring.

One of the things I would like to reframe for you - We hear the scream of the new-born as they go through this painful labour, as they are squeezed through the passage of life so to speak, and we watch the scream of the adolescent as they begin to react to the demands put upon them of responsibility, of moving away from those childhood behaviours, those child like behaviours - what Ashley Montague called the artless traits of being a child. I've listed some of the things that we could put look at as traits of the child. I think if there is a rebellion in adolescence - it is not a rebellion against you or me but a rebellion against having to leave things behind, this awesomeness, this need to learn all the ways that we say now don't question, just move on, just do it!. Gone are the days when the little kid could pick up the flower and say 'Oh Mummy Mummy look at the pretty flower' and Mummy says 'That's a daisy' and now when the child picks it up he sees a daisy and he no longer sees the flower. He just sees

the word. And that is what happens in adolescence - you are told to accept all that and see what you are told. To accept what some would call the adult value - to accept what value the adult puts on that. But the screams of the adolescent do not have to be the screams of a painful labour but they have to somehow be guided, guided within the boundaries of their experiences of transition and boundaries which are somehow defined by the support systems around them - and the support system around them for many adolescents includes you.

Another concept from Sheryl Perry's work on sex education but which has a lot of value in working with adolescents is that when a young person comes in to you they will often come in with some kind of complaint - or perhaps someone else will have that complaint. This happens particularly with those young people whose 'problems' are their solutions. They will not come in with a problem - their 'problems' are somebody else's problem - they are happy with them. Anyone have a drug problem? Drinking problem? Adolescents don't come in saying they have a drug problem. When I first moved to Los Angeles in 1970 we had a hot line ten, twelve thousand calls per year. I had an interest in substance abuse and I went up and I got them to pull all of their calls on substance abuse - only 98 calls - Los Angeles obviously does not have a drug problem. Kids in LA don't us drugs - of course they do - they just don't see it as a problem. They are part of what we saw as being an adolescent in those times and that is what goes on today - they have a drug solution - not a drug problem - it is we who see objectively the significance of what they are doing.

So health could fall into at least four domains and probably more. But these domains do not come nicely classified by the young person. With regard to physical health - if you have something wrong with your physical well-being ,you can come in with a sore leg or say 'I'm really confused and I can't think straight' - they won't come in and say 'I can't get a date - will you help me Doc?'.

They don't see that as a problem relevant to what you do. But they will come in and maybe say - 'I just can't seem to get it together' - while not spelling out how they really feel - but all these things are part of an individual. But what happens in the human organism is that a psychological problem may be expressed in one part of the body here, a personal health problem may be expressed here, or vice versa. The human organism does not have the wisdom to separate out these factors and such is the basis for psychosomatic - or what I prefer to call psycho-physiologic illness - the body saying - I don't feel good - I feel dis-ease. I feel uncomfortable and what we have to do in our process of evaluation is to somehow sort through these issues and provide the support, to provide help, to provide intervention in the growing organism.

Some issues discussed today that I would like to comment on in view of this new model of adolescent development - I will not comment on teen pregnancy which was so well covered by several speakers, except to say that of course there are controversies still in terms of whether competing nutrition during pregnancy leading to low birth weights. But what we can say with fair confidence is that adolescents who do experience a pregnancy do less well in terms of psycho- social adjustment than adolescents who do not - unless they have intense support by programmes that take into account the interaction that is going on between this adolescent who is coping with birth into life and the foetus which is going through it's birth into existence.

Substance abuse - let us look at this as initially a lubricant to transition - to attain the identity of the peer who is moving on through substance abuse. I had the unfortunate experience early in my career to work with an individual who was a substance abuser. I was proud of the fact that he stopped taking his amphetamines, but dismayed by the fact that he committed suicide. Because I did not provide an alternative for him. The drug was playing a role in his life and when I took that away, he stopped taking it for respect for me, he then turned on himself and felt so uncomfortable with himself that he ended his pain through suicide. So drugs can be and usually are used in that transition through adolescence.

It's like that with eating disorders. They start off almost as a voluntary behaviour but they then get driven by biological events. In the USA today we have an epidemic of disordered eating and eating disorders. Twelve year olds, ten year olds, eight year old girls, fat phobic - going to the supermarket looking at the labels, and saying Mum I'm not eating that it's got fat in it and they won't take anything that has fat. Now when you start with those behaviours you begin moving on to a spectrum of disorders which may lead you into a series of disorders which have a significant mortality and morbidity. Such as the starvation disorders and the binge purge disorders. And although they start as disordered behaviour they become driven by biological factors and then they end up just like the situation we have seen in substance abuse or being addicted to alcohol. It becomes a bodily driven event and then you can't stop. They can't just stop - they have CNS physiological changes in their endorphins which drive their behaviours and even when they want to stop, they can't stop. But if you can reframe that and have the ability to support them in that desire to stop and maintain that position until their physiology and their endorphin level can adapt and return to normal, whether you do that by pharmacological therapy, by inpatient treatment or by any other means.

One of the things that I reframe for them is that I say to them - you have a gift, you have a gift that has come to you in the form of an eating disorder , what you

have to do is to unwrap that gift and see what it means to you. And they look at you, because everyone else has said you have a disease, … you have a gift .. and when you work with them on that gift they will unwrap it and find out things about themselves they never knew. And when they discover those things they will be able to move on and they will find themselves back on the route of change and transition. As long as you tell them they have a disease, they will cling onto that disease, but these are high achieving individuals who will often be able to make that shift for you.

Having an eating disorder is a bit like being Humpty Dumpty - use language they are familiar with - they know the metaphor about Humpty Dumpty - he sat on the wall and Humpty Dumpty fell off the wall and all the King's horses and all the King's men couldn't put him back together again. And you as an eating disorder were sitting up there - nobody ever said who pushed Humpty Dumpty off the wall and no one ever said what knocked you off your wall and pushed you on the ground and you fell into pieces as a bulimic or as an anorectic and what you are trying to do is to put the pieces back together again and to use your eating behaviour as a glue to keep the pieces together. But what's going to do it is you from inside - and that's what were going to do, we're going to work on that - and that reframes their position and gives them the momentum to make change and to get back on the right trajectory which is going to lead back to a healthy adulthood.

Diana talked a little about my work with street youth which is a small part of our programme in Los Angeles but a very important one. We went out to the streets and said why are you here? Can we learn a bit about adolescents if we look at how they react to this environment. When we look at why youth are in the streets there is usually a reason and that reason is usually abuse. R it may be sexual identity issues - they were thrown out of their house because they told father they were gay, or he found out they were gay , or they were doing things their family totally disagreed with and they said - you cannot live in our house - get out! Or one of the fairly common ones in Los Angeles is that with high divorce rates the parent with whom they are living has a new relationship and with children around, this takes away from the spontaneity of their relationship and tells them to get out or abandon them - we call them throwaway kids. Their parents will go on vacation and the parents get up early in the morning and leave the kids there in the motel room - abandon them there - so the kids wander out onto the streets of life so to speak.

One of the things we found when you're dealing with this kind of population is that they go through a phase when they're out there on the street a period of adaptation - they are in this new environment and they are looking around - they may be frightened or feel street cool but they have never been in this situation

before so they are looking round checking how do I find a place to sleep, where do I find something to eat, who do I trust - that's a period of adaptation. That's the time you have to get at them within six weeks of living in that sort of environment - because after they go through that period of adaptation they begin to become assimilated - kids get to know them and they adapt them and mover them into the peer groups of the street and they begin to develop the mores of the street - they get a ring in their ear and a ring in their navel and a ring here and a ring there - they're everywhere they have become assimilated into the rules of the street and then they become acculturated - they become street kids. That's their identity -that's who they are - they're street kids and they become acculturated into the street. These kids are very difficult to get off the street - despite all the other underlying positive behaviours and inner resources they might have to get them off the street. They see the street as being their natural environment. So under the influence of the toxicity of society - they become mutants in that second birth - they become mutants in that acculturation process. They feel this is the way they have to live, this is all they have and this is all they deserve.

So how do we begin to draw upon youth as a resource? I have talked about language; about reframing the transition and how we think about them; about acknowledging the positive behaviours and down playing the negative behaviours - a sort of ying and yang thing - there is only so much room in that circle - if half the circle is positive - the other half is negative - so the more we emphasise the positive it will grow and eventually squeeze out the negativity of that individual. I've mentioned that youth want to do things well, they don't want to do things wrong and we need to accept that as part of the natural process of growing up and when they do things wrong that may be part of the toxicity of the environment or the toxicity of their second go at birth.

Youth do use services responsibly if they are allowed access to services and they do process information that you give them, they may not change their behaviour on the basis of it but they do want information and withholding information from young people makes them suspect of you as a provider in a sense that knowledge is their greatest friend and ignorance is their enemy because if you don't give them that knowledge they are going to reach out somewhere to find that. One of the ways to build on positivity and the resource of youth is to include Youth in things that we thought before were not possible - youth advisory boards, involve them in the decisions of clinics, of organisations that are going to affect them - involve them in those decisions, not necessarily rest on them as the only input into the decision but allow them to be involved in the decision making - it is a process of empowerment of letting them feel valued for their opinions.

It is a process we are all involved in, we are all dependant on the politicos for deciding what we do and they hold the purse strings - so if possible we should organise youth to be politically active. If they are within the voting age range - we should encourage them to register to vote - if we can get young people organised politically - they can be a powerful force that others will listen to - it happened at the other end of the age scale with retired people who used to be largely ignored , but when they organised themselves - they are now a force to be reckoned with and everyone addresses them for their vote. So we should ask politicians when they are campaigning - what is your position on young people? I once had a young physician who trained with me who was so turned on to political issues that when there was an election near his home he asked every candidate - what are you going to do for young people - and nobody had an answer - until someone said - Stan, why don't you run - and he did and he won - he became a member of the state assembly on the basis that he spoke up.

Let us look at the future - it is always difficult in today's environment because there are so many influences upon the future. I wish I could say that by creating a better environment - taking the toxicity out of the environment - depoluting the adolescent environment we could create a healthier adolescence. I think we probably could, but I think the pollution has to be modified rather than taken away or the person who is receiving the pollution must make some sense of it and put it in perspective, we can't take the pollution out of the media, we can't take the pollution out of the hearsay, it's there and we have to deal with that. But we must give young people a sense of meaning somehow and I don't know how to do that but that is our and their future, we have to give young people a sense of meaning so much of what gave young people a sense of meaning has been taken out of their environments.

In the USA because of legal reasons they do not have after school sports any more - nobody wants to be responsible for someone who hurts themselves in a high school game. It takes away a sense of meaning and a way to prove self - we must help them to participate in whatever process they are able to participate in legally to change their environment and their society and the toxicities we talked about. We need to enfranchise young people - someone talked about lowering the vote to sixteen - that might be difficult - but certainly enfranchising by encouragement - that is important.

What of the family? The family is that second womb, providing the nutrient for that second birth - how are we going to nourish the family - to make it the placenta which is going to nourish it's offspring - how are we going to do that. We need to look at ways, we can't just deal with the foetus during that first birth into existence, we can't just deal with the child in adolescence during that second birth - we have to deal with that thing which is providing the sustenance

for that individual. We must work with the community and work with the community as partners in creating an environment which is youth friendly - big measures, but at least we need to move out and work with agencies and between agencies. When we started the service in Hollywood in 1982 the most powerful part of that service was the fact that the agencies talked to each other and co-operated looking at the problems with a common language and a common view.

We need to educate professionals - there is still a need for knowledge among professionals who are having primary contact with young people - I've been doing this for twenty five years and I still have people coming up to me and saying - what's this thing I hear about adolescent development? They accept the physical changes - but have difficulty with the developmental emotional changes. We need to help them understand not only what they are seeing but how to respond to what they are seeing - to understand the unique problems which adolescents have - we need to show them how to function in a time effective way to use their skills to help. We cannot spend an hour with every adolescent, we need to learn and we need to show and transmit to other people how we can do this in a time effective way - and that's a whole other topic of conversation.

We need to speak up - to be advocates for youth - it is amazing that sometimes just a voice that is heard will get people thinking - a lot of what policy is made of is ignorance. We started a newsletter and sent it to the legislature - this was well received and they then knew how we stood when we were asking for changes.

So what I have learned after 25 years is that you have to value what you do - people who work with adolescents often have the reaction form others of 'how do you manage to do that' - others say - 'I just am happy to see my adolescent leave for school and I dread him coming home at night' . So we have to value what we do - you have to value yourself as the obstetrician, to believe in what you do - adolescents are not the sort of patients who will come back and thank you for what you do - they won't come back and say' Thank you doctor'. They somehow show it in how they behave - that they come back to see you. But after they have got themselves off the ground, if you keep at it long enough - they will sometimes write you wonderful letters. When they have got up back onto the wall, they have put the pieces together again, they are feeling back together and they are sitting happily on their wall - perhaps ten years later after they finish school - then maybe they will send you a letter that you were a most important thing in their lives. They say some of the things you said and that is their thank you - it doesn't come right away - but it helps you believe in what you do. You have to be committed to your work and it's not a commitment that is 9-5 sometimes.

I’m almost afraid to say this last thing but I’m going to say it - there is no such thing as a resistant adolescent. The only thing there is - is an ignorant professional. Not ignorant in the sense that we can’t learn - ignorant in the sense that we don’t know how yet. We used to have a lot of resistant tumours, cancers, but their number greatly lessened as we got smarter, as we began to understand more about tumours, less were resistant - the same with adolescents - as we become smarter and smarter and watch for what is before our eyes, there will be less and less resistant young people out there and we will be more effective as professionals.

So I challenge you to leave here today with the new knowledge that you have and perhaps to take some of the reframing that I have peppered in at the end and go home and look at what you are doing - perhaps not so much through new eyes, but perhaps through a new set of glasses. And perhaps you will come up with some different ways of doing things and of feeling the true joy of working with adolescents. Thank you.

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Published by “Youth Support”

ISBN 1 870717 09 0