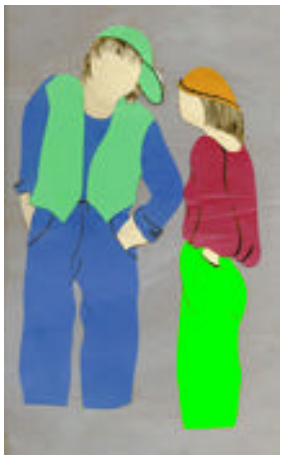
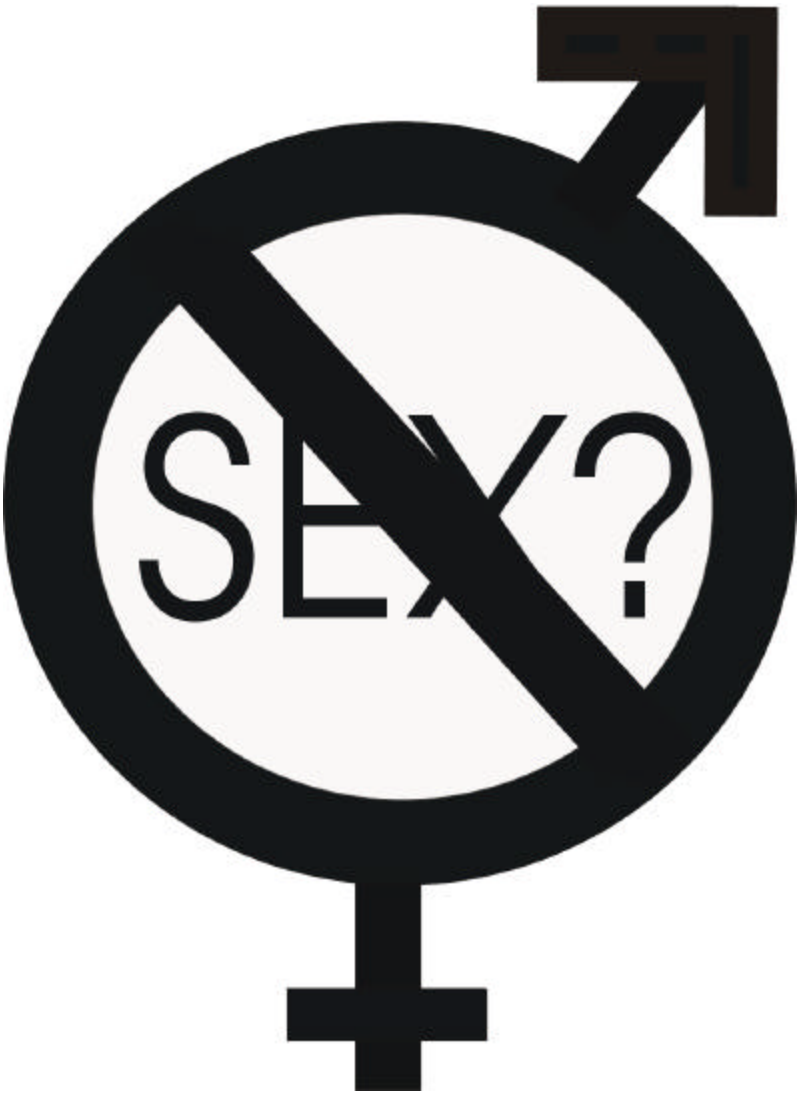
CANADIAN ASSOCIATION
FOR ADOLESCENT HEALTH

March & May 1999
Volume 8, Number 1 & 2



PRO-TEEN

PREVENT IT...



...OR PROTECT IT?

In this issue:

PRO-TEEN

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News from the Association

Acknowledgments

The onset of summer is marked by a tradition. It is a time when we wish to underline the efforts of all those who have collaborated in the Association's activities and in the production of PRO-TEEN.

We would like to thank André Malo for the important work he does as the coordinator of our main activities: he supervises the membership data bank, PRO-TEEN and other publications; sees to the logistics for conferences; manages and organizes secretarial and computer work; and coordinates the work of collaborators. For the second year now, CAAH is administering all his meetings without external agency's support.

Philippe Nechkov has done the layout for every issue of PRO-TEEN, changing the publication's look. The content of PRO-TEEN this year has benefited from the quality efforts of Julia Sheel who wrote and translated some articles. We are grateful to all members of the PRO-TEEN team for their work and dedication. We also wish to thank everyone who sent us articles, publication notices or news from their associations, thereby contributing to the quality and success of the final product. ***The number of documents received for publication is interestingly increasing.***

Within the Association, Philippe Nechkov managed the membership data bank and registered new members. Dany Martineau and Philippe Nechkov also entered hundreds names of individuals, agencies and institutions in the data bank, which meant that we could announce our activities to more and more professionals. We want to stress the work of Joseph Badette, who helps us in programming the data bank to give us needed lists and statistics.

As for our web site, still embrionic, Frédéric Douesnard Malo has work to increase the content and improve the design.

We have been contracted by the Canadian Pediatric Society, to do a study on the information network on youth health issues in Canada. This study was part of many national studies for the National Clearinghouse for Population Health, Health Canada, now the Canadian Health Network. We have interviewed more than 55 organizations who were providing health informatin on youth health issues and our report was sent in may 1999. Julia Sheel, Neil Désir and Yorik Janvier were very helpfull in completing this contract.

We call attention to the **generous contributions of Merck Frosst, Vaccin division.** We have received a substantial contribution from this Company for our publications and conferences. Through the support of this Company, we are able to pursue our activities. We would like to mention the work of **Mrs. Renée Marineau**, a strong supporter of our Association.

We would like to note the gracious contribution of Sainte-Justine Hospital, which backs our activities.

We would also like to highlight the outstanding work of the committees who organized CAAH meetings and conferences.

For the **5th National Scientific Meeting of CAAH** held in Montreal October 29-30, 1998, on the theme of " Eating Disorders in adolescents ", we acknowledge the work of Dr Jean-Yves Frappier and Dr. Franziska Baltzer, co-president, who organized the event with Dr. Jean Wilkins, Dr. Danielle Taddeo, Dr Eudice Goldberg, Dr. Roger Tonkin, Joanne Gusella PhD, Dr. Yves Lambert. The meeting was attended by 305 participants

For the **First Ontario Regional Meeting of CAAH**, held in February 20th 1998 in Toronto on the theme " Youth Substance Abuse treatment : Tools of the Trade ", we acknowledge the work of the Toronto Sick Children, Adolescent Substance Outreach Program, with Sheryll Littleton, Jane D'Alessandro, Dr. Karen Leslie, Dr. Stephen Rt-

vers, John Westland, Lyn Westwood. The meeting was attended by over 120 participants.

The Québec section committee of CAAH organized **the Eleventh Québec Regional Meeting of CAAH,** may 7, 1999, on the theme of "adolescence et pouvoir : un bogue de l'an 2000". The committee is composed of : Dr. Jean-Yves Frappier, Micheline Proteau, nurse, Ginette Ducharme, nurse, Danièle Bouchard, nurse, Pierre Chartrand, social worker, Danielle Delorme, social worker, Martin Benny and Mélanie Gagnon, PhD students in psychology. This meeting was attended by 220 participants.

The **Second Ontario Regional Meeting of CAAH**, held in Ottawa on May 14th 1999 on the theme " Assessment and management of Substance Use Disorders During Adolescence ", was organized by Dr. Suji Lena and a scientific committee of more than 15 professionals from the Ottawa region : Dr. Gonzalo Araujo, MD; Ginette Chouinard, Executive director, Walter Hempey, Program Co-ordinator, Centre David Smith Center ; Lynda Donaldson, Youth Co-ordinator, Serenity Renewal for Families ; Leo Etienne, Director of Training, SASSI Canada ; Dr. Steven Feder, MD, Head , Adolescent Clinic Children's Hospital of Eastern Ontario ; Jean Gagné, Executive Director, Maison Fraternite Program for Adolescents ; Anita Kaiser, Co-ordinator, Early Intervention Program, Royal Ottawa Hospital ; Marge Lanigan, Co-ordinator, Long Life Program, Vince Kicknosway, Healing and Wellness Co-ordinator, Odawa Native Friendship Centre ; Louise Logue, Youth Intervention Co-ordinator, Constable Angela Macdade, Ottawa-Carleton Regional Police Services, Youth Services Section ; Barbara McIlveen, Principal, Woodroffe High School ; Dr. Robert Milin, MD, Youth & Addiction Psychiatrist, Royal Ottawa Hospital ; Clara Panarella, Addictions Assessment, Services of Ottawa-Carleton ; Claire Purdue, Project Leader in Substance Use Prevention, Adolescent Health Program, Cathy Crowe, Supervisor, Reproductive Health Program, Ottawa-Carleton Regional Health Dept ; Isabelle Rivard, Snow Board Project Co-ordinator, Sarah Brandon, Satellite Coordinator, Youth Net ; Pauline Sawyer, Executive Director, Alwood Treatment Center ; Sean W. Scott, M.A. Psychology, Robert Smart Center ; Dr. Dan Sweet, MD, Family and Addiction Medicine ; Paul Welsh, Executive Director, Rideauwood Addiction & Family Services ; Dr. Jean-Yves Frappier, President CAAH. The meeting was attended by more than 150 participants. *It is the first meeting organized and administered entirely by CAAH outside Québec*.

In conclusion, I am grateful to all members who promote our activities and support us. Some of you have been members of CAAH for many years now and it is encouraging to see your names coming back as a sign of your appreciation of our work.

Have a nice summer,

Jean-Yves Frappier

Renewal 99

For those who receives a membership renewal form,
please fill it and send it with your contribution
as soon as possible.

Canadian Health Network

CAAH as part of a consortium, becomes youth affiliate

Thanks to the participations and support of organizations from across the country, the Canadian Health Network (CHN) is growing to meet the health information needs of Canadian consumers and health intermediaries alike. As you may be aware, the CHN is designed to improve access to timely, relevant, and credible information related to health and well-being and to strengthen health promotion networks across Canada.
While Health Canada is taking a leadership role in establishing CHN initially, the ultimate goal is to have an integrated and national health information service that is jointly managed and sustained by many partners.

The Canadian Health Network extend an invitation to no-for-profit organizations interested in becoming affiliates.

Critical to the development and sustainability of CHN are partnerships with organizations across the country. **Affiliate organizations** will have content expertise in a health topic and/or target group area, ie youth. They will play a key role in supporting the CHN operating centres by providing expert advice and responding directly to any consumer inquiries. They will also be responsible for developing and supporting a network of **associate organizations** that provide content specific information. In addition, affiliates will be part of a distributed network of organizations inputting data to support the ongoing development of the CHN Web site, and provide content to operating centres to respond to complex consumer requests using fax-back, call centre and/or interactive voice response (IVR) technologies.

As you may know, we recently heard from organizations across Canada who expressed an interest in becoming an **eastern or western regional operating centre**. All operating centres will provide the first point of contact for consumers and health intermediaries, and will work with affiliate and associate partners to provide credible information to Canadians in a timely fashion.

We are seeking approximately 19 affiliate organizations/consortium to support the vision of the Canadian Health Network in the 19 different health topic and/or target group area. The benefits to your organization in becoming an affiliate as part of a network of health information providers across the country include to:
. have a leadership role in developing this new national health information initiative;
. contribute to the development of health information networks;
. expand your scope of service and volunteer base; and
. enhance your organization's visibility and profile.

CAAH and CHN

CAAH had already worked for the predecessor of the CHN in the spring of 1998 to survey canadian organizations providing health information on youth health issues. This time, a consortium was formed to become affiliate for the youth component of CHN. The consortium includes TEEN NET project –University of Toronto, department of Public Health, Hospital for Sick Children-Adolescent Division-Toronto, McCreary Society (Vancouver), CAAH and la section de médecine de l'adolescence-Hôpital Ste-Justine, and Kids Help Phone.

CHN has accepted our proposal as affiliate for Youth issues. CHN prototype Web site :

(www.canadian-health-network.ca)

Advocacy Committee and Advocacy Issues

Advocacy Committee Protocol

Goals

The Advocacy Committee of the CAAH has been established with the following goals:

To provide a structure and support for those members of CAAH who wish to advocate for adolescents in matters of public affairs.

To have contacts with other adolescent health oriented groups which engage in advocacy. This will allow for joint advocacy ventures, and easy exchange of information about advocacy issues.

To have contacts with youth advocacy groups in order to provide them with professional support in advocacy matters and to allow for joint advocacy measures.

To help provincial sections of CAAH to act as liaisons for advocacy on public or legislative matters with their provincial or local governments.

To inform the membership of CAAH regarding adolescent health issues which are currently being debated in the public sphere.

Committee structure and membership

The committee will be composed of members of CAAH, with a core committee and subcommittees. There will be a core committee chairperson who will be named by the Board of Directors for a 2 years mandate, renewable. Subcommittees chairpersons will be either named by the core committee or elected by the subcommittee itself, upon approval of the Board of Directors. Core Committee will meet biyearly, with subcommitees meeting more frequently.

Responsabilities of the chairperson:

It will be the responsibility of the chairperson of the Core committee to present to the board of CAAH issues which will be advocated as "official CAAH positions". These issues and the actions being taken to support them will be presented to the CAAH membership via PRO-TEEN items containing education about the issue and update on tne CAAH advocacy activities.

The chairperson will be responsible for organizing the bi-yearly meetings, and coordinating the various advocacy issues before the committee, and providing support for members who are engaged in advocacy work.

The chairperson will prepare a yearly report for PRO-TEEN summarizing the activity of the advocacy committee.

Conclusion

It is hoped that the work of this committee will result in the CASH taking an even more active and official role in matters of importance to adolescent health at the federal, provincial and local level, and create even closer cooperation between CAAH and other adolescent health groups and youth advocacy groups.

Advocacy Committee members for now

Katherine Leonard, MD, Chairperson
Jean-Yves Frappier, MD
Betty Gerstein, MD
Miriam Kaufman, MD
Karen Leslie, MD

Advocacy Committee Request for members

We would also be interested in knowing if any CAAH members have a special interest or expertise in the following areas:

1. **The proposed tobacco legislation,**
2. **The Youthful Offenderes Act, and**
3. **The recent child pornography ruling.**

These would be three potential areas of action for the Advocacy Committee.

Advocacy Committee News: CAAH and Gun Control

Dear Dr. Jean-Yves Frappier

We would like to take this opportunity to thank you formally for your role in recent decision to seek intervenor status in support of the new gun control legislation (Bill C-68) at the Supreme Court of Canada.

In addition to the Coalition for Gun Control, the following municipalities and organizations have all filed their motions for leave to intervene in support of the law at the Supreme Court: Cities of Montreal, Toronto and Winnipeg, the Canadian Association of Chiefs of Police, Canadian Association for Adolescent Health, Canadian Pediatric Society, Alberta Council of Women's Shelters, CAVEAT, Fondation des victimes du 6 décembre and the Quebec Public Health Association.

Your support has meant a great deal in recent years and we hope we can continue to count on you in the next few months, as the Supreme Court considers the constitutionality of the law. With your help, we will also continue to work to ensure that the law is fully implemented.

Yours truly,

Wendy Cukier
Professor, Ryerson Polytechnic University

President, Coalition for Gun Control

Chantale Breton
Executive Director
Coalition for Gun Control

CAAH Represented at the Supreme Court

After the law on gun control was approved in parliement, the Government of Alberta contested the law. On September 29, 1998, the Alberta Court of Appeal voted 3-2 to uphold the new federal gun control legislation. Not only did Chief Justice Fraser find the law to be a valid exercise of the federal government's criminal law power, she also reaffirmed the importance of licensing and registration to any effective gun control system because these are: "… about the protection of public safety from the misuse of ordinary firearms. This is to be accomplished through a simple but compelling concept – individual responsability and accountability for one's ordinary firearms. This is a small price to pay for the priviledge of being allowed to possess and use a dangerous weapon." This was a strong validation of our position and a credit to our counsel, as well as to the many experts who filed affidavit.

Not content with the Alberta Court of Appeal's decision, the Alberta government announced that it would appeal that judgement to Canada's High Court. Saskatchewan, Manitoba, Ontario and the two Territories have recently announced that they will also join this appeal.

The gun lobby pressured these provinces considerably and the facts suggest that their decision to either challenge the law in court or refuse to implement it was motivated above all by these tactics, not public safety. For example, the Ontario Federation of Anglers and Hunters pressured the Ontario PCs to intervene. It later claimed to its members that it: "… saw one of its most important lobbying efforts pay off September 26 with the announcement that the Canadian government will face a constitutional challenge on its new gun control laws." The PC Party of New Brunswick also attempted to present a motion asking the provincial governemnt to join the constitutional challenge against the law. While the session ended before there was time to consider the motion, it shows that the gun lobby and its political allies are still quite active provincially.

Fortunately, a number of groups and municipalities have been granted intervenor status in support of the law at the Supreme Court:

Represented by Clayton Ruby, of Ruby & Edwardh Barristers:

. Coalition for Gun Control
. Canadian Association of Chiefs of Police
. Cities of Montral, Toronto and Winnipeg

Represented by Paul Monahan, of Fasken, Camp-

bell & Godfrey:
. Canadian Paediatric Society
. **Canadian Association for Adolescent Health**
. CAVEAT
. Fondation des victimes du 6 décembre contre la violence

Represented by Paul Larochelle, of Brochet, Dussault, Larochelle:

. Quebec Public Health Association.

Represented by Alex Pringle, of Pringle, Renouf, MacDonald and Associates:

. Alberta Council of Women's Shelters

The hearing should take place sometimes in the fall of 1999. Dr. Katherine Leonard, head of CAAH Advocacy Committee has led this battle for CAAH.

Gun Control is making some differences?

New firearm statistics released by Kwing Hung, Senior Statistician for the Department of Justice of Canada shows that progressive gun control measures over the last few decades have probably made some difference. The overall firearm death rate is at its lowest in thirty years (3.8 per 100,000 in 1996, compared to 5.2 in 1970) and in one short year, there has been a decrease in firearm suicide, from 911 incidents in 1995 to 881 in 1996. For 1995-96, hospitalizations for firearm injuries also dropped to an all-time low of 881, from 1,115 the previous year. We have every reason to believe that the new controls will ensure a continuing decline in firearm deaths.

Kids and Guns : Two Steps Forward and One Step Back

Our new law will go a long way in reducing firearm death among children and youth; registration, which will ensure that firearms can be traced back to their original owner, will help enforce safe storage regulations. But much more needs to be done. Canada's rate of children under 14 killed with guns is the fifth highest among industrialized countries. In some provinces, the rate of children killed with guns is actually higher than the combined rates of Israel and Northern Ireland.

Ontario Promoting Guns for 12 Year Olds. The Ontario government has recently lowered the legal hunting age to 12. While Bill C-68 accommodates minors' permits for 12-18 year olds in exceptional circumstances, the provincial government's Apprenticeship Program will actually promote gun use among youth. The program was a response to pressure from the Ontario Federation of Anglers and Hunters. In return, Toronto City Council recently passed a motion calling on Ontario to rescind that decision. Other organizations such as METRAC, CAVEAT and the United Church of Canada's Toronto Conference have also expressed concerns about the Ontario government's initiative. Moreover, there is no evidence that training programs increase safety for children, particularly at a young age.

Québec Project on Kids and Guns. In 1999, the Coalition will be holding conferences with experts in crime prevention and public health in the province of Quebec to develop a provincial strategy to help reduce firearm death, injury and crime among children and youth. This particular project is modeled on the Coalition's Toronto initiative Protecting Youth and Children from Guns and is being sponsored by the Quebec Public Health Department. A document should be available in the fall 1999. We are also seeking funding to develop similar projects in other provinces.

Coalition For Gun Control

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Toronto, Ontario M6P 3J9
Tel & Fax: (416)604-0209
E-Mail: **71417.763@compuserve.com**

Scientific Events

Sixth Annual National Meeting of CAAH Toronto, November 5th 1999

The sixth annual national scientific meeting of CAAH will be held in suburb Toronto, Friday November 5th 1999.

Dr. Katherine Leonard, along with colleages of the Adolescent Clinic at North York Hospital are working on the program under the theme of " Mental Health and Adolescence ".

For more information : CAAH. Section de médecine de l'adolescence, hôpital Ste-Justine, 3175 Côte Ste-Catherine, Montréal QC H3T 1C5. Tel (514) 345-4722. Fax (514) 345-4778. E-mail : acsacaah@microtec.net.

Practice and Education of Health Professionals Responsive to the Needs of Individuals and Communities

Moncton, June 26-29 1999

This Conference is co-sponsored by World Health Organization and organized in conjunction with the Francophone Summit of 1999. It is aimed at health professionals, educators, students, health administrators and community representatives. The scientific activities will focus on practice, education, research, management, innovation and community based activities in relation with partnerships, role of professionals in adressing health needs. There will be a core of presentation on youth topics.

For information : Conférence Acadie-Sherbrooke, PO box 946, Moncton NB E1C 8N8. Tel (506) 861-6341 or 1-800-974-7070. Fax (506) 855-1646. E-mail : secretariat@confacadie-sherbrooke.org. Web : www.confacadie-sherbrooke.org

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Sexual Health Education: a literature review on its effectiveness at reducing unintended pregnancy and STD infection among adolescents

Lisa Evans, Med, Elijah Smith Elementary School, Whilehorse, Yukon

Introduction

Over half of Canadian teenagers are engaging in sexual activity. In a survey of Canadian youth, 26% of Grade 9 students, 45% of Grade students, and 69% of college/university students reported having engaged in sexual intercourse at least once (King, Coles & King, 1991 as cited in Woloshyn & Rye, I 995). The results from a recent Ontario study on adolescent sexual behaviour also found that the rate of sexual intercourse increased for both genders as age increased (Thomas et al., 1998). The study subsequently found that the largest annual increase of first sexual intercourse, for both genders, occurs between the ages of 13 and 14.

In Canada, over 45 000 young women aged 15-19 years become pregnant each year (Walker & Miller as cited in SIECCAN, 1998). Statistics also show that the population at highest risk for developing sexually transmitted diseases are heterosexual adolescents and young adults, 14-22 years old (Macdonald, C.J. as cited in Genuis, 1993). Particularly, health officials are concerned about the high Chlamydia rate among 15-19 year olds. If left untreated this STD can lead to Pelvic Inflammatory Disease and infertility (Patrick, 1997 as cited in SIECCAN, 1998). Also of great concern in Canada is the significant drop in median age of HIV infection. The most recent Statistics Canada report shows that the Yukon has one of the highest rates of teen pregnancy. The pregnancy rate per 100 000 women aged 15-19 in the Yukon was over double that of Ontario (Wadhera & Miller, 1994). A 1995 Health Canada report showed the rate of Chlamydia per 100 000 people to be five times higher in the Yukon than in Ontario (Patrick, 1997).

The problems associated with teen sexuality are nothing new. In 1987, the Federal / Provincial/ Territorial Working Group on Adolescent Reproductive Health was formed to address the serious issues around adolescent sexual health. Some very specific recommendations were developed with respect to sexual health education. The most relevant recommendations cited in the report (Health Canada, 1987) are as follows:

> That provincial and territorial health departments advocate more vigorously (to departments of education) mandatory sexual health education in school curricula.
> That it be ensured that educators recognize that there is a specific, unique body of knowledge pertaining to adolescent reproductive health. This should be appropriate to specific target groups and incorporated in: the training and education of health service personnel, the education of teachers and parents, educational materials which are made available to families, teenagers raising children, adolescents and their peers and service personnel (p.5-6).

At the present time Canada does not have mandatory sexual health education in all provinces and territories. The quality and scope of sex education varies greatly among Canadian schools with the extent of instruction and implementation left to the discretion of the school board or individual school administration. The time allotted for "health education" covers many topics including nutrition, hygiene and sex education. Traditional subjects are often given precedence over health education and it is common for teachers to disregard sex education completely because of their own lack of comfort with the material.

Recent survey research reported by The Sex Information and Education Council of Canada (SIECCAN) consistently shows that Canadian parents and students want schools to provide sexual health education programs. Over 85% of Canadian parents surveyed agreed with the statement, "Sexual health education should be provided in the schools" (SIECCAN, 1998). The

classroom is an ideal setting for sexuality education, as it is a gathering place for the majority of adolescents, more than any other sector of the community (Fisher & Barak, 1989 as cited in Woloshyn and Rye, 1995). Mckay and Holowary (1997) found that 89% of the adolescents surveyed felt that it was important for them to receive sexual health education. From six possible sources, the adolescents rated the school as their most preferred source of sexual health information. Adolescents rated twelve topic areas as the most important areas to be addressed. They were as follows: preventing sexually transmitted diseases, sexual assault/rape, how to get testing and treatment for STDs, methods of birth control, conception/pregnancy/birth, building good/equal relationships, making good decisions about sexuality and relationships, saying no to sex, parenting skills, talking with girlfriends/ boyfriends about sexual issues, peer pressure, and puberty. The findings of this study have been recently replicated (SIECCAN, 1998). SIECCAN strongly supports the provision and implementation of high quality, broadly based sexual health education in the prevention of sexually transmitted diseases and unwanted pregnancies among young people.

Research shows that well designed programs, which provide information, motivation, and behavioural skills, are effective in delaying adolescents' first intercourse and increasing the proper use of contraceptives/condoms by those who choose to be sexually active (Brown & Eisenberg, 1995; Frost & Darroch Forrest, 1995; Kirby et at., 1994 as cited in SIECCAN, 1998). Opponents of sex education claim that providing young people with broadly-based sex education will result in the earlier onset of intercourse (Mckay, 1993). A number of studies have investigated this issue and there has been no association found between exposure to formal sex education and the earlier onset of sexual intercourse (McKay, 1993). Kirby et al. (1994) concluded, from their extensive review of sex education programs, that including discussions of contraception in combination with other topics do not hasten the onset of intercourse. Empirically-based evidence will be presented to support the implementation of sex education programs, more specifically what programs have shown to be effective in changing the sexual health behaviour of teenagers. Sexual health behaviour refers to sexual intercourse and the use of contraception, particularly condom usage to prevent pregnancy and HIV/STDs. General conclusions will be presented as well as recommendations with respect to policy formation and development and implementation of sexual health programs for adolescents.

Effective Sexuality Education Programs-Research Based Evidence

In 1993, the World Health Organization commissioned a far-reaching review of published studies examining the reported effects of sex education on young people's sexual behaviour. Grunsiet & Aggleton (1998) concluded from their review of forty-seven studies that the programs that are most effective in reducing adolescents' high risk sexual behaviour are those that focus on delaying sexual intercourse as well as provide skills and information related to contraception and condom use for pregnancy and STD prevention. Kirby et al. (1994), in their review of effective sexual health education programs, remark that:

these programs are neither value-free nor moralistic. They do not simply lay out the facts and the students decide for themselves what is best, nor do they preach that sexual intercourse before marriage is always wrong. Instead, they emphasize that it is a good idea for young teenagers to delay sex and that it is important for young people to practice effective contraception if they are going to have sex (p. 254).

Researchers in the area of sexuality education recommend the implementation of theory driven, broadly based, sexuality education programs. Canada has a very detailed, empirically based set of guidelines for sexual health education. The Canadian Guidelines for Sexual Health Education is described by head research coordinator for SIECCAN, Alexander McKay, as a comprehensive framework for development of effective sexual education programs. A comprehensive approach to effective sexual health education emphasizes the shared responsibility of the community including parents, peers, places of worship, schools, health care systems, governments and the media

(Health Canada, 1994). The Sexual Health Education Guidelines were developed on the recommendations of the Expert Interdisciplinary Advisory Committee on Sexually Transmitted Diseases in Children and Youth and the Federal/Provincial/ Territorial Working Group on Reproductive Health. The Guidelines were formulated around an "educational philosophy that is inclusive, respects diversity, and reflects the fundamental precepts of education in a democratic society" (SIECCAN, 1998, p.3). The Guidelines (Health Canada, 1994) state that effective sexual health education:

enhances sexual health within the context of an individual's values, moral beliefs, religious or ethno-cultural background, sexual orientation or other such characteristic;
emphasizes the self-worth and dignity of the individual;
instills sensitivity to and awareness of the impact of one's own behaviour on others, stressing that sexual health is an interactive process that requires respect for the self and others;
provides accurate information that counters misunderstanding and reduces discrimination based upon race, gender, sexual orientation, religion, ethno-cultural background or dis ability;
is structured so that attitudinal and behavioural changes arise out of informed individual choice and are not imposed by an external authority .

According to the Guidelines, sexual health education involves a combination of educational experiences that will enable learners to:

acquire knowledge that is pertinent to specific health issues;
develop the motivation and personal insight that is necessary to act on this knowledge;
acquire the skills they may need to maintain and enhance sexual health and avoid sexual problems;
help create an environment that is conducive to sexual health.

Research consistently indicates that positive sexual health outcomes are most likely to occur when the above mentioned components are integrated into a sexual health program (Health Canada, 1994). In addition to supplying factual information, effective sexual health education programs provide people with educational experiences which will equip them to engage in specific behaviours to avoid sexual problems and to enhance their sexual health (Health Canada, 1994). An effective sexual health program also takes into consideration the specific needs and goals of the target population and the community. *A* review of the literature reveals that there are many sexual health programs that are available. Unfortunately, the effect of these programs, in terms of significant changes in sexual behaviour, has not been empirically documented. The studies and interventions presented are the most salient of the research that is available at this time.

Traditional Sex Education

Traditional sex education programs lend to focus solely on student acquisition of knowledge about reproduction and birth control. These programs do not involve any skill development related to that knowledge. There is an assumption that adolescents will translate the knowledge into avoidance of unprotected sex (McKav, 1993).

There are some positive findings that come from a number of studies using large random samples of teenagers, indicating that exposure to some form of sex education does have a positive impact on adolescent sexual behaviour. Dawson (1986) analyzed the 1982 U.S. National Survey of Family Growth and found that female adolescents who received contraceptive education were more likely to practice contraception at first intercourse than those who did not receive formal instruction. It was also found that the female adolescents who received formal sex education were not more likely to begin having intercourse than those who had not been exposed. The data did not reveal any significant relationship between exposure to sex education and the risk of premarital pregnancy among sexua1ly active teenagers. Marsigho and Mott (1986), using a nationally representative sample of 12 686 U.S. youth of both sexes aged 14-22, found that sexually active girls who had received sex education were significantly more likely to use an effective method of contraception than sexually active girls who never had a sex education course. Pope et al. (1985 as cited in

Woloshyn & Rye, 1995) also found that women who participated in educational programs tended to use oral contraceptives more often than did non-participating students, who were more likely to use less effective birth control methods or no methods.

With respect to the Sexual Health Guidelines, providing sexual health knowledge is important in terms of raising awareness. There has been no compelling evidence, however, that programs based only on factual information significantly lowers adolescent pregnancy rates and decreases the reported cases of sexually transmitted diseases.

Broadly-Based, Theory-Driven Sexuality Education Programs

The following programs are based on some aspect of social learning, social inoculation and cognitive behavioural theories, where behaviour change is the result of the acquisition of knowledge and the practice of skills specifically related to that knowledge. Broadly-based programs address knowledge, skills as well as attitude and motivation, specifically related to sexual health.

Safer-Sex: HIV Risk-Reduction Intervention

Jemmott, Sweet, and Fong (1998) examined HIV risk-reduction interventions for a group of high-risk African American adolescents. Their goal was to determine which behavioural intervention strategy is most appropriate and efficacious for reducing HIV risk-associated sexual behaviour. Three interventions were created for the study: an abstinence intervention which acknowledged that condoms can reduce risks but emphasized abstinence to eliminate the risk of pregnancy and STDs; a safer-sex intervention which focused on abstinence as the best choice but emphasized the importance of using condoms to reduce the risk of pregnancy and STDs, including HIV, if participants were to have sex; a health promotion intervention which focused on behaviours associated with risk of cardiovascular disease, stroke, and other health problems associated with African Americans. Each intervention consisted of eight, one-hour modules. All three programs included group discussions, experiential exercises and skill-building activities. The safer-sex program, in particular, was designed to:

> increase HIV/STD knowledge and the specific belief that using condoms could prevent pregnancy, STDs, and HIV;
> enhance hedonistic beliefs to allay participants' fears regarding adverse effects of condoms, on sexual enjoyment;
> increase skills and self-efficacy regarding their ability to use condoms, including confidence that they could negotiate condom use with sexual partners (p.1531).

The participants were 659 African American adolescents recruited from sixth and seventh grade classes from three different middle schools in Philadelphia. The significant findings from the study are as follows:

> Adolescents in the safer-sex intervention were more likely to report consistent condom use at the 3-month follow-up than were those in the control group or the abstinence group. This effect was sustained 6 and 12 months after intervention.
> Self-reported frequency of condom use was also significantly higher in the safer sex group than in the control group. Adolescents in the safer sex group reported fewer days on which they had unprotected sex than those in the control group reported.
> Among sexually experienced adolescents, those who received the safer-sex intervention reported less unprotected sex than did those in the control group or the abstinence group. This effect was still sustained at 6 and 12-month follow-up: at six-month follow-up, the abstinence intervention did not reduce self-reported sexual behaviour compared with other interventions.

The researchers conclude from this study that the use of intensive theory-based, culture-sensitive interventions designed to influence mediators of risk behaviour, including HIV knowledge, behavioural beliefs, self-efficacy, and skills, can decrease sexual behaviour and increase condom use.

Our finding that the safer-sex intervention cured unprotected sexual intercourse, whereas the abstinence intervention did not, suggests that if the goal is reduction of unprotected sexual intercourse, the safer sex strategy may hold the most promise, particularly with those adolescents who are already sexually experienced. Moreover, safer-sex interventions may have longer-lasting effects than abstinence interventions.

With respect to the Canadian Guidelines this safer-sex program addresses the components of knowledge, motivation (positive attitude toward preventative behaviour) and skill development.

Reducing the Risk: Building Skills to Prevent Pregnancy, STDs and HIV

The Reducing the Risk program is based upon several interrelated theories: social learning theory, social inoculation theory and cognitive-behavioral theory. The educational basis for the program asserts that learning follows from action. The students are required to actively participate in role-play situations that simulate those that they are likely to confront outside the classroom (Barth, 1993). Kirby (as cited in Barth 1993) explains that:

the curriculum is designed to enhance skills to resist unprotected sex by modeling those skills and then providing opportunities for practice. It emphasizes explicit norms against unprotected sex by continually reinforcing the message that youth should avoid unprotected intercourse, that the best way to do this is to abstain from sex, and that if youth do not abstain from sex, they should use contraceptives to guard against pregnancy and against sexually transmitted disease (STD) especially the human immunodeficiency virus (HIV).

The curriculum is divided into 16 one-hour lessons. The teachers who implement the program must attend a 3-day training session focusing primarily on role-playing and other class activities.

Kirby et al. (1991) conducted a quasi-experimental, rigorous evaluation of the Reducing the Risk curriculum. Important methodological components were employed including a large sample size, good comparison groups, and long-term follow-up. The program was implemented at 13 California high schools; 758 students were assigned to treatment and control groups. The students were surveyed before their exposure to the curriculum, immediately afterwards, six months later, and 18 months later. The treatment group received the curriculum while the control group received a more traditional sex education course of the same length. Kirby (as cited in Barth, 1993) presents the following significant findings from the 1991 study:

Among all youth the curriculum significantly increased knowledge and the students retained this greater knowledge for at least 18 months. Though the curriculum did not seem to diminish the perceived proportions of students their age who had never had sex, it did apparently prevent those perceptions from becoming worse over time.

The curriculum increased parent/child communication about abstinence and contraception.

Among students who had not initiated intercourse prior to the pretest the curriculum significantly reduced the onset of intercourse at 18 months-the proportional reduction was 24 percent.

Among those relatively few students who did initiate intercourse after the curriculum was implemented, larger percentages of the program group than of the comparison group used contraceptives. This effect was still significant at the 18-month follow-up.

An analysis of measures of unprotected intercourse (derived from both abstinence and use of contraceptives) revealed that the curriculum significantly reduced unprotected intercourse among all students who had not initiated intercourse prior at pretest. The estimated proportion reduction was approximately 40 percent.

These effects extended across a variety of subgroups including different ethnic groups, both sexes, and lower-risk youth. The curriculum was particularly effective for lower-risk and female students.

The combination of findings indicated that the curriculum delayed the onset of intercourse, but

did not significantly affect the frequency of sexual intercourse or the use of birth control among those students who had initiated intercourse prior to program participation. This suggests that whenever possible the curriculum should be implemented in schools before most youth initiate intercourse. It appears that it may actually be easier to delay the onset of intercourse than to increase contraceptive practice (Kirby et al, 1994).

The data from this study suggest that the theoretical approach and the design of activities as found in the Reducing the Risk program is more effective at producing the desired behavioural changes than are more traditional approaches (Kirby as cited in Barth 1993). The knowledge, motivation and skills components of the Canadian Sexual Health Guidelines are incorporated into this program. The researchers caution, however, that the Reducing the Risk curriculum is not a total solution to the problems of unprotected intercourse; many youths in the treatment group failed to abstain or to use contraceptives (Kirby et al., 1994). More comprehensive programs that involve the school, parents and the community are required. The Reducing the Risk curriculum could be an effective component of a more comprehensive program (Kirby as cited in B&ih, 1993).

Skills for Healthy Relationships

The largest study ever undertaken in Canada on the long-range outcome of a school-based sexuality program was developed by the Social Program Education Group at Queen's University, Kingston Ontario (Francoeur, 1997). The program, Skills for Healthy Relationships, was developed by the Social Program Education Group in response to the need for AIDS and other STD prevention programs and the need to educate adolescents about AIDS and other STDs. The impetus for the development of the program came from the findings of the Canada Youth and AIDS Study (King, et al., 1988) which revealed that, although adolescents are relatively knowledgeable about AIDS and other STDs, they still take many risks that result in their contracting and transmitting HIV and other STDs (Social Program Evaluation Group, 1994). The main objectives of the program are that students will:

gain AIDS and STD-related knowledge;
act as positive role models for risk reduction behaviours in promoting health-enhancing peer group norms;
develop positive attitudes toward STD prevention and AIDS-related issues;
- develop the skills (interpersonal, cognitive, self-management and practical) necessary to maintain an HIV/AlDS/STD-free lifestyle and to apply those skills in real-life situations where appropriate;
develop the motivational supports for risk reduction (e.g., self-efficacy, positive relationships, support from parents and peers);
develop compassion and support for people with HIV and AIDS;
develop an understanding and non-discriminatory attitudes towards people of different sexual orientations (p.5).

This curriculum designed for grade nine students (age 13-14) was developed using the Guidelines for Sexuality Education in Canada and thus encompasses all components: knowledge, attitude and skill development. An additional component was added, motivational support, which focuses on self-efficacy, parents and peers. The 15 hour program features cooperative learning (small groups), parent(guardian involvement (six interactive activities), active learning (role playing, behavioural rehearsal), peer leaders (in small groups, modeling skills), video instruction, journalling and development of a personal action plan (assertiveness goal) (Francoeur, 1997). The skill component is a major feature of the program.

The evaluation study involved 2000 grade nine students in four provinces. The students were divided into treatment group and comparison group. The comparison group received their school's regular grade nine AIDS/STD program. Outcome measures were obtained just after the students' comple-

tion of the program, one year late and two years later. Wanen and King (1994 as cited in Francoeur, 1997) report that two years later, students who took the program stated that the program affected them in a number of ways. These include: more comfort talking about personal rights with a partner (72 percent), talking about condoms (67 percent), ability to refuse or negotiate something they don't want to do (58 percent), more assertive (53 percent), and always use condoms with a partner (61 percent). Compared to the comparison group, participants at the two year follow-up:

> were more likely to have gained compassion toward people with MDS;
> had more positive attitudes toward homosexuality;
> showed greater knowledge of HIV/AIDS;
> were more likely to express the intent to communicate with partners about condom use;
> were no more likely to have the intent to use condoms (this was initially high in both groups);
> were no more likely to report "always" using a condom (about 41 percent of both treatment and comparison groups said they always did so;
> about half reported using a condom the last time they had intercourse); and
> females were more likely to declare that they would respond assertively if they were pressured unwillingly to have sex (p.243).

It was not surprising that, in the period from grade nine to grade eleven, the proportion of students who had experienced intercourse increased for both sexes in both the treatment and comparison groups (Francoeur, 1997). The percentage of both sexes who said they had ever had intercourse was slightly lower in the treatment group. For males in the treatment group, 42 percent versus 51 percent in the comparison group. For females, 46 percent in the treatment group versus 49 percent in the comparison group. In both the treatment group and the comparison group, the most likely to have unprotected sex where those who took risks in the areas of alcohol consumption, use of marijuana, and skipping school (Warren & King, 1994 as cited in Francoeur, 1997). This observation highlights the influence that social and relationship factors have on behaviour which in turn are difficult to change through school-based interventions alone. The researchers emphasize the importance of having a program that fits the specific needs of the population, particularly when considering high-risk youth.

Multi-Dimensional Programs

Multi-dimensional programs are broadly-based and theory driven. The added dimension is that they incorporate resources and services within the community as part of the program.

Vincent, Clearie and Schluchter (1987 as cited in Christopher, 1995) report on a comprehensive program that was implemented in a rural, low income, undereducated community. The community had a high percentage of African-Americans in comparison to other racial groups. The goals of the program were to convince adolescents to postpone sexual activity as a positive and preferred choice and promote the usage of effective contraception among those youth who were sexually active. The intervention took place on a community and school level. Advisory groups were established which to help connect agencies within the community. Education and training courses were offered to all members of the community including parents. Teachers were given the opportunity to attend graduate level courses free of charge.

A comprehensive program was implemented, from kindergarten through grade twelve. The initial evaluation on the program consisted of comparing pregnancy rates for two years prior to the intervention with rates 3 years post-intervention. The target community was compared with three other similar rural communities where the intervention program had not been implemented. Estimated pregnancy rates in the target community dropped significantly in the first year of the program (60.6% to 37.3%). Comparison communities experienced significant increases during the same period of time. A second evaluation, using six

matching comparison communities revealed similar dramatic results.

Christopher (1995) suggests that certain network and/or community processes, which had not been a part of the formal evaluation process, "may have a positive effect on getting teens to comply with abstinence and contraceptive messages (p.387)." The program effects (decrease in pregnancy rate) did disappear, however, after five years. The evaluators noted that a program nurse who was dispensing contraceptives to participating youth was forced to leave due to negative publicity and subsequent state legislation. It was also noted that the teachers who had initially received graduate level training had left the school prior to the pregnancy rate increase.

Zabin et al. (1988 as cited in Christopher, 1995) also reported on the success of a multi-dimensional program, which resulted in significant reductions in pregnancy rates of their target population. This program implementation was conducted in an urban, lower class, predominately black community. The program was designed to emphasize abstinence but to also provide information about effective contraception to those who did choose to be sexually active. The participating adolescents were provided with an in-school program consisting of classroom presentations, discussion groups, individual counselling, and an after-school clinic which provided free educational intervention, medical examinations, counselling and contraceptives. A three-year follow-up revealed that the adolescents that had participated in the program delayed first intercourse, started using effective contraception earlier in their sexual activity, and most significantly, reduced their pregnancy rate by 30% in comparison to the control group, which experienced a 57% increase.

Safer Choices: A Multi-dimensional School-Based HIV/STD and Pregnancy Prevention Program for Adolescents

The Safer Choices program focuses on reducing the number of students engaging in unprotected sexual intercourse. It does this by reducing the number of students who begin or have sexual intercourse during high school years, and by increasing condom use among those students who do have sex (Carol Kirby. Parcel, Basen-Enquist, Rugg & Weil, 1996).

Secondary purposes of the program include reducing the number of students who have multiple sex partners or use injectable drugs, and increasing the number of students who seek HIV/STD counselling, testing and consultation.

Safer Choices uses a multi-dimensional approach that addresses change at the student, school and community level. The conceptual bases for the program include social cognitive theory, social influence theories and school/change improvement models. This school/change improvement model was a unique aspect of the Safer Choices program in that it addressed the influence of the school environment on student behaviour. A School Health Promotion Council, consisting of parents, teachers, administrators, other staff, students and member of local community agencies, was formed at each intervention school.

The Safer Choices curriculum consists of separate 10-lesson series for grades nine and ten students. The grade 10 program builds on and reinforces the grade nine lessons. The program is based on the program, Reducing the Risk, which was described earlier in this report. Consistent with social cognitive theory and social influence models, the lessons focus on attitudes and beliefs, social skills (particularly refusal and negotiation skills), functional knowledge, social and media influences, peer norms, and parent-child communication. A systematic approach to skill development is utilized. This includes clear explanations of skills to be learned, opportunity for skill practice and positive as well as corrective feedback. The skills are specific to sexually responsible behaviour i.e. refusal skills to avoid sexual intercourse or to not engage in unprotected intercourse.

Classroom teachers trained by project staff implement the curriculum. Teachers also receive on-site technical assistance and coaching. The curriculum also uses students as facilitators for selected activities. These students are given an ad-

ditional three hours of training and are asked to model skills and assist with small group activities.

There is also a parent education component which is designed to help parents provide accurate information to their children, and to reinforce the norm that youth should avoid unprotected intercourse. There are a number of additional activities which focus on adult/teen communication about sexuality, including Council-sponsored information nights.

A very important aspect to the Safer Choices program is the school-community linkage. The students learn about resources available in the community. Homework assignments encourage them to find out about community organizations and local youth services where they can go for more information.

Safer Choices was evaluated in 20 schools in California and Texas. In each location, the schools were randomly assigned to the intervention curriculum (Safer Choices) or the comparison condition (a standard knowledge-based curriculum). Nearly 4000 grade nine students were evaluated for 30 months. Periodic interviews were conducted. Results showed that students attending schools where Safer Choices had been implemented were more likely to avoid behaviour that would put them at risk than students attending schools where the standard knowledge-based curriculum had been implemented (SHOP Talk, 1998). In addition, sexually active students reported:

- fewer acts of unprotected intercourse;
- increased usage of HIV and pregnancy prevention methods;
- significant gains in HIV knowledge, parent communication, and attitudes;
- self-efficacy related to protecting themselves against HIV/STD infection.

The Safer Choices curriculum seems to encompass all aspects of the Canadian Sexual Health Education Guidelines and can be considered a truly comprehensive program. This program was presented at the June, 1998, World AIDS Conference in Geneva, Switzerland.

School and Community-Based Clinics

Clinic-based programs provide health services, which could include dispensing of contraceptives, sexual health information, medical exams and/or counselling.

Kirby et al. (1991) evaluated the impact of six school-based clinics located on six high school campuses in different parts of the United States. The clinics provided a wide range of health care services appropriate for adolescents. Two of the clinics referred for contraceptives, one clinic wrote prescriptions that could be filled at a nearby Planned Parenthood clinic and three clinics dispensed contraceptives in the school clinics. The education programs that each clinic provided varied from site to site. The results of the study were mixed. At one clinic, which targeted high-risk youths, pregnancy prevention was emphasized and oral contraceptives were dispensed. There was a significantly greater use of oral contraceptives among females at the clinic site than among females in the comparison school. There was no difference, however, in condom use. At two other sites which dispensed both condoms and oral contraceptives but did not have a strong educational component, no significant differences were found between the clinic and comparison schools in use of condoms by male students or use of oral contraception by female students . At the site that prescribed contraceptives and had a strong educational component, male students reported higher rates of condom use and female students reported higher rates of contraceptive use than did their counterparts at the comparison school. It must be noted that these results applied to students who had been sexually active prior to the set-up of the clinics. Though the results of Kirby's study appeared promising for school-based clinics, a examination using 5 years of pre-clinic data and 6 years of post-clinic data revealed a weak link between school-based clinics and a decrease in live birth rates among teenagers (Christopher, 1995). Pregnancy rates (the sum of live births, therapeutic abortions and miscarriages/stillbirths) were not considered in this study.

Franklin, Grant et al. (1997) conducted a meta-analysis of the effectiveness of prevention programs for adolescent pregnancy. Their findings

indicated that community-based programs i.e. health services provided off school grounds and which provided contraceptive knowledge and contraceptive distribution, were more effective with respect to pregnancy outcome measures than were other sex-education programs. Note that social-cognitive and learning-based approaches to sex education were not included in the analysis. The analysis also concluded that contraceptive programs seem to work best with older adolescents (aged 15-19) who were already sexually active. The researchers stress the importance of developing age-phased, developmentally based, sex education programs. More research is needed in this area.

Abstinence Only Programs

Abstinence programs typically focus on the importance of abstinence from sexual intercourse until marriage. They do not provide students with the opportunity to learn the necessary information and skills to reduce the risks of sexual activity if they do choose to have intercourse.

It has been suggested that abstinence-only sex education programs are the solution to teen pregnancy and STD infection. There are a number of studies that evaluate the effectiveness of abstinence programs. These programs tend not to discuss contraception or they briefly discuss failure of contraceptives to provide complete protection against pregnancy (Kirby et al., 1994). "Success Express" and "Project Taking Charge" are two such programs. Concerns have been raised about programs that rely exclusively on a premarital abstinence approach (Scott & Roosa, 1990). Though positive short-term outcomes have been reported, most of the effects involve changes in attitude and not in behaviours, and these effects were found to deteriorate over time (Olsen et al, 1984 as cited in Scott & Roosa, 1990). These programs are inherently insensitive in that they ignore students who have already experienced sexual intercourse or who were possibly victims of rape or incest (Scott & Roosa, 1990). The Sex and Information Council of the United States (SIECUS) report (1993) which examined 11 abstinence-only based curricula, found the following strategies common to all of the programs:

Scare tactics are used as the major strategy for encouraging premarital abstinence from sexual behaviour;
information about contraception methods is often omitted;
if the availability of contraception is mentioned, failure rates are emphasized and often overstated; students are required to look exclusively at the negative consequences of sexual behaviour;
opportunities are not provided for students to explore their own values about premarital sexual behaviour; medical misinformation about abortion, STDs, HIV/ AIDS and sexual response is prevalent;
sexist bias is evident in descriptions of anatomy/ physiology, sexual response, and sexual behaviour;
sexual orientation is not discussed or homosexuality is described as an unhealthy "choice";
people with disabilities are entirely omitted or are illustrated as non-sexual;
racist and classist comments exist within the texts and stereotypes about various communities are underscored;
religious bias influences the curricula and only one viewpoint on sexual behaviour is discussed;
a limited number of family structures are included and non-traditional families are depicted as troubled (p.2).

Kirby et al. (1994) report that there is inadequate evidence to determine the effectiveness of school-based abstinence programs on delaying intercourse or affecting other sexual or contraceptive behaviours. The U.S. Office of Population Affairs, Office of Adolescent Pregnancy Programs, has supported many research projects to evaluate abstinence programs (Jorgenson et al., 1993). The results have been far from encouraging (particularly those assessing changes in adolescent sexual behaviour). After more than a decade of evaluation, there is little evidence of their effectiveness in the scientific literature.

Recommendations

1. In the short term, it is important that sex education be provided to all adolescents attending

school in the Yukon. It is not realistic to expect that a comprehensive sexual education program will be implemented in the near future. There should be support, however, to keep the existing programs up and running i.e. public health nurses and the Health Promotion Unit in the schools. Existing curricula such as Skills for Healthy Relationships, Reducing the Risk, and Safer Choices, should also be considered for use as guidelines to develop programs that will meet the needs of adolescents in the Yukon. It would also be advised that community awareness programs, targeting adolescents, continue to be developed and implemented.

2. Health professionals should consider the feasibility of a teen clinic which provides sexual health education and related health care.

3. From a proactive standpoint, creation of sexual health education policy specifically for the Yukon Territory is necessary. Students need to be provided with comprehensive, age-appropriate, sexual health education. The Yukon should initiate a process to develop such a policy, beginning with an assessment of the needs and wants of the community with respect to sexual health education. A commitment must be made to the full process, including policy development, curriculum creation, and curriculum implementation.

4. It is imperative that well-trained, informed individuals, implement and instruct sexual health education programs. Training programs should be provided for individuals wishing to instruct sexual health education programs.

5. At this point in time there have been no studies that have included the Canadian North. There should be some serious consideration into providing funds and conducting research in this unique region of Canada. The Yukon and the Northwest Territories have the highest teen pregnancy rates and greatest rates of Chlamydia in Canada. These statistics deserve some attention.

References

-Alteneder, R.R., Price, J.H., Telljohann, S.K., Didion, J., & Locher, A. (1992). Using the PRECEDE Model to Detennine Junior High School Students' Knowledge, Attitudes, and Beliefs about AIDS. Joumal of School Health, 62, (1 0), 464-470.

-Ansuini, C.G., Fiddler-Woite, J., & Woite, R.S. (1996). The Source of Accuracy, and Impact on Initial Sexuality Information on Lifetime Wellness. Adolescence, 31, (122), 284-289.

-Barrett, M. (1990). Selected Observation on Sex Education in Canada. SIECCAN Joumal, 5, (1), 21-30.

-Barth, R.P. (1989). Reducing the Risk: Building Skills to Prevent Pregnancy, ST D & HIV. ETR Associates: Santa Cruz.

-Christopher, S.F., & Roosa, M. 91990). An Evaluation of an Adolescent Pregnancy Prevention Program: Is "Just Say No" Enough? Family Relations, 39, 68-72.

-Christopher, S.F. (1995). Adolescent Pregnancy Prevention. Family Relations, 44, 384-391.

-Cagampang, H.H., Barth, R.P., & Kirby, D. (1997). Education Now and Babies Later (ENABL): Life History Of a Campaign to Postpone Sexual Involvement. Family Planning Perspectives, 29, (3), 109-113.

-Coyle, K., Kirby, D., Parcel, 6., Basen-Enquist, K., Banspach, S., Rugg, D.,& Weil, M. (1996). Safer Choices: A Mulitcomponent School-Based HIVISTD and Pregnancy Prevention Program for Adolescents. Journal of School Health, 66, (3), 89-94.

-Dawson, D. (1986). The Effects of Sex Education On Adolescent Behavior. Family Planning Perspectives, 18, 162-170.

-Fisher, W.A. (1997). A Theory-Based Framework For Intervention And Evaluation In STD/HIV Prevention. The Canadian Journal of human Sexuality, 6, (2), 105-111.

-Francoeur, R. T. (Ed.). (1997). The International Encyclopedia of Sexuality (Vol.1). New York Continuum.

-Franklin, C., Grant, D., Corcoran, J., O'Dell-Miller, P. & Bultm an, L. (1997). Effectiveness of Prevention Programs for Adolescent Pregnancy: A Meta-Analysis. Journal of Marriage and the Family, 59, 551-567.

-Furby, L., Ochs, L.M., & Thomas, C.W. (1997). Sexually Transmitted Disease Prevention: Adolescents' Perceptions of Possible Side Effects. Adolescence, 32, (128), 781-809.

-Genius, S.J., & Genius, S.K. (1995). The Challenge of Sexually Transmitted Diseases in Adolescents. Adolescent Pediatric Gynaecology, 8, 82-88.

-Genius, S.J., & Genius, S.K. (1993). The Dilemma of Adolescent Sexuality, Part I: The Onslaught of Sexually Transmitted Diseases. Journal of the Society of Obstetri-

cians and Gynaecologists of Canada, 15, (3), *552-565*.

-Genius, S.J., & Genius, 5K. (1993). The Dilemma of Adolescent Sexuality, Part II: The Onslaught of Sexually Transmitted Diseases. Journal of the Society of Obstetricians and Gynaecologists of Canada, 15, (9), 1063-1074.

-Grimely, D.M., & Lee, P. (1997). Condom And Other Contraceptive Use Among A Random Sample of Female Adolescents: A Snapshot In Time. Adolescence, 32, (128), 771-779

-Gruber, E., & Chambers, C.V. (1997). Cognitive Development And Adolescent Contraception Integrating Theory and Practice. Adolescence, XXII, (87), 663-670.

-Grunseit, A.C., & Aggleton, P. (1998). Lessons learned: an update on the published literature concerning the impact of HIV and sexuality education for young people. Health Education, 2, 45-54.

-Health Canada. (1994). Canadian Guidelines for Sexual Health Education. Ottawa: Health Canada.

-Health Canada. (1987). Report on Adolescent Reproductive Health. Ottawa: Health Canada.

-Jenmort, J.B., Jenmon, L., 7 Fong, G.T. (1998). Abstinence and Safer Sex HIV Risk-Reduction Interventions for African American Adolescents. Journal of the American Medical Association, 279, (19), 1529-1 536.

-Jorgenson, S.R., Potts, V., & Camp, B. (1993). Project Taking Charge: Six-Month Follow-Up Of A Pregnancy Prevention Program For Early Adolescents. Family Relations, 42,401-406.

-Kantor, L.M. (1993). Scared Chaste? Fear-Based Educational Curricula. SIECUS Report, 21, (2), 1-1 5.

-Kirby, D., Korpi, M., Barth, R.P., & Cagampang, H. (19970. The Impact of the Postponing Sexual Involvement Curriculum Among Youths in California. Family Planning Perspectives, 29, (3), 100-109.

-Kirby, D., Short, L., Collins, J., Rugg, D., Kolbe, L., Howard, M., Miller, B., Sonenstein, R., & Zabin, L.S. (1994). School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness. Public Health Reports, 109, (3), 339-359.

-Kirby, D. Resnick, M.D., Downes, B., Kocher, T., Gunderson, P., Potthoff~ S., Zelterman, D., & Blum R.W. (1993). The Effects of School-Based Health Clinics In St. Paul on School-Wide Birthrates. Family Planning Perspectives, 25, (1). 12-16.

-Kirby, D., Barth, R. P., Leland, N., & Fetro, J.V. (1991). Reducing the Risk: Impact of a New Curriculum on Sexual Risk-Taking. Family Planning Perspectives, 23, ***(6).*** *256-263.*

-Klein, N.A., Goodson, P., Serrins, D.S., Edmunsdson, E., & Evans, A. (1994). Evaluation of Sex Education Curricula:Measuring Up to the SIECUS Guidelines. Journal of School Health, 64, (8), 328-333.

-Ku, L.C., Sonenstein, F.L., & Pleck, J.H. (1992). The Association of AIDS Education and Sex Education with Sexual Behaviour And Condom Use Among Teenage Men. Family Planning Perspectives, 24, (100), 102-106.

-Lamport, L., & Andre, T. (1993). AIDS Knowledge And Sexual Responsibility. Youth and Society, 25, (1), 38-61.

-Langille, D.B., Androu, P., Beazley, R.P., & Delaney, M. E. (1998). Sexual Health Knowledge of Students at a High School in Nova Scotia. Canadian Journal of Public Health, 89, (2), 85-89.

-McKay, A.& Holowaty, P. (1997). Sexual Health Education: A Study of Adolescents' Opinions, Self- Perceived Needs, And Current And Preferred Sources of Information. The Canadian Journal of Human Sexuality, 6, (1), 29-43.

-Mckay, A. (1993). Research Supports Broadly-Based Sex Education. The Canadian Journal of Human Sexuality, 2, (2), 89-97.

-Marsigho, W., & Mort, F.L. (1986). The Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancy Among American Teenagers. Family Planning Perspectives, 18, (1), 151-161.

-Miller, B.C., Norton, M.C., Jenson, 6.0., Lee, T.R., Christopherson, C., & King, P. K. (1993). Pregnancy Prevention Programs: Impact Evaluation Of Facts & Feelings: A Home-Based Video Sex Education Curriculum. Family Relations, 42, 392-400.

-Oakley, A., Fullerton, D., Holland, J., Arnold, S., France-Dawson, M., Kelley, P., & McGrellis, 5. (1995). Sexual health education interventions for young people: a methodological review. British Medical Journal, 310, 158-162.

-Patrick, D.M. (1997). Chlamydia Control; Components Of An Effective Control Strategy To Reduce The Incidence Of Chiamydia Trachomatis. The Canadian Journal of Human Sexuality, 6, (2), 143-150.

-Sex Information and Education Council of Canada. (1998. June). Common Questions About Sexual Health Education. Toronto: SIECANN

-Social Programs Evaluation Group. (1994). Skills For Healthy Relationships: A Program about Sexuality, AIDS and other STD. Kingston: Queen's University.

-Stodghill, R. (1998, June 15). Wliere'd You Learn That? Time Magazine, 6, 52-59.

-Stout, J.W., & Rivara, F.P. (1989). Schools and Sex Education: Does It Work? Pediatrics, 83, (3), 375-379.

-Thomas, H., DiCenso, A., 7 Griffith, L. (1998). Adolescent Sexual Behaviour: Results from an Ontario Sample. Canadian Journal of Public Health, 89, (2), 90-93.

-Thomas, H., DiCenso, A., 7 Griffith, L. (1998). Adolescent Sexual Behaviour: Results from an Ontario Sample, Part II: Adolescent Use of Protection. Canadian Journal of Public Health, 89, (2), 94-97.

-Wadhera, S., & Millar, J. (1997). Teenage Pregnancies, 1974-1 994. Health Reports, 9, (3), 9-16.

-Walter, H.J., Armstrong, B., & Tiezzi, L. (~995). School- Based Health Care for Urban Minority Middle School Students. Pediatric Adolescent Medicine, 149, 1221-1225.

-Weiler, R.M. (1997). Adolescents' Perceptions of Health Concerns: An Exploratory Study Among Rural Midwestern Youth. Health Education and Behavior, 24, (3), 287-299.

-Woloshyn, V.E. (1995). Using Bloom's Learning Taxonomies To Conceptualize Effective Sexuality Education For Adolescents. The Canadian Journal of Human Sexuality, 4, (3), 155-166.

Reproduced from The Reproductive Health Reports, Spring 1999, vol. 1 no 2. (Yukon Health and Social Services).

A Perspective On Abstinence

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The 1996 decision by the Surrey School Board to ban Planned Parenthood programs and materials from Surrey classrooms demonstrates the degree to which sexual health education remains controversial. Many educators and health care providers are distressed by this development, while a proponent of the Surrey School Board decision declared that *"if young people were taught abstinence they would not need to know about condoms and such ".*

The flaws in this reasoning are obvious, considering that sexual health issues were ranked third in importance as health issues (behind emotional health and drug use) by youth who participated in The McCreary Centre Society's Next Step seminars. The sexual health issues identified by the 600 participants included: unsafe sexual practices; the spread of STDs and AIDS; unintended pregnancy; lack of access to condoms and birth control; lack of confidential services; and a lack of appropriate or effective sexual health education. The youth outlined several recommendations aimed at improving the sexual health of youth. One of these is to provide more in-depth, explicit information within the context of health education in schools.

The perennial controversies and issues connected with the provision of sexual health education are similar to those associated with other domains of human sexuality (for example, sexual preference, birth control, and abortion). With regard to "abstinence", professionals and parents generally agree that the obvious advantage of abstinence is that it avoids problematic consequences, but many also recognize that developmental, social, cultural and personal factors strongly influence the timing of a person's sexual "debut" and capacity to abstain.

Issues and Concerns Regarding Abstinence Only Education

- There is no universally accepted definition of abstinence. The Concise Oxford Dictionary refers to abstinence as "refraining... from pleasure, in the sense of continence or fasting..." With regard to sexual behaviour it is generally understood to mean "no intercourse ", but opinions vary about whether any other sexual behaviours are allowed. For the purpose of this discussion, abstinence will refer to the avoidance of sexual intercourse (and because of the acknowledged

risks, anal intercourse).

- In classroom and family discussions there is a strong need for a balanced approach that recognizes and validates the significant numbers of students who are abstinent, whether by choice or by circumstance, while providing crucial health-preserving information in a non-judgemental manner.
- A focus on promoting abstinence alone would not meet the short-term nor the long-term needs of youth. Most people ultimately begin to have sexual experiences, including intercourse, and for many, school programs offer a once-in-a-lifetime opportunity for access to this important aspect of health education.
- A program focused on abstinence education alone would be as ineffective as would be a

SEXUALITY DECISION-MAKING TREE

Preamble: Brainstorming activities: Reasons why people have intercourse
Reasons why people do not have intercourse

INTERCOURSE

YES **NO**

USE BIRTH CONTROL	**NO BIRTH CONTROL**	**USE CONDOM**	**NO CONDOM USE**	**OPTIONS**
Discussion of Methods: -Withdrawal -Fertiltity Prediction -IUD Barrier Methods: -Contraceptive Foam -Condoms -Diaphragm -Cervical Cap -Sponge/Lea's Shield Hormonal Methods: -Oral Contraceptives -Injection (Depo-provera) Implant (Norplant) Post-coital (morning after pill) Sterilization	(80% chance of pregnancy within a year) OPTIONS Carry the pregnancy Keep the baby -single parenthood -marriage -common-law relationship Relinquish the baby -adoption: Open/closed -foster care Termination of pregnancy (abortion)	Discussion of proper use	Risk of STDs such as: Chlamydia (most common STD) Gonorrhea Herpes Condylomata (genital warts)	Total abstinence: Avoid sexually stimulating experiences; Concentrate on other meaningful and mutual enjoyable activities Negotiate mutually acceptable limits or boundaries for: -Necking -Petting -Mutual or solitary masturbation Enjoy the freedom from having to make all those other big decisions until you are ready and able!

one hour discussion about various birth control methods if it occurs outside the context of comprehensive health education.

Another Approach to Sexual Health Education

A guided discussion of the sexual decision-making continuum is one approach to sexual health education that acknowledges the wide range of sexually-related values and behaviours in a typical classroom setting (See Sexual Decision Making Tree). It offers an opportunity for students to discuss choices and consequences in a theoretical and non-judgemental manner.

As a preamble to the guided discussion, an exploration of various factors that influence sexual decision-making will place the discussion in a reality-based context, will promote insight into human sexual behaviours, and will offer opportunities for correcting misinformation.

Summary

The "forbidden territory" cachet attached to the concept of abstinence may, in fact, be counter-productive, and the developmental need to become autonomous and self-actualizing is unlikely to be met in an "abstinence only" approach to sexual health education. Programs that meet developmental needs respect the right of youth to own and manage their own sexuality; offer complete and explicit information regarding growth and development, reproduction, sexual health promotion, decision-making, and communication skills; encourage access to medical and social support systems that are respectful of the needs of youth; and encourage youth to participate in planning these programs and services.

Adapted from Healthier Youth, vol 7 no 1 1996, McCreary centre Society

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Sexual Health Education

From Canadian Guidelines for Sexual Health Education

Research consistently indicates that positive sexual health outcomes are most likely to occur when sexual health education effectively integrates knowledge, motivation, skill-building opportunities and environmental supports for sexual health. Effective sexual health education involves a combination of educational experiences that will enable:

Acquisition of knowledge

. Information relevant to personal sexual health
. Understanding of individual and cultural differences in beliefs about sexual health
. Information about ways to achieve/maintain sexual health

Development of motivation/personal insight

. Acceptance of one's own sexuality
. Development of positive attitudes toward sexual health-promoting behaviour
. Critical consciousness raising about sexual health issues

Development of skills that support sexual health

. Ability to formulate age-appropriate sexual health goals
. Ability to carry out sexual health-promoting behaviours to reach those goals
. Ability to evaluate and modify one's sexual health plan as necessary

Creation of environment conducive to sexual health

. Developing personal awareness of environmen-

tal influences on sexual health
. Acquiring skills needed to identify and influence the social practices/policies/structures that affect sexual health

To obtain a copy of Canadian Guidelines for Sexual Health Education, contact : Division of STD Control, Bureau of communicable Disease Epidemiology, LCDC, Health Canada, Ottawa, Ontario K1A 0L2
Tel: (613) 957-1342 Fax: (613) 957-0381

Adapted from Healthier Youth, vol 7 no 1 1996, McCreary centre Society

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Support for Sexual Health Education

Kathy Cassels, Directorate of Agencies for School Health (DASH)

Some recent opposition to sexual health education for students comes at a time when national studies continue to report significant numbers of students having sexual intercourse without taking necessary precautions against pregnancy and disease. It doesn't take much understanding to realize that young people do not begin their sexual acrivity with a deliberate plan to experience the negative health consequences associated with their decision.

What could be preventing young people from taking greater precautions? Researchers have told us that adults and youth do not openly acknowledge and discuss their emerging sexuality. Consequently, youth often make risky sexual decisions without consultation with their parents, health professionals or trusted adults.

At a Directorate of Agencies for School Health (DASH) "Living School Health Conference", 48 students participated in a youth plenary session titled "Where the Rubber Meets the Road". The students' message to teachers, parents, counsellors, administrators, health professionals and all others was that youth needs must be priorities for everyone involved in health promotion for children and youth. Students want and need to be involved in helping each other make healthy choices about all aspects of life.

Healthy decisions about sex must represent a balance of the needs of self, significant other, societal expectations, and knowledge. Therefore, rather than limiting student access to sexual health education, local School Boards, Boards of Health, and Social Service agencies, in consultation with parents and youth, should:

- develop comprehensive and explicit policies on sexual health which are based on research findings;
- support implementation of a comprehensive health education curriculum;
- ensure that accessible sexual information, as well as referral and counselling services, be readily available to adolescents;
- promote a climate free of harassment;
- involve students and families in the process.

Enlisting Parents' Support

The probability of these actions meeting with success will depend on a community's ability to enlist the support of the majority of parents who quietly support sexual health education for their children. The following are strategies to enlist the support of parents.

Show Respect for Parents'Beliefs. Parents beliefs permeate a young person's whole life and constitute a powerful frame of support. Do not criticize parents'beliefs. It is best to listen respectfully to parents and try positive approaches.

Understand Parents' backgrounds. We live in a pluralistic society with diverse beliefs and values. Remember, every parent will be unique and different.

Take Issus to a Personal level. Remind parents that sexual curiosity and sexual experimentation are part of the growing process. Help parents remember their own childhood, such as where and when they received sexual information. Is it reasonable to expect today's youth to be any different?

Share experiences. Relate common situations parents experience with their own children and sex education topics. This will provide an opportunity for everyone to relate, laugh together, and not feel attacked.

Increase Awareness of the Benefits. Help parents become aware of the benefits of a comprehensive health education program which included sex education. Sexual Health education not only helps children and youth but it helps pocketbooks, too. A recent study done by the Centers for Disease Control in the United States has examined the cost-benefit ratio of an effective school-based sex education program. They first verified that the program had a positive effect on sexual behaviours. The savings in health care costs were then calculated. A conservative estimate was that for every dollar invested in sex eduation, there is a savings of $5.69 (US) in related health care costs.

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Adapted from Healthier Youth, vol 7 no 1 1996, McCreary centre Society

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Sexual Abuse of Adolescents with Chronic Conditions

Adolescent Medicine Committee, Canadian Paediatric Society (CPS)
Paediatrics & Child Health 1997;2(3):212-3

Contrary to the popular belief that young people with disabilities and serious chronic illnesses are protected from abuse and exploitation, there is evidence that this group of adolescents is, in fact, at an increased risk for sexual abuse. In a British Columbia survey of 16,000 high school students, for example, 38% of those with chronic conditions reported being sexually abused or assaulted, compared with 17% of those without.[1] For purposes of analysis, individuals were defined as having a chronic condition if they met one of three criteria: defined themselves as disabled, missed significant amounts of school for health care, or had a high degree of contact with the health care system. While this statement addresses the issue of sexual abuse, it appears this population is also at an increased risk for both physical and emotional abuse.

Factors which increase risk of abuse

Some adolescents with chronic conditions are particularly vulnerable to abuse as a result of cognitive, sensory, or communicative problems. All too frequently, they may find themselves in situations where they are dependent on the unsupervised care of others in schools, institutions or at home. Societal values and the care systems which exist for these young people may, in addition to their disease or disability-specific characteristics, further increase the risk for abuse.

Societal Factors

Chronically ill and disabled individuals often have little control over decisions directly affecting them, particularly regarding health care and education. This lack of power means both the potential victim and the abuser see persons with chronic conditions as externally controlled, and as such, helpless to stop abuse or mistreatment. With disempowerment comes a lack of voice, a reluctance on the part of individuals and institutions to hear what abused adolescents have to say.

For many ill and disabled people, the social isolation caused by institutionalization, hospitalization, "specialty" education and/or overprotection can push them to the fringes of society, where they are vulnerable to predators, often with little

chance of detection. In many cultures, people with visible disabilities are viewed negatively, creating feelings of unease, pity and contempt, with non-disabled individuals perceiving themselves to be superior. For young people, growing up with a disability or illness can instill feelings of being flawed or bad, causing them to believe that mistreatment or abuse is deserved and so should not be resisted or reported.

Educational Factors

Lack of education also plays a significant role in abuse of this population. All too frequently, youth with chronic conditions receive less formal sexual health education than their peers, primarily as they are considered asexual or unable to understand sexuality. Recurrent absences from health education classes, because of frequent hospitalizations and appointments, may also account for this lack of sexual health instruction. In many instances, the availability of appropriate educational materials is also limited.

Health Care System Factors

For young people with chronic conditions, tolerating and expecting a low level of privacy and a high degree of physical intrusion is a way of life. At times, they may have been forcibly restrained when resisting frequent physical examinations or attention to bodily needs, and therefore have learned not to struggle or protest. Increased exposure to procedures involving sedation or anaesthesia may potentially increase the risk of abuse. If procedures are performed in demeaning or insensitive ways, children may feel they should tolerate the abuse.

Individual Factors

Added to these external factors are limitations imposed by the adolescent's particular condition. A chronically ill youth with generalized weakness, for example, may have difficulty fighting off an attacker. Someone afflicted with mobility problems may be unable to escape such an attack. Other limitations, such as speech and language difficulties, may interfere with the ability to call for help, verbally resist the abuser, or report the abuse. Youth, especially those with limited intellectual abilities, may be manipulated into "consenting" to sexual acts.

Recognition of abuse

Parents, caregivers, and health care workers should maintain a high level of suspicion regarding sexual abuse against this population. Patients who present with STDs, vaginal or anal trauma, unexplained UTIs, and who do not report consensual sexual activity, must be questioned about sexual abuse, using the patient's preferred method of communication (e.g., ASL or Bliss). Other less specific indicators frequently associated with abuse are: unexplained fear of physical or gynecologic examination; avoidance of specific caregivers or caregiving situations; self-mutilating behaviours; sleep disturbances; encopresis; sexualized behaviour; sex experimentation with age-inappropriate partners; sexually abusive behaviour toward others; eating disorders; running away; and somatic complaints with no organic cause.

Disclosure

To facilitate and ease the process of disclosure, questioning of patients should be conducted according to their preferred method of communication. The medical community should be aware of current concerns with regard to false allegations that have been made through "facilitated communication." The formal process of disclosure must conform to legal and reporting standards. In instances where the patient has a communication disorder, it may be difficult to find an interpreter skilled both in interpretation and sexual abuse issues. In communities where there are no such qualified individuals, physicians should promote the creation of educational programs to train them. Also important is identifying individuals to whom children and youth with chronic conditions can turn for help if they are abused.

Prevention

Institutional

Physicians should advocate for institutional policies, including:

- thorough screening and monitoring of employees and volunteers;
- chaperoning of physical examinations and procedures;
- supervision of outings;
- patient privacy; and

- investigation and reporting of allegations of sexual abuse.

In addition, parents should be advised to inquire about these institutional policies and to conduct their own intensive screening when hiring private caregivers. Those working with teens with chronic conditions should also understand the full range of normal sexual activity (including masturbation) for this age group, and should respect the privacy requirements of adolescents.

A review of the available material makes it clear that proper training of licensing officers in issues of sexual abuse is essential. Physicians can be involved in the development of resources for this training.

Educational

Adolescents with chronic conditions, parents, and caregivers place high priority on access to appropriate information about sexuality. This includes information specific to different developmental levels and disabilities with regard to personal rights, safer sex, and sexual abuse, and could also include a component on assertiveness training and self-defense. Physicians could have a list of resources available for parents on recognizing their children's own expression of sexuality and on their vulnerability to abuse.

Physicians

Respect for privacy during physical examinations is imperative. Physicians have an excellent opportunity to demonstrate this respect by draping patients and allowing them to stop the examination if they feel uncomfortable. Attending physicians should also model sensitive, respectful physical examination techniques to trainees. In addition, physicians should encourage adolescents with chronic conditions to take a more active role in decision-making by helping them feel less dependent and more powerful in determining their own care. To achieve this, a happy balance between cooperation and normal demands for autonomy needs to be encouraged. Excessive reliance on rewards and punishments is not wise, as it may undermine patients' ability to recognize and resist abuse.

Conclusion

Paediatricians are in an ideal position to play a significant role in preventing sexual abuse of children and youth with disabilities. Over the years, they establish long-term relationships with the families of children and youth with chronic conditions. It is imperative, therefore, that paediatricians, as part of their mandate to educate and advocate for the welfare and well-being of children and youth, assume the responsibility to start early in providing anticipatory guidance regarding sexuality, empowerment and abuse.

References

1. Peters L, Murphy A. Adolescent Health Survey. McCreary Centre Society, Province of British Columbia. 1993

Kick Butt for Two

Mothers who smoke and children who are exposed to smoking and ETS (Environmental Tobacco Smoke) are at risk of developing multiple health problems. Pregnant adolescents have the highest relative risk of giving birth to a low birth weight infant. *The Teachable Moment* (1992), an Ontario wide study developed by St. Mary's Home, revealed that 56% of maternity home clients smoked during pregnancy and only 19% quit smoking while pregnant. These findings indicated a much higher prevalence of smoking in this already high risk population as compared to smoking rates of the general public.

Kick Butt for Two, which began in 1995, is a program for young single parents and pregnant teens. It was developed by the Young/Single Parent Support Network and funded by Health Canada. It is now managed by Brighter Futures for-

Children of Young Single Parents , a project of the Network.

Kick Butt for Two allows program participants to make an informed choice of goals: abstinence or moderation. The program assists clients to develop effective, alternate stress reduction and coping strategies to prevent relapses. By learning and implementing new behaviours, coping skills and cognitive restructuring, clients gain problem-solving skills and positive self-images. New coping skills emphasize self-care and non-destructive methods of achieving personal goals. Program participants play an active role in the program development, delivery and evaluation.

The **Kick Butt for Two** program has four goals:

- smoking prevention
- smoking reduction
- smoking cessation
- protection of non-smokers.

These four goals have been operationalized into five objectives:

- encourage the client population to quit or reduce smoking
- improve the coping skills of clients
- provide on-going support and follow-up
- protect the health and rights of non-smokers (including fetuses, infants and children)
- increase the knowledge of clients about dangers of smoking for themselves and their children.

The core sessions of the program are:

- Introduction and orientation - getting to know each other and designing the rest of the sessions.
- Preparing to reduce or quit
- Reduce or Quit Day
- Coping with quitting
- Preparing for post-group temptations.

The guiding philosophy of the program supports the concept that success is not measured by quitting alone. Success can be attained by reducing, having a smoke-free home, protecting children from second hand smoke, changing smoking behaviour or quitting smoking. The incorporation of this philosophy into each session avoids setting up participants for failure. They know up front what is meant by "success" and are therefore provided with multiple opportunities to achieve success.

Kick Butt for Two has demonstrated positive changes in both smoking behaviours and attitudes of clients and staff. The program has reduced the number of pregnant and parenting adolescents who smoke as well as the number of children exposed to ETS. It fills a void in smoking cessation programs designed for teens by targeting at risk pregnant and parenting teens with very few resources. Developing a program specifically for pregnant adolescents and young/single parents allows for focus on specific issues relevant to this client group.

A *Kick Butt for Two Facilitator's Guide* has been developed and is available to others who wish to deliver the program. It includes a sample Public Service Announcement. It is available in either French or English, at the cost of $35 (plus $5 for shipping and handling).

Kick Butt for Two /
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Ottawa ON K1K 3K1
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Anger/Stress: The H.E.L.P. Toolbox

(Healthy Emotions, Loving Parents)

In 1994, the Young/Single Parent Support Network identified the need to address the issues of anger and stress and how they affected the lives of young/single parent families. The development of an anger management program was incorporated into the workplan of the Health Canada CAPC (PACE, Santé Canada) project, Brighter Futures for Children of Young Single Parents, and an 8 week program was developed and piloted in 1995.

After two years of piloting the new program, an update was initiated. The program needed to incorporate more time for participants to practice new skills being learned, and include sessions related to coping and self-esteem. Lengthy waiting lists confirmed the popularity of the program. Program participants recommended unanimously that the program be longer than 8 weeks.

Funds were applied for and received from Health Canada's Population Health Fund for this initiative. The Young/Single Parent Support Network and its Brighter Futures project established an Intersectoral Advisory Committee with representatives from Health, Education and Social Services to oversee the professional development of the program. This committee was unique as it brought together representatives from a variety of local agencies to work together and finalize the manual and workbook. These agencies included the Ottawa-Carleton Health Department, community health centre representatives, Rideau High School, Algonquin College, the Children's Hospital of Eastern Ontario, Probation Services, the Children's Aid Society and several others. Two participants of the Brighter Futures project were key members of the committee.

The ***Anger/Stress H.E.L.P. Toolbox*** program provides participants with some of the tools and skills for coping with everyday stresses. It is carefully designed to build awareness and to reinforce positive attitudes and behaviors in key areas:

Anger
Self-Confidence
Coping
Parenting
Stress

The program is organized into a series of five modules (one for each area), with each module consisting of four 2 hour sessions. Participants are able to choose which of the modules they want to complete. As each module is only 4 weeks long, the waiting list for new participants should not exceed 3 weeks. The emphasis of the ***Anger/Stress H.E.L.P. Toolbox*** is on education and prevention.

The program is designed to be led by an experienced facilitator – ideally someone who has had formal training in facilitating groups. However, the kit also contains useful information for the less-experienced facilitator who is prepared to take on the challenge by "learning on the job".

The ***Anger/Stress H.E.L.P. Toolbox*** program was originally developed for young single parents but can be adapted to suit the needs of a variety of groups. It can be offered in various settings, from the more traditional classroom to a living room setting in a drop-in centre or group home. Little special equipment is required. *The Facilitator's Planning Guide* at the beginning of each session provides a list of any equipment and supplies that will be needed.

The manual consists of three segments:

The Introduction, which includes an overview of the program and of basic facilitation skills;
The Facilitator's Guide, which includes a list of necessary materials for each session, as well as tips and red flags for managing difficult situations; and,
The Participant's Workbook which allows group members to have a record of their work for each module. This section is easy to photocopy.

The manual is available at a cost of $100.00 (plus

$5.00 for shipping and handling).

As part of the introduction to the manual, a one day facilitator training workshop has been developed and was piloted in June 1998 at two Eastern Zone CAPC sites for front line staff and community partners. *Brighter Futures* hopes to offer future training workshops to interested sites. A French version of the program has also been produced.

For more information on ***Anger/Stress: The E.L.P. Toolbox***, please contact:

Brighter Futures for Children of Young Single Parents
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Emergency Contraception

Adolescent Medicine Committee, Canadian Paediatric Society (CPS)
Paediatrics & Child Health 1998;3(5):359-361

Emergency contraception has been in use in North America for over two decades. Often referred to as the morning-after pill, emergency contraception is an effective way to prevent pregnancy after unprotected intercourse. Despite this, many teenaged girls are not aware of its existence or do not know how to obtain it. The term morning-after pill should be avoided because this name implies that it can only be used the next day. Young women may not present for emergency contraception because they think it is too late.

Because neither method of emergency contraception in use will work if implantation has already occurred, these methods are not to be considered as abortifacients.

Emergency Oral Contraception

The most commonly used method is called the Yuzpe method (1) and uses combined high dose estrogen-progestin pills. It is postulated that hormonal emergency contraception works by preventing implantation of a fertilized ovum through changes in the endometrium (2), delaying ovulation or interfering with corpus luteum function (3). Studies indicate that hormonal emergency contraception is very effective (4). Without intervention, eight women in 100 will become pregnant after a single act of unprotected intercourse during the middle two weeks of the menstrual cycle. With emergency contraception, about two women in 100 will become pregnant.

Who can use emergency contraception?

Young women who have attained menarche and have had consensual or nonconsensual unprotected sexual intercourse can be given emergency contraception (Table 1). Adolescents can take emergency contraception if they have no history of stroke, estrogen-sensitive tumour or thrombophlebitis, active liver disease or untreated hypertension. If estrogens are contraindicated (a rare event in adolescents), progestion-only pills can also be considered. A copper-coated intrauterine contraceptive device (IUCD) is a highly effective method of emergency contraception that can be used within 120 h of intercourse. However, it is not usually available in paediatricians' offices or emergency rooms. If it is felt that an IUCD is the only option, prophylactic antibiotic coverage for both gonorrhea and chlamydia should be considered. The IUCD can be removed during or after the next period.

When to take emergency contraception?

Emergency contraception can be used at any time during the menstrual cycle. Most research is based on emergency contraception used within 72 h of intercourse, but it has been suggested that emergency contraception might be effective for up

to five days (5). If a young woman presents after three days, emergency contraception can be tried up to 120 h after intercourse, as long as the young woman is informed that it might be less effective. It has been shown that the timing of the initial dose (within the first three days) is not essential (6).

How to prescribe emergency contraception?

Paediatricians, family physicians and others who care for teens should consider having emergency contraceptive pills (ECP) available in the office (Table 2). Some teens will have difficulty getting a prescription filled, and may not be able to manage a visit to both the physician's office and the drugstore.

The most commonly used emergency contraception regimen is two norgestrel-ethinyl estradiol (Ovral, Wyeth Ayerst) tablets given with 50 mg dimenhydrinate initially; the entire dose is repeated 12 h later. The timing of the second dose is important. For practical reasons, the first pills can be delayed so that both doses are given during the teen's normal waking hours. If the second set is missed, the entire course must be repeated.
If norgestrel-ethinyl estradiol is not available, four lower dose oral contraceptive pills, such as norgestimate-ethinyl estradiol (Cyclen, Janssen-Ortho or TriCyclen, Janssen-Ortho [darker blue pills only]) or levonorgesterel-ethinyl estradiol (Triphasil, Wyeth-Ayerst [yellow pills only]) per dose, can be used instead. However, these have not been evaluated in clinical trials.

Short and long term effects

Nausea and vomiting are frequent side effects when ECPs are given without antiemetics. To increase the efficacy of the antiemetic, it can be given 1 h before the hormones. Giving the antiemetic after nausea occurs is not helpful. Adolescents who vomit more than 1 h after taking a dose do not need to retake those pills because absorption has occurred, and the nausea and/or vomiting are likely to be a result of treatment. Breast tenderness, headaches and dizziness are less common side effects of ECP.
Physicians should reassure adolescents that their next period may be either early or delayed, but will probably occur within 21 days of treatment.

Given that no teratogenic risk has been found with pregnancies that occur while women are taking high dose birth control pills, it is unlikely that there is an increased risk of birth defects in babies born to young women who have taken emergency contraception during pregnancy. Pregnancies that occur do not need to be terminated because emergency contraception was used.

For adolescents taking medications that induce liver enzymes, the dose should be increased to three Ovral, taken twice.

Liver Inducing drugs: Carbamazepine, Phenytoin, Barbiturates, Isoniazid, Rifampin, Metronidazole, Tetracycline, Benzodiazepines.

Clinical Practice points

History and physical

Adolescents may come specifically for emergency contraception, or indication for emergency contraception may be discovered during routine history taking. In either case, the date and nature of the last menstrual period should be elicited, as well as when she has had intercourse since that period. She should also be asked about her history of contraceptive use and history of contraindications to oral contraceptives.
Physical examination should include determination of blood pressure. Pelvic examination is indicated if the last menstrual period was unusual and the physician suspects that the patient is pregnant, has concerns about sexually transmitted diseases or if an IUD will be inserted. If a pelvic examination is performed, specimens should be taken for chlamydia and gonorrhea cultures.

Discussion with the teen

After determining whether emergency contraception is indicated, explain the method to the adolescent and the possibility of failure of the method. Explain that the next period might be early, on time or late. Discuss her options should she become pregnant. Explain that if she is going to have intercourse before her next period, she should use a barrier method with a spermicide. If the patient is taking emergency contraception because she has missed birth control pills, she can start a new pack of pills the Sunday after she takes emergency contraception.

Because emergency contraception is not 100% effective, follow-up is important. Teens should be advised to return for a pregnancy test if their next period is more than one week late or if the next period is unusual in any way. They should also return if they have heavy bleeding or pain. An appointment can be scheduled for one week after the next expected menstrual period. This appointment is an opportune time for counselling around the teen's choices about her sexual activity, contraception, sexually transmitted diseases and safer sex. The adolescent can be praised for coming in for emergency contraception, and a suggestion made that she consider another method of preventing pregnancy. If she chooses oral contraceptives, pills and condoms can be given to her with instructions.

Summary

Emergency contraception is an effective way to prevent a pregnancy from occurring following unprotected intercourse. Paediatricians and family physicians should have oral emergency contraception available in the office to give to teens at risk of unwanted pregnancy.

References

1. Yuzpe AA, Lancee WJ. Ethinylestradiol and dl-norgestrel as a postcoital contraceptive. Fertil Steril 1977;28:932-6.
2. Rowlands S, Guillebaud J. Postcoital contraception. Br J Fam Plan 1981;7:3-7.
3. Ling WY, Wrixon W, Acorn T, et al. Mode of action of dl-norgestrel and ethinylestradiol combination in postcoital contraception. III. Effect of preovulatory administration following the luteinizing hormone surge on ovarian steroidogenesis. Fertil Steril 1983;40:631-6.
4. Trussell J, Stewart F. The effectiveness of postcoital hormonal contraception. Fam Plan Perspect 1992;24:262-4.
5. Grou F, Rodrigues I. The morning-after pill – How long after? Am J Obstet Gynecol 1994;171:1529-34.
6. Trussell J, Ellertson C, Rodriguez G. The Yuzpe regimen of emergency contraception: How long after the morning after? Obstet Gynecol 1996;88:150-4.

TABLE 1: Unprotected intercourse and its equivalents
Totally unprotected intercourse
Ejaculation onto genitals
Coitus interruptus
Condom breakage
Intrauterine contraceptive device expulsion or midcycle removal
Spermicide alone at midcycle
More than three missed pills or pills started more than two days late
Missed minipill within 48 h
Sexual assault (not on oral contraceptive pill)
Condom alone or spermacide alone plus recent teratogen exposure

TABLE 2: Emergency contraception pills kit contents
Two envelopes containing two norgestrel-ethinyl estradiol (Ovral, Wyeth Ayerst) and one antiemetic each can be marked with time to take
Information sheet
Number to call if concerns
Appointment card for follow-up

Advice for Adolescents and Caregivers

Emergency contraception

You can become pregnant if you have unprotected intercourse even just once! Maybe you tried to protect yourself but the condom broke. Perhaps you were taking birth control pills but missed two or more of them, or you usually get a birth control shot every three months but missed your last shot. Or you thought that if your boyfriend didn't ejaculate inside you, you couldn't get pregnant. Possibly in the heat of the moment, you just didn't think about birth control. Maybe you were sexually assaulted.

If you have had sex in the past few days, it isn't too late to prevent a pregnancy using emergency contraception. Although sometimes called the morning after pill, emergency contraception can be used up to three days after intercourse (even up to five days after).

What are emergency contraceptive pills?

Emergency contraceptive pills (ECP) are high dose birth control pills. They aren't 100% effective, but they do reduce greatly the chance of getting pregnant

What if I am already pregnant?

Emergency contraception will not make your pregnancy go away. It is not an abortion pill. However, if you find out after you have taken it that you are pregnant, don't worry. Many women have taken estrogen and progestrone (the hormones in ECPs) in early pregnancy without harm to the fetus.

What are the side effects of emergency contraception?

The most common side effects of ECPs are nausea and vomiting. A pill to lessen the symptoms is given with the ECPs, called gravol. If you throw up within an hour of taking the first dose of ECPs, you need to repeat it. Some women will have sore breasts for a few days, and others have complained about headaches. These problems are much less common.

How do I take it?

You will be given three pills (two are emergency contraception, one is antinausea, gravol) to take immediately, and three pills to take 12 hrs later. If you will be unable to take them in 12 hrs, you can delay your first dose so that you can take the second dose 12 hrs later. For instance, if it is 10 o'clock at night, and at 10 tomorrow morning you will be in class, you can wait until midnight to take the first pills and take the next ones at lunchtime. The second dose of pills is very important.

- Do not drive or drink any alcohol for the next 24 hrs after the second set of pills. The medication that you take to prevent nausea may make you feel drowsy.
- Do not take any extra birth control pills. They will not decrease your chance of getting pregnant and will likely increase nausea and vomiting.

When will I get my period?

Some women get their period a few days after taking emergency contraception. Others have it when they are expecting their next period or even a bit later. If you haven't started a period within three weeks of taking the ECPs, you should have a pregnancy test.

How long will emergency contraception protect me?

Do not count on emergency contraception to protect you if you have unprotected intercourse again. You should use condoms and spermicide if you are going to have intercourse. Talk to your doctor about starting a reliable form of birth control.

Why not just use emergency contracep-

tion each time I have sex?

Emergency contraception is not as good at preventing pregnancy as other methods of birth control such as birth control pills taken regularly or birth control shots. In addition, you should be using condoms to prevent sexually transmitted diseases like AIDS.

Where can I find more information?

Your paediatrician, family doctor or local public health department will have more information about this. On the Internet, you can try: www.opr.princeton.edu/ec/

This information should not be used as a substitute for the medical care and advice of your physician. There may be variations in treatment that your physician may recommend based on individual facts and circumstances.

Depo Provera: A Contraceptive Alternative For Adolescents

Adapted from: Charbonneau L. MD, FRCPC, Baltzer F. MD, Quiros E. MD,FRCSC.
Depo Provera A Contraceptive Alternative For Adolescents.
The Canadian Consensus Conference on Contraception. Journal SOGC 1998, Bérubé J.
Le depo-provera : une alternative intéressante. Le Médecin du Québec, mai 1998.

Depo-provera : clinical tips

Depomedroxyprogesterone acetate (DMPA) is an injectable progestin that has been used as a contraceptive throughout the world in the last 30 to 35 years. Political, cultural and scientific reasons prevented its widespread use in North America until it was approved by the American Food and Drug Administration in 1992. In Canada, in 1997, the Health Protection Branch has approved depo-provera as a first choice contraceptive option. Recent reviews in the United States have shown that for many years, physicians have considered DMPA as a preferred method for certain populations, notably in young women with severe mental or physical deficiencies. The Society of Obstetric and Gynecology of Canada has recommended it in a policy statement in 1993 and has included depo-provera in its Canadian Consensus Conference on Contraception in 1998.

Depo-provera work by suppressing ovulation. It also renders cervical mucus impermeable to sperm and induces endometrial atrophy. It is injected in the deltoid or gluteal muscle. The dosage for immediate contraceptive efficacy is l5O mg and it is given on the first five days of the menstrual cycle or of the post partum (no adverse effect on lactation) or immediately following an abortion. Maximum contraceptive effect is achieved within 24 hours. It is repeated every 11 to 13 weeks, preferably every 12 weeks.

The action of DMPA is reversible but there is a variability in return of ovulation. At six months after last injection, 50% of women will have returned to regular menses; 90% at two years. DMPA offers contraceptive protection of 99.7 percent when given at 12 week intervals. An injection cost between 32-45$. Once a dose is drawn from a newly opened multidose bottle, the rest of the bottle has to be used within 9-12 months.

According to the SOGC policy statement, there is no indication that women taking DMPA have higher risks of thrombosis and a history of thrombophlebitis or thromboembolism is not a contraindication to DMPA.

Indications of DMPA:

- When pregnancy is absolutely contraindicated (risks for mother or fetus)
- When estrogens are contraindicated or not

tolerated
- After giving birth and nursing
- Women over 35, who smoke
- Women taking medication that interacts negatively with oral contraceptives (e.g. phenytoin)
- Women who may benefit from amenorrhea (e.g. endometriosis, severe dysmenorrhea, menorragia)
- Failure and compliance problems with other methods
- Women with accompanied migraine headaches
- Women with epilepsy
- Women with sickle cell disease

Contraindications to DMPA

- Known or suspected pregnancy
- Undiagnosed vaginal bleeding
- Known or suspected breast cancer (no proof of danger)
- Active thrombophlebitis, thromboembolism or past history of thromboembolism, or cerebral vascular disease (indicated in CPS, but SOGC does not suggest so)
- Active liver disease
- Known hypersensitivity to the product or one of its componants.

Non contraceptive benefits of DMPA:

- reduces anemia by decreasing blood loss
- reduce dysmenorrhea and premenstrual syndrome
- reduce pelvic inflamatory disease
- may increase volume and duration of lactation in post-partum
- decreases ovarian and endometrial cancer
- improves sickle cell anemia by inhibiting intravascular sickling and increasing survival of red blood cells
- decreases risk of ectopic pregnancy
- reduces pelvic inflammatory disease and candidal vaginitis
- is effective in relieving symptoms of endometriosis
- may reduce seizure frequency in epileptic women

Side effects of depo-provera

- Amenorrhea after one year (50%)
- Irregular bleeding
- Weight gain : 2.5 kg after a year
- Weight loss (20%)
- Headaches (17%)
- Mood changes (11%)
- Decrease intestinal motility (11%)
- Hypoestrogenism: dyspareunia, etc (8%)
- Nausea (3%)
- Acne (1%)
- 4-7% of Bone density reduction (not significant-reversible)

Counselling and follow-up

The adolescents being prescribed depo-provera should receive information on all the side effects. A pregnancy test could be considered before the first injection.

Treatment of irregular bleeding

The major side effect of depo-provera is irregular bleeding. If this is the case :

- Reassure the adolescent
- Check the hemoglobin if important bleeding
- Look for STD
- Decrease the interval between injection from 12 weeks down to 8 weeks
- Increase the dose to 175, 200 or 225 mg

Also, high dose of Non Steroids Anti-infalmatory can be prescribed (motrin 800 mg T.I.D. for 5 days or 400 mg Q.I.D. for 7-14 days); they decrease bleeding by 40%. Estrogens can be prescribed : premarin 0.625 to 1.25 mg for 7-21 days.

Management of missed appointments

It can happen that the adolescent will miss her appointment for injection. The injection is good up to 13 weeks. If the adolescent shows up after 14 weeks and had protected intercourse since the 14th week, depo provera can be administered. She should wait 7 days for contraceptive efficacy and a pregnancy test could be done 3 weeks later.
If the adolescent shows up after 14 weeks and hashad unprotected intercourse since the 14th wwek, a pregnancy test is performed, offer post-coital contraception if indicated, wait 14 days, perform a second pregnancy test, if negative, administer depo-provera; after 3 weeks, another pre-

gnancy test could be performed if fear of pregnancy persist.

Depo-provera : A Research in Adolescents

Charbonneau L. MD, FRCPC, Baltzer F. MD, Quiros E. MD, FRCSC.

Contraception in the adolescent population is considered an important public health issue. The options for preventing pregnancy are not well suited to all adolescents and as health care workers who face pregnant adolescents in our daily practice, we are prepared to consider any method that may improve compliance. In 1981, Fraser had already described the advantages of DMPA that could make it an appealing choice for teenagers, such as long action following a single injection, simple to administer, independent of coitus, freedom from "fear of forgetting ", which may occur with the pill, no estrogen side effects or complications, highly effective contraception and amenorrhea that may be a health benefit.

In most reviews of experience with DMPA and the implant Norplant in teenagers, the authors do not evade questions on the ethical acceptability of these methods and acknowledge the fact that time and experience will provide more answers. However, the safety and effectiveness of DMPA are well-known and we believe that there are, here and now, teenagers to protect and any number of pregnancies that are prevented or delayed becomes a good enough reason to offer a long term "passive" contraceptive.

Material and Method

The Adolescent Program of the Montreal Children's Hospital and La Clinique des Jeunes Saint-Denis, a community based youth clinic in Montreal, offer contraceptive services to teenagers. A consultation for birth control includes a complete history, physical examination, screening for sexually transmitted disease, counseling on sexuality and contraception. The counseling provided by a registered nurse or a physician gives background education in the current contraceptive methods, their effectiveness, routes of administration, side effects and cost. The teenager is also assessed as to her lifestyle, her place in the family and her ability to take charge of her life and health. Confidentiality is respected when required by the adolescent and most of the time samples of birth control pills provided by the pharmaceutical companies are given in order to increase chances of compliance. DMPA injection is provided by both institutions and given free. The nurses are available for further information and advice on the phone during the clinics' working hours and will see adolescents who present without an appointment for concerns about birth control.

Both clinics also provide first trimester abortion services to adolescents who are patients of the clinics or referrals from other adolescent services, private physicians and school based nurses.

Table 1:
Profile of patients given DMPA N : 151

. Mean age at first injection	16.7 years
. Parity (GPA)	GO: 48 (~%) Gl: 63 (41%) (P1 : 15; A1 : 48) G2-4: 40 (26%)

From 1993 until February 1996, one hundred and fifty-one female adolescents ages 14 to 19 were prescribed DMPA (Table 1). Only nine of them were given the injection because of mental retardation. The rest chose DMPA mainly after giving birth, going through an abortion or when compliance to oral contraception was a problem (Table 2).

Table 2:
Reasons to choose DMPA (more than one possible): N:180

. Pregnancy	93 (50%)
. Non compliance to contraceptive	

Method	61 (30%)
. Side effects to oral contraception (OC)	19 (10%)
. Handicapped	9 (5%)
. Confidentiality	6
. Absolute contraindication to OC	1

Results

A review of the files of the 151 patients who opted for DMPA from 1992 to February 1996 shows that 61 (40%) were still using the method; we must point out however that with our growing experience, we have used it more often in the last year so that many had received only one or two injections by the time this review was completed. Therefore, in our study, a very small number of patients have taken up to six (6) injections and the average number of injections is 2.6.

Table 3.
Reasons for discontinuing DMPA (more than one possible) N : 105

. Irregular bleeding	28 (27%)
. Weight gain	15(14%)
. Other side effects*	13 (12%)
. Did not need contraception	12 (11%)

* These included small numbers of headaches, depression, nausea, acne.

Table 3 lists the main reasons given by the adolescents to discontinue DMPA. It is important to note taht 37 (35%) simply did not show up for appointment. Other reasons include: desire for pregnancy, fear of the product and being closely watched by the parents who would be likely to question the irregular bleeding pattern or the amenorrhea. Table 4 list the side effects on the first 47 adolescents on depo-provera in our series.

Table 4 :
Side effects in adolescents on DMPA
N= 47

. Spotting	12 (32%)
. Amenorrhea	6 (16%)
. Menorrhagia	6 (16%)
. Continuous bleeding	3 (8%)
. Headaches	3 (8%)
. Weight gain	3 (8%)

In 47 files, information was available as to the adolescents' satisfaction with the method. Thirty-two (32) claimed they were satisfied, citing the ease of use of DMPA as the main reason. However, this did not significantly correlate with compliance.

Discussion

This review has allowed us to illustrate two major drawbacks to the use of DMPA: the failure to recognize the product as an available method for all women and the choice of patients to whom it is now prescribed. DMPA is not yet a well-known and widely used contraceptive method in Canada and it cannot be offered as a first choice for birth control. Therefore, many family planning clinics and physicians in private practice are not familiar with it and do not venture to recommend it. Some of our patients have had problems finding a clinic who will agree to provide the injections along with the required infomation and counseling.

DMPA has side effects that influence a woman's daily lile, her sex life and many of her beliefs and fears. She may have been told that any irregular bleeding can be a sign of cancer, that no bleeding at all means pregnancy or an accumulation of poisonous material inside the body. Intercourse when bleeding is considered by many women and men as unhygienic, uncomfortable or prohibited by religion. Adolescents are especially vulnerable to these disturbances.

Therefore, health care providers have to be familiar with these aspects of the method and they must feel comfortable in addressing these issues with a woman. Handing out written information and being available for repeated counseling are important ways of insuring compliance.

In our review, *irregular bleeding* was responsible for the 50 percent discontinuation rate and possibly more since we have no information on 35 percent of our adolescents who did not show up for subsequent injections. This compares with Siqueira's review of 194 adolescents where 44 percent were still taking the injections after one year and 25 percent after two years. Their major reason for discontinuing the method was also irregular bleeding. In Harel's study of 35 patients who stopped the method, 60 percent cited irregular bleeding as the first reason.

Disruption of the menstrual pattern, both the irregular bleeding and the amenorrhea usually observed in about half of the patients within the first year of use proved to be our main problem with such a young population. Most of them would not be compliant to relieving bleeding with adding a cycle of birth control pills, conjugated estrogen (1.25mg X 14 days) or an estrogen patch to alleviate the symptoms. Those who reached amenorrhea rapidly tended to be more satisfied. Even though all girls were repeatedly informed of these side effects and the relative benign aspect of them, most had trouble coming to terms with this, especially since DMPA is still thought by many to be experimental or illegal.

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Innovations in Mental Health Promotion: Youth Net/Réseau Ado

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Canadian youth are at a disturbingly high risk for mental illness and mental health problems (1). Furthermore, research has revealed that death by suicide remains the second most common killer of youth in Canada. and that adolescents are the only age group where the rate of suicide is on the rise. It appears that, depending on the methods used. about one of five Canadian children or adolescents has a significant mental health problem or psychiatric disorder (2). The Canadian Youth Mental Health and illness Survey (3) showed that main-stream Canadian youth have significant concerns regarding their own mental health, that they are largely dissatisfied with existing mental health services. and that they are most willing and comfortable to interact among themselves around such issues.

The above findings were the impetus for the development of a regional (Eastern Ontario and Western Québec) youth mental health promotion and mental illness prevention program. Youth Net/ Réseau Ado (YN/RA). YN/RA is a bilingual program run by youth, for youth. that strives to promote awareness and increase communication among youth regarding mental health and illness issues, as well as to empower youth to develop connections with a safety net of 'youth4riendly' professionals. Through focus groups, run by young (aged 18 to 25 years old) trained facilitators, YN/RA provides a forum for open discussion of mental health and illness. Its goals are to destigmatize mental illness while promoting good mental health; to facilitate the early identification of mental health concerns and connection to services; and to respect what youth are saying to make present mental health services more youth appropriate.

YN/RA has been developed as an innovative way of combining both macroscopic and microscopic approaches to mental health intervention with youth. At a macroscopic level, youth are connecting with youth to discuss mental health and illness openly. YN/RA also encourages young peo-

ple to create their own mental health promotion and mental illness prevention initiatives. Such Initiatives might include youth-focused support groups concerning depression, self-esteem or relationship issues; a mental health board game; question and answer boxes; or newsletters (ie, *YOUTH FAX. FAX ADO).* YN/RA is available to assist with the implementation of such youth-generated programs and offers training to interested youth. YN/RA also supports the translation of traditional and formal mental health and illness information into youth-friendly language or 'youth speak'.

At a microscopic level, YN/RA links adolescents in the most acute need with professionals and more traditional mental health services through a youth-friendly and community-based program. These efforts include screening and identification of youth in focus groups who may be at risk of suicidal behaviour, with strict adherence to a crisis protocol when such situations arise. By showing respect for and being attentive to the youth perspective, YN/RA has gained the trust of youth. This enables YN/RA to serve as the bridge to assist youth with making that first step of reaching out to more formal supports when necessary. An overall objective of the program is to demystify mental health and illness for youth while educating professionals about the flexibility and sensitivity required to serve all youth better. Both the macroscopic and microscopic components of YN/RA are supported by an infrastructure of mental health professionals.

Friends, parents and teachers are usually the first to recognize that an adolescent may be having significant problems (see Table 1 for warning signs of mental illness or suicide).

YN/RA continues to offer focus groups throughout Eastern Ontario and Western Quebec. Youth have provided very positive feedback on the YN/RA philosophy and programs. More formalized evaluation of the impact of this program at both an individual and a community level is being developed. As well. plans to replicate the YN/RA model through satellites in 10 different communities across Canada are underway. We truly believe that, as stated so well in *The Health of Canada's Children: A CICH Profile*: "It is our responsibility to work with youth to find ways to maintain, enhance and improve their health (including mental health). Not only do our approaches have to move with the times and the changing society, but also with the attitudes and perceived needs of and by our youth (1)."

YN/RA seeks to provide the opportunity for youth to voice their concerns and to respect the role that youth will play in the evolution of mental health services.

References

1. Hanvey LH. Avard D. Graham I. Underwood K. Campbell J. Kelly C. The Health of Canada's Children: A Canadian Institute of Child Health (CICH) Profile. 2nd edn. Ottawa; CICH, 1994.
2. Offord DR. Boyle MH. Fleming JE. Munroe Blum H. Rae Grant NI. Ontario Child Health Study. summary of selected results. Can J Psychiatry 1989:34:483-91.
3. Davidson S, Manion 1G. Facing the challenge; Mental health and illness in Canadian youth. Psychol Health Med 1996; 11:41-56.
4. Davidson S. Manion 1G.1994. Youth and Mental Illness. Ottawa Canadian Psychiatric Association. 1994. (Brochure)

TABLE 1: Warning signs for mental illness or suicide

Behavioural signals

- Marked deterioration in school performance or increase in absenteeism
- Excessive use of alcohol and/or drugs
- Marked changes in sleeping and/or eating habits
- Consistent aggressive or nonaggressive violations of rights of others: opposition to authority, skipping school, thefts, vandalism, etc
- Withdrawal from friends, family and regular activities Poor appetite, difficulty sleeping
- Frequent outburat of anger and rage
- Unusual neglect of personal appearance
- Uncharacteristic delinquent, thrill seeking or promiscuous behaviour
- Occurrence of previous suicidal gestures or attempts
- Self-mutilation
- Planning for death; making final arrangements; giving away favourite possessions

Physical/psychological symptoms

- Many physical complaints Iheadaches, stomach aches)
- Depression shown by continued, prolonged negative mood and attitude or thoughts of death
- Low energy level, poor concentration, complaints of boredom
- Loss of enjoyment in what used to be favourite activities
- Intense fear of becoming obese with no relationship to actual body weight
- Marked personality change
- Sudden cheerfulness after prolonged depression may be a manifestation of relief because a decision has been made

Verbal signals

- Comments about feeling rotten inside, wanting to end things, and soon no longer being a problem for others
- Nihilistic comments such as "life is meaningless", ."filled with misery", "what's the use of it all?"
- Verbal or written threats

Adapted from reference 4. It should be noted that there is a group of individuals who may show no signs or very subtle signs before their suicidal behaviour.

Suicidal Behaviour in Youth: Risk and Protective Factors

Ian Manion PhD C Psych, Simon Davidson MB BCh FRCPC

Suicide is the second leading cause of mortality among Canadian youth, surpassed only by accidental death. All who work with youth must know the risk factors, warning signals, and possible precipitating events or stressors that can contribute to suicidal thoughts and/or gestures. Paediatricians, family doctors and adolescent health specialists are in a position to screen for risk of suicide in the same way that they might assess other types of health concerns or risk behaviours. The Table below outlines some key issues that anyone working with youth should notice to increase the likelihood of identifying a youth at risk and to decrease the risk of suicidal behaviour. These guidelines have been developed from a review of the clinical literature on youth suicide and the authors' clinical experience working with youth, and have been adapted by the Youth Net/Re'seau Ado Program, a mental health promotion program run for and by youth, which regularly screens for sui-

cidal risk as part of its communitybased activities with youth.

A vital element in looking for risk factors and warning signals is identifying a significant change in a youth's behaviour from a baseline state. It is important to note that a minority of youth who attempt and commit suicide show no apparent signs of risk. It is equally important for professionals to increase their familiarity with protective factors and ways to decrease the risk of suicidal behaviour. Such factors have also been included in the table. A person working with youth needs to be aware that his or her willingness to discuss this issue with youth in an open and supportive manner actually increases the individual's sense of connectedness and starts to decrease the risk of suicidal behaviour.

1. Risk Factors for Youth Suicide

A. Youth factors

Poor physical health and disabilities (eg, chronic illness)
Poor mental heath (depressive disorders, substance abuse, conduct disorders)
Deterioration in school performance
Prior suicidal behaviour
Physical/emotional/sexual abuse
Life stress (eg, relationship break-up)
Risk-taking behaviours (eg, running away, substance use)

B. Psychological factors

Cognitive distortions and hopelessness
Impulsivity
Lack of assertiveness
Poor affect modulation
Poor interpersonal problem-solving skills

C. Family factors

Transient lifestyle
Family disintegration (hostile separation or divorce, family violence)
Family history of psychiatric illness (including suicidal behaviour)
Parental unemployment (low socioeconomic status)
Perceived or real lack of family support

D. Environmental factors

Contagion/imitation (direct exposure; indirect exposure -fiction IWerther effect], nonfiction)
Alienation (any minority groups, gays and lesbians)
Rural (isolated) residence
Access to firearms

2. Warning Signals

A. Behavioural indicators

Loss of interest in former activities (withdrawal from social contact)
Difficulty in concentrating, problems with judgement and memory
Dramatic shift in quality of school work and academic performance
Feelings of sadness, emptiness and hopelessness, often expressed in written assignments
Sleep disturbances
Strong and overt expressions of anger and rage
Excessive use of drugs and/or alcohol
Promiscuous behaviour
Uncharacteristic delinquent, thrill-seeking behaviour

B. Verbal or nonverbal symbolic communication

Occurrence of previous suicidal gestures or attempts Statements revealing a desire to die or a preoccupation with death
Nihilistic comments. life is meaningless, filled with misery, what's the use of it all?
Verbal or written threats
Self-mutilation
Planning for death, making final arrangements, giving away
favourite possessions
Sudden cheerfulness after prolonged depression may be a manifestation of relief because a decision has been made

3. Precipitating Events

Break-up with boy- or girlfriend
Conflicts and increased arguments with parents and/or siblings
Loss of a close friend
School-related difficulties - conflicts with teachers, classmates
Difficulties with the law
Change in parents' financial status
Serious illness or injury in family member
Any perceived or actual loss (friendships, Status, reputation)

4. Protective Factors for Suicide

Ethical and religious motivations
Aspirations, hopes, plans for the future
Access to and connection with support networks
Good mental health

5. Suicidal Impulses Decreases by

Increasing hope
Increasing problem-solving skills
Increasing communication
Increasing ability to tolerate psychic pain (adolescent and family)
Increasing connectedness
Increasing sense of belonging

P.E.P : Peers Empowering Peers

The P.E.P. (Peers Empowering Peers) program evolved from a pilot program named Y.A.P. (Youth Assisting Peers) that was run at Lester B. Pearson High School, Aldershot High School and Q.E. Park High School in Burlington and Oakville, Ontario. The pilot was run between December 1997 and March 1998. The program was written by Ray Pidzamecky, M.S.W., Co-Director of Lifecycle Counselling/Parent Watch and Susan Kozbor, Substance Abuse Nurse for the Region of Halton Health Department.

The focus of the Y.A.P. program was as follows :

-To dispel myths held by younger students re: substance abuse and the broader social culture among older adoledsents.
-To give youth information coupled with harm reduction messages that don't necessarily require abstinence from drug use.
-To address any issues that grade 9 students are faced with.

A number of things quickly became apparent as the pilot program continued:

-A majority of grade 9 students stated that they had been exposed enough to the drug issue and in some cases drugs prior to entering grade 9.
-Some students felt that current drug prevention programs had little to do with students'choices of whether to use drugs or not.
-Grade 9 girls appeared to have been more "adultified" than boys in both presentation and appearance.
-The topic of eating disorders was a significant issue for the girls.
-Grade 9's were more eager to want to discuss issues surrounding dating, sex, gender attitudes, parents, relationships.
-The issue of harassment and discrimination were important topics.

The decision to have senior students (grades 12 to O.A.C.) inservice grade 9's was in fact an empowering tool that allowed a number of grade 9 students to express their fears and concerns in ways that they were never able to before. The grade 9's overwhelmingly expressed the following opinions :

-They liked having senior students inservice them.
-They wanted more sessions and follow-up.
-They wanted co-ed classes to follow.
-The forum helped to make them feel more comfortable and more willing to speak.
-Other grades should be inserviced by seniors.
-Students felt more comfortable around seniors and felt that they were more approachable.

As a result of the comments and topics generated by the grade 9's and current Addiction Research Foundation Statistics, we believe that drug prevention programs have not, for the most part, been successful. As a result of drugs now being a significant part of our youth's culture, we believe that the focus should be both on abstinence and harm reduction.

It would appear that students find peer mentors to be a more effective medium than adult educators with regard to current social issues. The issue of drugs was not the most important topic of discus-

sion for the grade 9 students. Rather, drugs are only one part of the larger culture that students find themselves dealing with. Therefore, we have taken the next step an created the P.E.P. program. The P.E.P. program is an attempt to offer the broadest base of discussion pertaining to youth issues.

P.E.P. (Peers Empowering Peers) : A Senior Led Peer Education Program

Target: Grade 9 students

Objectives:

-To dispel myths held by younger students.
-To give youth information coupled with abstinence and harm reduction messages.
-To encourage discussion around the issues of harassment, discrimination, intimidation abuse and violence.
-To address any issues that grade 9 students struggle to cope with/understand/deal with.
-To help foster a sense of community between senior and junior students.
-Impact is a meaningful way as to reduce the risks of death and harm to our youth whether that be through intentional or accidental actions

Strategy:

To achieve the above objectives by utilizing senior students to communicate information, share opinions and respond to questions from grade 9 students under the supervision of social workers.

Selection of Peer Leaders/Educators:

Criteria: Cross reprensentation of grade 12 to OAC students who have familiarity and/or comfort in discussing selected issues. The students are perceived as "social" leaders and respected by their peers. A minimum of 3 senior boys and 3 senior girls per grade 9 class.

Process: School Social Worker, in conjunction with Heads of Student Services, Physical Education and interested teachers will select potential seniors

Student Leader Training

The School Social Workers to meet with selected students for one class of training.

Implementation

-Grade 9 classes to be divided by class period and gender.
-Each gender will separately meet with both the male and female senior students to be completed within on week.
-Next, each student will be in one mixed class combining male and female grade 9's so that they can receive an inservice dealing with harassment and discrimination, conducted by the Regional Police Service High School Liaison Officers.
-At the end of the week all grade 9 students will be brought into an assembly for one class period. Their respective period teachers, along with any others who are available and the police will also be in attendance.

Class Outline for grade 9's

Introduction:

Ray Pidzamecky M.S.W. & Penny Smith M.S.W.
Ground rules: sensitive issues, speak for yourself only, don't name names, ask questions for yourself, seniors will not respond to personal questions unless they choose to do so, attendance taken by teacher at the start of the class, then teacher will leave. Although we cannot guarantee confidentiality, you are encouraged to not mention anyone's name outside the class. Everyone is permitted an opinion.

Seniors Introduce Themselves :
Name and grade

Break Up Into Three Smaller Groups To Discuss Topics:

Break students into small groups to discuss 7 topic areas. Each student will be encouraged to write one question on a piece of paper with regards to the 7 topics. Questions will be read out loud to seniors by social worker.

Senior girls inservice gr. 9 girls (discussion from female perspective). Senior boys inservice gr. 9 boys (discussion from male perespective). Senior girls inservice gr. 9 boys (discussion from female perspective). Senior boys inservice gr. 9 girls (discussion from male perspective)

Top 7 Topics To Discuss With Grade 9's (Write on blackboard before class breaks into three small groups)
-Drugs / alcohol
-Intimidation / violence / harassment
-Fiting in / friends
-Rumours
-Parties / dances
-Parents / teachers
-Body image / sexuality

Compile List of Issues

Back into large group. Large Group Discussion (Social Worker reads questions from pieces of paper). Question and answer interaction. If grade 9's are slow to begin, senior students start off discussion.

Regional Police Service High School Liaison Officer Inservice On Harassment/ Discrimination

All of the grade 9 students will receive an inservice for one period on harassment/discrimination. This topic is of particular importance because of the incidents of date rape, assault, and harassment that occurs amongst our young people today. This portion of P.E.P. is a concerted effort to help grade 9's empower themselves and reduce levels of risk and harm.

Grade 9 Assembly

Welcome and Review of P.E.P.: Social Worker

Yes/No Warm-up Activity:

-Introduction to activity: Social Worker
-Activity: Senior led
-Read statement and ask students to respond yes or no by raising hands. (E.g. raise your hand if you have seen drugs on school property)
-Summary: Senior led
-All of you are unique but yet most of you share the same issues/concerns.
-Senior students and adults also share some of your issues/concerns.

Police officers interviewed on their impressions of grade 9's and their issues
Social Worker to interview officers

Personal stories and perspectives on issues:

At least four senior students to speak (2 from each gender). Also have one female student read "Death of an innocent".

Gender statement activity:

-Introduction by social worker
-Activity: Senior led
-Read statements made by gr. 9 males about gr. 9 girls and gr. 9 girls about gr. 9 males withregards to their perspective of the opposite sex's issues. Grade 9's asked which sex they think made the statement by a show of hands

Panel discussion with senior students:

Social worker to interview senior students
Request for feedback from grade 9's, seniors and teachers at assembly.

Wrap up & thank you. Social Workers.

Comments of students

I liked the idea that we got the chance to talk to the OAC, 11, 12's about problems that they might have gone through. I'm glad because they are from our school as well and know about the stuff that goes around and it's easier because they can give us advice about the situation. I'm also glad because they have us some helpful advice, because we have a lot in common with them because some of them might be our friends or because they related more to the "students" than the teachers and it's more helpful.

I felt it was really helpful in some ways, it was fun, it wasn't really serious like taking notes and stuff, but yet it was. It was a good idea to have students talk to students because they understand more because sometimes older people don't realize that kids our age are actually going through some serious issues. They think we are so innocent when we are not. It helped us, as grade 9's to get to know older students. I think it was a good idea to talk about these issues. It would be a good idea to do this next year for the new grade 9's.
I thought the seniors coming in to talk to us this year for health was a really good idea. I was thin-

king before class "why do we have to learn about drugs again?" But I found it very informative, and I think they should do this every year for the gr. 9's. One thing I think we should have done, is mix the girls & boys class and have the senior girls and boys come talk to us together. I really had fun talking to these people and I think the gr. 9's might have made a few new friends.

Peers Empowering Peers
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Parent Watch

A Free Community Based Model For Parent Support

Parent Watch is a support and information forum where parents and helping professionals can meet in a positive skill development/problem solving process that will create "lived" solutions for family conflitcs. Through this process of empowerment, Parent Watch can provide parents with a persistent feeling of confidence in dealing with their children and the difficulties that occur in adolescence.

Rationale for Parent Watch

The teen years can be a time of stress for teens, their families and friends and the community at large. As they enter adolescence, our children are inundated with new pressures and new decisions. Many are confused by peer pressure, the demands of school, careers, the future -even advertizing- at a time when they are least likely to turn to adults for answers. Drugs and alcohol continue to be a provocative debilitating element and are now considered to be a normal part of the adolescent experience. There is evolving an entrenched lack of hope and opportunity for 15-19 year olds. This can influence their ability to delay gratification, plan their lives and sustain their progress toward adulthood. Cutbacks have left dangerous gaps in treatment and support services for adolescents and their families thereby exacerbating the problem while further diminishing hope.

However, despite these negative pressures and lack of service, the prevalence of problems among teens may be as much an indication of their parents just not knowing what to do rather, than a sign that the world is falling apart, or that we are all at the hands of "drug-crazed, adolescent psychopaths". Many parents don't know how to respond effectively to their teenagers. The majority of parents who struggle with these issues are good parents who have become so child focused that they have lost control of their own homes. There are some that would want us to believe that behind every delinquent youth is an abusive and uncaring parent. This is in fact a myth. In their determination to be caring parents they may doubt the value of their experience, compromise their values and rationalize unacceptable situations or behaviours. We do agree that the males of this society must take more responsability for their children through direct and positive participation in their child's life.

Parent Watch provides an effective, systematic and economical community-based program that assists families in overcoming conflict. The greatest reason for Parent Watch is to remind parents that they are the adults and that they do have the skills to protect themselves, their children and their homes.

Parents are often amazed at the information networks their children have developed, networks that allow kids to provide each other with support, information, places to sleep, news about possible confrontation with other kids or authorities and more. Parent Watch assists parents in creating their own information networks to allow them to provide each other with support strategies, coping skills and understanding. In Parent Watch, parents reach out to each other with problems and solutions, in a supportive setting with professional guidance. Once parents learn how to identify and cope with crises and unacceptable beha-

viours they can begin to regain control of their homes and their lives.

Evolution: How Parent Watch Started

Ray Pidzamecky MSW, a high school social worker in Oakville Ontario, created Parent Watch. After responding to a call from a frantic young boy, Pidzamecky enlisted the help of Officer Mike Michalski of the Halton Regional Police Service, to help get the boy out of a gang that he had been a member of. Once they had done this, Pidzamecky and Michalski spent time with the youth to talk things over and to discuss possible sources of help. For Pidzamecki, this incident crystallized the importance of parents and professionals working together to help solve the problems affecting teens and families today. Pidzamecky realized that parents needed to be made aware of the issues affecting teens. More importantly, they needed help in learning new ways to respond to the crisis that affects their families. The impetus for the Parent Watch formula came from Pidzamechy's concern for the adolescents and parents with whom he worked, his understanding of the power of the group process, the need for on-going support for parents and his personal commitment to using the expertise of the people on the front lines, such as the police, social workers and of course, other parents, to solve problems.

Parent Watch was launched in May 1993 in the basement of a restaurant in Oakville Ontario when Pidzamecky met with Officer Michalski and several interested parents. The meetings occurred once a month in the evening. As parents came together they found they had common questions but what they needed was information as well as support. A social worker and police officer could provide the information they needed. Once regular meetings were established, parents realized that they could benefit from a place to go to talk to other parents. Many felt that there were abundant supports available when their children were young but non-existent when their children became teenagers and the parents had more questions than ever.

In 1996, Pidzamecky invited fellow high school social worker Penny Smith MSW, CSW, to co-lead the ever-growing number of Parent Watch groups and help formalize and develop the Parent Watch program.

In just over five years, Parent Watch has emerged as a creative and effective grass roots organization. Its members have initiated several community forums, establishing recommendations and participating in carrying them out. Parent Watch has emerged as a de facto standard in parent support groups. But it's essential to remember that the greatest contributors to the success of Parent Watch have been the parents who have attended diligently, courageously told their stories and made fundamental changes in their lives and those of their children.

Why Parent Watch? How Does It Work?

The first step in problem solving is identifying the problem. In a complex system like a family this requires shutting down the noise and confusion and guilt without shutting out support and information. Adolescents can suffer multiple problems ranging from poor attendance at school or failing grades to drug use, even criminal charges. Teens can lapse into depression or appear out of control. Teens in trouble or out-of control kids embarrass and frustrate parents who, in turn, become isolated in their frustration. A hostage situation can evolve with parents under the control of their kids and giving into their demands. Extensive damage can occur in the home. Parents often feel they have nowhere to turn and may feel rebuffed by other parents who don't have, or deny having, similar problems. Parents can find themselves and their children in crisis with long waits for conunselling or too distrustful to submit to a process they feel will judge their parenting skills and their children. Adults as well can suffer depression and a child may have to be forcibly removed from the home. At best, the balance of power shifts away from the adults and onto the adolescent.

Parent Watch helps parents regain control by providing a structured, non-judgmental forum where they can depend on and use the back up and support of other parents. The Parent Watch facilitators, including a police officer, attend and lead every meeting to help parents learn how and when to use community agencies to assist them in maintaining control. Parent Watch provides a balance between supportive, well-intentioned parents who have the same or similar problems and the accurate information provided by professio-

nals. Progress can then occur as the balance of power shifts away from the kids and back to the parents.

Perhaps a quote from the media sums up Parent Watch best: "Most of all, Parent Watch helps turn anomymous suburbia into an old fashioned village in which adults know kids by name and by sights-and, here's the rub, the kids know that the adults know them" (Burlington Spectator, April 3, 1996).

The Role of Parent Watch Facilitators

The group facilitators are there to keep the focus on you, your issues and your work. Their job is to facilitate, make your learning and information sharing easier and more productive, and encourage you to ask questions and to discuss issues as a group. Although the facilitators will provide some direction and advise at times, they are not there to lead. They will also provide you with access to other professionals' services and sources of information that you request or need. The facilitators' goal is to help you and other parents work toward solutions and to make sure that you get from Parent Watch what it was created to provide: effective solutions for your family.

Confidentiality

Parent Watch groups have a specific format and clear "rules" for the sharing of highly sensitive material. Parents will only share what may be their worst nightmare in a supportive atmosphere that is grounded in mutual trust. Confidentiality must be assured to protect the family's privacy and in extreme cases, its' safety. While rules and guidelines cannot guarantee confidentiality, the importance to all concerned must be reinforced at the beginning of each Parent Watch meeting. Parents, interested others and media representatives must make every effort to avoid revealing any identifying information outside of a Parent Watch meeting.

Past accomplishments:

-Well-attended parent group for 5 years.
-Significant reduction in loitering and vandalism in Bronte due in part to Parent Watch strategies such as "walk abouts" and the "pumpkin patrol".
Facilitated the first "Citizens On Patrol" group in Ontario with the assistance of the Halton Regional Police Service.
-Organized comprehensive support for school board professional student services personnel during board cutbacks.
-Parent Watch Co-Director Ray Pidzamecky, Officer Michael Michalski of the Halton Regional Police Service and an adolescent from the community appeared on Terence Young's (M.P.P.) cablenet show to provide information on substance abuse use among youth in Halton and to respond to "phone in" requests for information.
-Regional forum held on drug use among adolescents and a regional presentation co-sponsored with the Halton police and health department on "brush parties".
-Report on "Recommendations for Responding To Halton Youth Drug Abuse"s produced and disseminated throughout the Halton Region.
-Hosted the prevention package "Never Be A Victim" (developed by Officer Jim Byrne And Sony Wonder) in Oakville, Burlington and Georgetown.
-Co-sponsored and co-hosted "Youth Assisting Parents" forum in Burlington. A 10 member senior student panel that informed parents of the issues grades 9's are dealing with today.
-Presentors at the Halton "Victim-less" Community Policing Conference 98.

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Publications

Books from Family Planning Association of England

& **Strides: A practical guide to sex education with young men**

By Simon Blake and Joanna Laxton

The workbook offers clear advice and practical tips for working with 14 to 25 years olds in youth and community settings and schools. You'll find also advice on preparing and supporting your work; over 30 participatory activities suitable for a variety of settings; tips how to put up a group and keep it going; backup notes and phocopiable handouts. Price: £15.99

& **4 Boys : A below-the-belt guide**

A colourful illustrated booklet for 13 to 16 year olds gives reassuring and factual answers to the questions commonly asked by teenage boys. Price: £10.00 for 50 copies

& **Let's hear it For the Boys! Supporting Sex and Relationships Education for Boys and Young Men**

Clear and accessible advice for those wishing to develop a gender perspective to their work in schools, health and youth and community settings. Price: £12.50

& **Man's World : A Game for Young Men**

Board game designed to help young men (14 years plus) talk about their feelings, gain knowledge and examine attitudes to being male. Price: £15.00

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Exceptional Parents

1999 Resource guide- Special issue

A magazine for parenting children or young adults with disability or special healthcare needs. In this issue you'll find a directories of national organisations, associations, products and services including Canadian resources. This year, there is a selection of informative Web site addresses. In addition, there is a special section on accessible theme and amusement parks. *Price: $12.00*

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STARs (State of the Art Reviews) – Adolescent Medicine

q ***1997 Issue***

Lesbian and Gay Youth: Care And Counselling

By Caitlin Ryan, MSW, AVSW and Donna Futterman, MD

The first comprehensive guide for medical care and counselling of lesbian, gay and bisexual adolescents. It offers a review of the latest research, practice wisdom and state-of-the-art knowledge for providing medical care and counselling, but also a step-by-step medical interview, protocols for medical, mental health and HIV-related care and HIV counselling and testing. Although lesbian and gay youth have special needs related to invisibility, lack of support and coping with stigma, their care and counselling should be provided in the context of care for all adolescents. The guide divides in three parts: experience and needs; primary care and prevention; HIV-AIDS. *175 pages – illustrated.*

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Each book is 150-250 pages and contains numerous illustrations and tables. Price: $33 (U.S.) - $36 (outside U.S.)

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Reminder

Advocacy Committee and Advocacy Issues

Advocacy Committee Request for members

We would also be interested in knowing if any CAAH members have a special interest or expertise in the following areas:

1. The proposed tobacco legislation,
2. The Youthful Offenderes Act, and
3. The recent child pornography ruling.

Sixth Annual National Meeting of CAAH Toronto, November 1999

The sixth annual national scientific meeting of CAAH will be held in suburb Toronto,Friday November 5th 1999.

Dr. Katherine Leonard, along with colleages of the Adolescent Clinic at North York Hospital are working on the program under the theme of " Mental Health and Adolescence ".

If you wish any information on these subjects, please contact:

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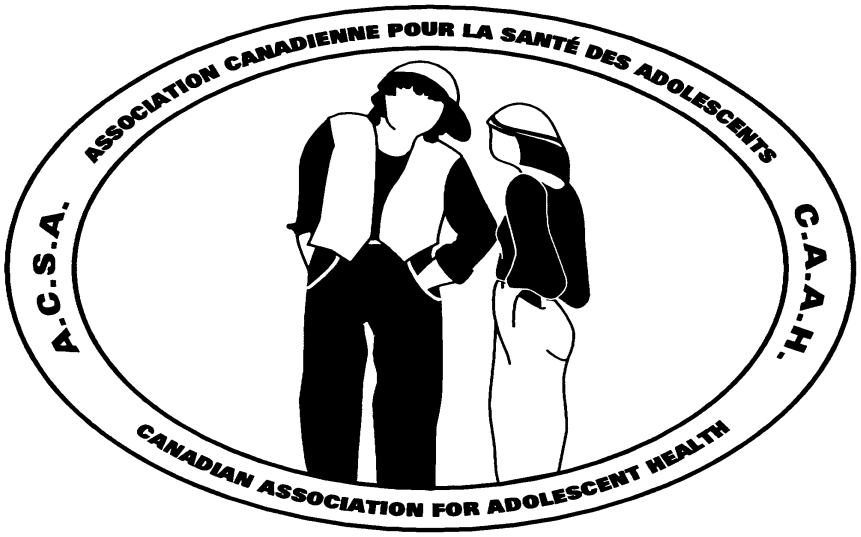

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The CAAH need your financial support.

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This publication is made possible through a grant from Merck Frosst Vaccine Division

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