CANADIAN ASSOCIATION
FOR ADOLESCENT HEALTH

June 2001

Volume 10, # 1&2

PRO-TEEN

Inside this issue:

PRO-TEEN

Publisher : CAAH

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Legal Deposit, National Library of Canada ISSN 1201-5474
Canada Post-Convention number 1482351

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 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. Mr Malo also coordinate the work under contracts for the Canadian Health Network. For the fourth 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. The content of PRO-TEEN this year has benefited from the quality efforts of David Blasco. 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.

Within the Association, Philippe Nechkov managed the membership data bank and registered new members. As for our web site, the content and the design are due to the work of John Duong. The work done for the Canadian Health Network, ie, the francophone Québec mapping survey and the youth affiliate partnership has been coordinated by André Malo with John Duong as the youth affiliate assistant and Djordje Janjic, Éric Villiard and Philippe nechkov as assistant for the mapping survey. David Blasco has offered support to all our team on different project.

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 3rd Ontario regional meeting of CAAH held in Ottawa, October 27th 2000, on the theme of « Eating Disorders in Adolescents», we acknowledge the work of Dr Steve Feder and his team at the Eastern Ontario Children's Hospital and in the community: the committee members were: Dr. Gonzalo Araujo, psychiatrist, Dr. Jane Blouin, psychologist, Sarah Brandon, coordinator Youthnet, Joanne Currant, parent, Debbie Gomez, nutritionist, Dr. Suji Lena, pediatrician, Helene Lowell, public health, Heidi Mack, prevention program in the community, Sheila Mather, author and consultant, Mary Ross, School Danse, Jean-Yves Frappier, pediatrician. The meeting (in English) was attended by 140 participants

For the 1st Maritimes Regional Meeting of CAAH held in Moncton, November 17-18 2000, with a program in French on the theme "Ado-santé mentale-action", we acknowledge

the work of Dr Aurel Scofield of the family Medicine Unit in Dieppe and his multidisciplinary team. This successful meeting was attended by 175 participants.

In conclusion, I am grateful to all members who promote our activities and support us. ***Send us news, description of your program or activities or an article for publication in the journal.*** 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,

Youth and Society Research Group

Dear Colleagues,

The Youth and Society Research Group recently held an adolescent health and well-being conference titled "Adolescent Health Risks: Setting Priorities for the New Millennium". This networking conference enabled a multi-disciplinary group of well-established scholars across Canada to discuss research priorities for the promotion of health in adolescents. One objective of the conference was to generate a directory of adolescent health researchers in Canada that could be distributed for the purpose of identifying individual scholars and groups who can become part of a coordinated agenda to address adolescent health research. We are compiling this directory and would like your help locating persons who would be interested in being listed. We require the following information:

Name:
Email address:
University and department or agency name:
Key words or a short statement describing research interests:

If you would like to be entered in the directory, please forward this information to the Youth and Society research Unit, University of Victoria. Also, please forward this note to interested colleagues, or inform us of the names and e-mail addresses of others who we may contact.

Thank you for your interest and collaboration.

Sincerely,

Rachel Phillips and Veronique Mercier, Research Assistants

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A273 Cornett Building
University of Victoria
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Victoria, BC Canada V8W 3P5
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Email: ysr@uvic.ca
Web site: youth.society.uvic.ca

Scientific Events

CAAH 8th National Annual Meeting

Montreal, Fall 2001

The Canadian Association for Adolescent Health will hold its 8th Annual National Meeting in November 2001, at la Maison Notre-Dame (Westmount). This meeting will present a concomitant French and English program under the theme :

« Adolescence : the teen, the family, the team and the network ».

It will be an opportunity to discuss adolescent-parent relationships, health care worker-adolescent relationships, the difficulties to work in team and the problems of networking. Some workshops will focus on intervention for specific problems of adolescents.

The program will be distributed at the end of summer with registration forms.

Please consult the webiste during the summer for incoming information about the Meeting.

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4th International Conference on Adolescent Health & Welfare

24th-26th October 2002, London England

We are pleased to announce the Fourth International Conference on Adolescent Health & Welfare. A varied and full program including Keynote Addresses, Plenary Lectures, Workshops, Discussion Groups, Free Papers and Poster Presentations. This Conference will be held in . Each day begins with a keynote address by one of our special guests, delegates will then be able to attend either plenary lectures or workshops concentrating on their specialist chosen subjects. Please note that you will be required to indicate your preferences. Topics included in this Conference are: Pregnancy & Parenthood, Adolescent Development, Youth & The Law, Social & Spiritual, Sexuality & Sexual Orientation, Substance Abuse & The Drug Culture, Mental & Psychological Health, Research Issues and Disability & Chronic Illness.

Proceedings from this conference will be published in a future Youth Support publication. All Youth Support publications are available via booksbooksbooks.org. Keep up-to-date with the programme and contact us via our conference website www.youthsupport.com A final programme will be available at registration. You are encouraged to book early to make full use of discounted fee and avoid disappointment at the sessions you wish to attend. Abstracts for plenary lectures, workshops, free papers, poster presentations and commercial displays are welcomed and should be approximately 250 words on A4 or sent via email through the website or directly to conference@youthsupport.com please include your name, title, organisation and contract details. Closing date for abstracts July 30th 2002, but please forward early to avoid disappointment.

For more information and a complete program:

Youth Support Conference Secretariat
13 High Street, Penge,
London SE20 7HJ, England.
Tel: 44 208 325 8612
Fax: 44 208 325 8647
Email via: www.youthsupport.com

Articles

Raising awareness about discrimination

By Cathy Campbell

A security guard stops a group of teens at the entrance to a mall. "Each of you has to show me $5," he says. "Or get out of here."

What begins as a friendly shopping trip ends with a group of teens feeling like criminals.

This anecdote spurred the beginning of The Open Door, a project undertaken by The McCreary Centre Society in Burnaby, B.C., to look at the issue of youth discrimination. The youth-run project gathered 3,000 report cards on B.C. businesses from 22 communities across the province in 1996 and 1997.

More than 75 per cent of teens reported that they weren't treated with respect when they went into a store.

Aileen Murphy, project coordinator with The McCreary Centre Society, says that while the survey wasn't scientific, it "raised awareness and started discussion about how young people feel."

Youth gave a thumbs-up to some projects, including a Qualicum coffee shop that joined forces with the local chamber of commerce to start a "Youth are welcome here" sticker campaign. The idea showed support for young people.

Youth said they want to be made to feel welcome by shopkeepers. They don't want to be followed around while shopping because merchants assume that they plan to steal something. They want to be treated like every other customer, regardless of their age or how they dress.

According to McCreary's wideranging *Adolescent Health Survey II,* released in 1999, almost half of youth feel that they are the victims of age-related discrimination.

"To me, what's ironic is young people are a large market ...," Ms. Murphy says. Merchants want their business, but don't give them respect.

"I think what we've found is it seems to be a theme or experience of all young people - in urban and rural communities."

Yet, at the same time, youth are not being recognized for their good deeds. For example, the survey found that 87 per cent of female teens and 74 per cent of males had done volunteer work within the previous year.

Reproduced from: Families & Health, September 2000, Volume 13.

Adolescents with Learning Disabilities

Risk and Protective Factors Associated with Emotional Well-Being: Findings From the National Longitudinal Study of Adolescent Health, Setaz M. J.A.H.: 27 (5), 340-348

In the very early days of this century, when cyber-literacy and mastery of technology seem to be the basic ingredients for survival in the competitive job market, the number of children and adolescents with learning disabilities (LL's) appears to be increasing. Today LDs appear to have prevalence in the order of 5% of children and youth.

The association between LDs and emotional problems has been well described. Although the federal definition of LDs excludes those that are secondary to emotional disturbance, adolescents with LDs have a high incidence of emotional and behavioral problems. Additionally, Jackson et al. found that compared with non-learning disabled peers, those with LDs saw themselves to be significantly less socially competent and were rated lower in social competency by their respective teachers. Given that a critical element of social skills is the ability to accurately perceive the environment and interpersonal relationships, this deficit contributes to social isolation. Deficits of social perception improve during developmental maturation; however, for those with LDs, it appears that a lag persists through adolescence.

Methods:

Data were obtained from the National Longitudinal Study of Adolescent Health. This is a longitudinal study of adolescents in grades 7 through 12 and the multiple social contexts in which they live. Initially 80 high schools were identified across the United States.

In the present analysis, LD was defined as an affirmative response of parents to two questions: (a) Does your adolescent have LD and (b) has he or she ever been in special education classes? The comparison group consisted of those adolescents whose parents answered no to both questions. Because of the complex sampling design, each case was assigned a weight so that the resulting analyses are generalizable to the U.S. adolescent population. These sample weights were used in the analyses. The longitudinal sample consisted of 16,340 adolescents, (78.6%) of whom 1603 met the criteria for LDs.

The sample of young people with LDs were disproportionally male (twice that of females), older than the comparison group, and more likely to be on welfare.

Measures:

The three outcome variables included: suicide attempt, emotional distress, and violent behaviour. Suicide attempt was based on a dichotomous variable: "have you attempted suicide in the last year?" Violent involvement was based on an eight-item scale that has a Cronbach a of .83. Emotional distress was measured by a 17-item scale that had a Cronbach a of .86. Details on scale construction have been previously reported.

Results:

To explore the relationships of having a LD with emotional outcomes of emotional distress, suicide attempts, and violent involvement, odds ratios were computed controlling for age, gender, grade, socio-economic status (SES), family structure, and race. Having a LD was associated with nearly double the odds ratio (OR) for emotional distress. Likewise the OR was 1.67 overall for suicide. Violence involvement was also greater for both males and females, compared with peers. Adolescents with LDs were at least twice as likely as teens without LDs to report emotional distress. Boys with LDs were also twice as likely to report

suicidal attempts; the same was true for girls.
Secondly, youths with LDs were significantly more likely than others to report involvement in violent behaviors.
Adolescents with LDs were more likely to report carrying weapons: 13% vs. 9% with differences reported for both boys and girls.
Adolescents with LDs were as likely to report that they feel connected with their families as were those in the comparison group. They were less likely, however, to report that they engaged in activities with their parents but they reported more parental presence throughout the day.
School connectedness did not differ significantly for young people with or without LDs. Both boys and girls with LDs were less likely to report that they perceived prejudice from other students in their schools than did comparison groups.

Multiple Regression Analyses:

Specifically, youth with LDs who had emotional distress reported eight times the number of suicide attempts and five times the violence involvement as those without distress. Factors associated with the increased risk included: having had intercourse before the age of 12 years, weapon carrying, and substance use. Those young victims were twice as likely to report emotional distress, 3 times as likely to report a history of a suicide attempt, and almost 80 times more likely to report to be engaged in violent activities than peers who did not report such victimization.
Among the factors associated with lower levels of emotional distress, suicide attempts and violence involvement, religious identity was one of the strongest individual level variables associated with lower risk for the three outcomes; however, it was statistically significant only for suicide.

Family connectedness was the most strongly associated with lower risk for the three study outcomes. However, across the individual, family, and school factors for each of the three outcomes: distress, violence, and suicide attempt, school connectedness was the factor associated with the lowest risk.

Protecting Youth with Learning Disabilities:

The present study may be the first to explore factors that are associated with diminished risk for emotional distress, suicide attempts, and violence involvement. Factors that emerge include: family connectedness, school connectedness, and religious identity.

Reproduced from: The Monthly News in Adolescent Medicine, November 2000.

Families fortify teens

By Cathy Campbell

Loving and supportive families have a major impact on the health of teenagers, according to a B.C. research organization. Dr. Roger Tonkin, executive director of The McCreary Centre Society, a non-profit, non-governmental group based in Burnaby, says research shows that "what families and schools do makes a difference."

In 1999, The McCreary Centre Society released a wideranging survey of 26,000 students, called *Healthy Connections.* It shows that youth are less likely to take risks when they feel that parents and teachers care about them and treat them fairly.

This is the second major youth health survey and the largest ever done in B.C.; McCreary's first adolescent health survey was conducted in 1992.

"Generally speaking, Canadian youth are in pretty good shape," says Dr. Tonkin.

According to the survey:

- Teens are waiting longer to begin having sex; 77 per cent of students in the survey say they have never had sex, compared with 70 per cent in 1992.
- 15 per cent of girls in the survey reported a history of sexual abuse, down from 21 per cent in 1992.
- More youth are using bike helmets; 30 per cent of students always wear a helmet when riding, up from six per cent in 1992.

Survey: Youth 'in good shape'

Dr. Tonkin says that Canada's national agenda is focusing on children under the age of five, but survey results show that strong family, school and community connections are just as important for youth.

Strong families give teenagers the resilience to pull back from difficult situations, he says. "We have 45 per cent of teenagers who try cigarettes, but 15 per cent who are regular smokers," he says. "What did that other large group of kids decide to do that made them just experimenters?"

'It's a little bit scary because kids are starting to use marijuana at a younger age and they're using it more often.' Dr. Roger Tonkin, executive director, The McCreary Centre Society However, not all of the news about adolescent health is good. "The real story is the increase in marijuana use," Dr. Tonkin says.

According to the 1999 health survey, which was administered to students in grades 7 to 12 in 1998, 40 per cent of teens have used marijuana, up from 25 per cent in 1992. And 13 per cent of respondents had used marijuana 40 or more times, compared with six per cent in 1992. Among 13-year olds, 20 per cent of those surveyed in 1998 had used marijuana, compared to 10 per cent in the 1992 survey. Among 17-year-olds, 58 per cent had used marijuana in 1998, compared to 39 per cent in 1992. "These are really substantial increases," Dr. Tonkin says.

Dr. Tonkin says that increases may be attributed to a number of factors, including the recent national discussions around the medical use of marijuana, the lenience with which Olympic athletes caught using the substance have been treated, and the general belief that marijuana is a safer recreational drug than alcohol.

"It's a little bit scary because kids are starting to use marijuana at a younger age and they are using it more often," Dr, Tonkin says. At the same time, "the potentcy of modern marijuana is greater than in the late `60s and early `70s" when many of these teens' parents would have tried the substance. "We're asking the question:

Is this acceptable nationally?," says Dr. Tonkin. Researchers don't know the connection between involvement with the marijuana culture and school delinquency and violence. "We certainly cannot hide our heads in the sand and say that marijuana is just a friendly little backyard drug," he says.

Dr. Tonkin says the public's response to marijuana use is "worrisome." "Young people do things in response to prevailing public attitudes," he says. For example, the fact that sexual activity among teens has decreased reflects a change in society's attitude, Dr. Tonkin says.

The report's findings have been disseminated to youth health forums across British Columbia. The forums are evaluating the survey's findings and making recommendations. "That process is going on right now. That report has yet to be written," he says. By passing the results back to youth, the survey is helping to change the social climate.

Reproduced from: Families & Health, September 2000, Volume 13.

Please help us!

- Pay your membership fees on time or remind your organization to renew their membership. Close to 20% of members wait two years to renew their membership.
- Publicize the CAAH. Our survival chances increase with each new member.
- Publicize and attend the CAAH's Conferences.
- Send us articles, news, information regarding interesting events, programs, publications or videos for PRO-TEEN.

Thank you

Immigrant Youth in Canada: A preview

The Canadian Council on Social Development (CCSD) is publishing a companion report to the 1999-2000 edition of their annual report, *The Progress of Canada's Children.* The new report, entitled *Immigrant Youth in Canada, will* provide a statistical profile of children and youth who have recently immigrated to Canada; describe the acculturation experiences of these young people; and detail the capacity of social service organizations to respond to the needs of immigrant children and youth.

Analysis in the report is based on data from the National Population Health Survey, the Longitudinal Immigrant Database from Citizenship and Immigration Canada, focus group discussions among recent immigrant children and youth, as well as a survey of organizations that serve immigrant families, children and youth.

Findings at a glance

Each year, nearly 200,000 immigrants come to Canada, and since 1996, one-third of these new Canadians are under the age of 25. While most of these youth come to Canada with their families, others come to pursue an education.

Most of the youth appear to be integrating well in Canada and most are happy to be here. In fact, most have adapted more easily than their parents. They reported that learning the language - either French or English - was one of their greatest challenges and the English as a Second Language (ESL) programs offered at school were an important method of integration. Not only do these programs enable young people to learn the language, they also provide an opportunity to form friendships with other youth in similar situations.

"Freedom" and "opportunity" were identified most often by very recent immigrants as "the best things" about being in Canada. In many cases, this was the result of increased freedom from their parents that they had gained by moving to Canada's more permissive society. In other cases, it was the result of having more human rights and freedom from state-sponsored oppression. Most youth believe that Canada offers greater economic opportunities than their countries of origin, with more access to jobs and post-secondary education.

The majority of respondents reported that the ability to maintain their culture, heritage and language was very important. Canada's focus on multiculturalism has made this possible for many immigrants. One participant stated, "When I want to be Indian, I can be Indian and when I want to be Canadian, I can be that too, but I don't feel like I have to be Canadian all the time."

Unfortunately, racism and bigotry were experienced by most participants in the CCSD's focus groups, particularly by immigrant youth who are members of visible minority groups. For younger youth, the problem occurred mainly at school; for older youth, it was felt when looking for work. Very few individuals were overly concerned about this problem, because they recognized it as being part of human nature and an issue that is endured in all parts of the world.

As Canada explores the possibility of opening the doors to an increased number of immigrants in the coming years, the findings in this report will prove particularly useful and hopefully will help to improve the experiences for all new immigrants to the country. Look for more interesting findings within the report, which will be published by the CCSD this spring.

For ordering information, visit the CCSD website at www.ccsd.ca or call (613) 236-8977.

Reproduced from: Preventing Crime Through

A piercing issue: Tribal adornment'part of popular culture

By Cathy Campbell

Nick is a 19-year-old franco-Ontarien student who hopes to one day pursue a career in international law.

He's charming, fluent in three languages, and he has piercing brown eyes.

But they're not the only *piercing* things about him.

Nick also has his ears, tongue, nipples and scrotum pierced.

"I guess it's a way to express myself," he says. This past summer, Nick worked in the dining hall of a large family many as 80 per cent of the 70 staff members, who ranged in age from 16 to 22, had multiple piercings.

Eyebrows, navels and tongues were among the most common.

"It's not a fad, it's not a trend," says Tom Brazda, owner of Stainless Steel, a piercing studio on Queen Street in Toronto. "Piercing is something that has been around for a very long time and it's something that's primal within us."

Many young people think so, too. Although there are no piercing statistics, a dramatic rise in the number of piercing studios in most major Canadian cities indicates the practice is gaining popularity.

Pierced: 'It goes with the outfit'

The emergence of body piercing as a popular trend is quite recent in Western society, according to 1999 Health Canada *Infection Control Guidelines.*

Mr. Brazda, who recently spoke on "tribal adornment" at a University of Guelph conference on sexuality, credits *National Geographic* magazine - and its photos of African tribes - with bringing piercing to the West.

Although there is limited medical literature on body piercing, Health Canada reports that many complications have been identified.

Possible risks of body piercing include deep tissue infection, excessive bleeding, scar tissue, salivary gland injury (tongue piercing,) corneal abrasion or eye infection (eyelid piercing,) loss of sensation of movement in a small area of the forehead (eyebrow piercing,) cyst or abscess behind the nipple that could impair future nursing (nipple piercing), and urethral damage (penile piercing.)

Further risks of tongue piercing are reported in dental literature, including chipped teeth and airway obstruction due to aspiration of the jewelry or swelling of the tongue.

A survey of 51 individuals who had tongue piercings found that 13 reported damage to teeth, eight noticed increased salivation, four experienced gum injury, three developed infection and two sought medical or dental treatment.

And a report to the Canadian Dermatology Association's annual meeting in Montreal in June revealed that piercing hazards include allergic reactions, torn skin, scarring, and even diseases such as hepatitis B or C.

Dr. Danielle Marcoux, of Sainte Justine Children's Hospital in Montreal, told the conference that while body art is portrayed by the media as a carefree, risk-free behaviour, "in some cases, the fashion is short-lived and the damage is permanent."

One unpleasant consequence of piercing is keloids. "It's probably the most disfiguring lesion, which is a huge overgrowth of skin due to an abnormal healing process," says Dr. Lynn From, president of the dermatology association.

"Certainly (young people) probably wouldn't have undertaken the piercing if they knew they were going to end up with great, huge, cauliflower-like tumours in areas where they had the body-piercing done."

So, considering the risks, why do teens do it? Nick first got his ears pierced at 16, partly because his friends were piercing theirs. "I thought it looked good on most of my friends." Later, he got a piercing under his lip, which has since grown in. "That one hurt the most because it started chewing up the inside of my gum," Nick says.

He had his tongue pierced, his nipples and his scrotum.

In three years, he has visited a piercing studio six times.

He thinks piercings look good and feel good. "If you're a wakeboarder, you have nice wakeboarding pants and a nipple ring goes well with the whole outfit," Nick says.

"We look in magazines and see cool people who have nipple rings and are making a lot of money."

He compares getting a piercing to buying a new pair of shoes.

Body piercings, generally, cost about $30-$70 each, and that includes the earring.

After each piercing a rigorous cleansing routine with antibacterial soap is followed to ensure that it heals properly.

Nick says the piercing "in my lower region" hurt the least of all. Asked why he did it, he replies: "I guess it's kind of a little surprise for anybody who ends up down there."

Youth see piercings as a way to wear jewelry. "It's like wearing a ring on your finger," he says.

Nick says his parents shrug it off whenever he reveals a new piercing. "My mom always says `You're going to ruin your body.' And, my dad laughs."

But, he admits, piercings are "still a shock to many adults."

"I find it's not anybody's say what piercings I can get ... I don't think people should get upset. It's like if I got upset because I didn't like someone's hair colour."

Although piercings appear to be most popular with youth, Mr. Brazda says that all age groups are doing it.

"Doctors, nurses, lawyers, school kids, university students. Anywhere from 16 to 85 years old. It's just that a lot of the older people have stuff that you can't really see - like nipple and genital piercings."

Eyebrows, nostrils and lips seem to be the domain of the young, he says, because "most people who are older can't get away with it at work."

Tongue piercings are also very popular. "If you've got an oral fixation, it's like having a permanent piece of candy in your mouth," Mr. Brazda says.

Navel piercings continue to be very popular. And genital piercings are also increasing in popularity among males and females, he says. "Mainly it's for stimulation." Among males, it's also "like a medal," he says. "People think that if you've got a piercing there, you must be brave."

Mr. Brazda says that the piercing industry is not regulated by the government.

He recommends people considering a piercing seek out a place that others have recommended, and where they feel comfortable.

So, what's the upcoming trend in piercing?

"In France, they're piercing right through the cheek," says Nick.

Reproduced from: Families & Health, September 2000, Volume 13.

Crime rate declines

By Eef Harmsen

In Ottawa, a young British engineer is gunned down by young offenders. An elderly Montreal couple is clubbed to death by three young teenagers. In Victoria, a girl is beaten to death by her schoolmates. All these horrible stories fuel public opinion that youth crime is on the rise, getting more violent, and that the federal Young Offenders Act is too lenient.However, is this really so? Across Canada, the overall crime rate is declining and so is the youth crime rate.

Between 1991-97, the crime rate for youngpeople dropped by 23 per cent from 643 to 495 incidents per 10,000 youth.

In 1997, 82 per cent of youth charges were for nonviolent crime like theft, drug possession and contempt of court orders, although the violent youth crime rate in 1998/99 was up two per cent from 1992/93. Half of all violent youth crime cases involve minor assaults. Major assaults such as aggravated assault and robbery increased by about 30 per cent over the last seven years, while major decreases were reported for sexual offenses (39 per cent), dangerous use of weapons (25 per cent), possession of weapons (24 per cent) and sexual assault (21 per cent). Murder, manslaughter and attempted murder represented less than one per cent of all violent crime cases heard in youth courts.

The justice system treats youth more harshly than adults, according to the 13th report of the House of Commons Standing Committee on Justice and Legal Affairs, released in 1997. There are about 3.5 times more adults charged than youths for all offenses, while for violent crimes the adult/youth ratio is more than five times greater. Despite this ratio, there are more youth incarcerated than adults. In 1992, the rate of detention for adults in Canada was 151 per 100,000 adults whereas 229 per 100,000 youth were incarcerated. This means that youth will be jailed four times more frequently than adults!

Also the House of Commons Standing Committee noted that the rate of youth incarceration in Canada is twice that of the United States and 15 times higher than in

Australia, New Zealand and many European countries. The percentage of young offenders diverted from the criminal justice system here is less than in the U.S. In 1997, only 25 per cent of young offenders in Canada were dealt with through processes outside the formal justice system, compared to the U.S. (53 per cent), Great Britain (57 per cent) and New Zealand (61 per cent).

The majority of all youth crimes are caused by only a small group of repeat offenders. These adolescents frequently have a long history of aggressive, disruptive, antisocial behavior, which started early in childhood. Research from Richard Tremblay of the Université de Montréal shows that it is possible to identify these children early. And there are programs which significantly reduce their risk of future delinquency. These social intervention programs are expensive, but research indicates that, in the long-term, they are highly cost-effective.

In contrast, punishing high-risk youth who have little stake in their school or community does not discourage reoffending behaviour and is expensive as well. Incarceration of a child or adolescents costs $250 a day.

Reproduced from: Families & Health, September 2000, Volume 13.

Anxiety Disorders

By Dr Sacks & Dr. Driver, Toronto

Anxiety disorders are the most common form of psychopathology in children (1,2,3) Many forms of anxiety disorders previously considered adult disorders are now noted to be present at a much earlier age (4). Children with anxiety disorders are more likely to develop mood disorders and severe behavior problem (5), One third to one half of children with anxiety are found to be clinically depressed (6). There is strong evidence for childhood and adolescent anxiety disorders to be risk factors for significant psychopathology in adulthood (7,8). Anxiety disorders are often very disabling during childhood and adolescence. One can see the roadblock anxiety would place in the way of accomplishing the tasks of adolescence. Separating from one's parents, obtaining a self-identity, forming a peer group and setting goals for educational and economic progress can all be ground to a halt because of anxiety? The not infrequently seen comorbidity of obsessive-compulsive disorder and depression make normal development even more difficult. ADD also seen in children with anxiety further marginalizes these children and youth from their peers. Many of these adolescents present to their physician with physical complaints of headaches, stomach pains, dizzy spells, shortness of breath, chest pain and other symptoms that keep them from participating in normal day to day activities. These youth are put through enormous amount of testing at great expense to their anxious bodies and minds as well as to the health care system. These tests also keep them out of school and add greatly to their parents anxieties. Cognitive therapies have been used for a long time in anxiety disorders but was integrated with behavioral techniques by Beck as presented in his text "Cognitive Therapy and the Emotional Disorders" (9). Cognitive behavioral therapy (CBT) is a short term active highly structured psychotherapy that helps the children assess their thoughts, images, attitudes and beliefs which lead to cognitive distortions and errors that make their world a very dangerous place for them, in addition, children and youth with anxiety disorders underestimate their ability to deal with these presumed dangers. In groups that we run at North York General Hospital, we first teach the adolescents about anxiety disorders. We explain current thoughts on etiology and also the pathophysiology of anxiety. We then teach them to recognize their own bodies response to this anxiety. Instruction in behavioral approaches such as relaxation breathing, progressive muscle relaxation, positive imagery, and problem solving techniques is given to bring their physical symptoms under control. This enables them to identify and question their cognitive distortions and errors. In some cases we even get the adolescents to recognize the core belief that may form the foundation of their anxiety disorder. We run concurrent groups for the parents to educate them about anxiety CBT and how to help their teens. In 1994, Kendall published his results of a randomized trial of CBT of children with anxiety disorders (10), At the end of treatment 64% of patients no longer met diagnostic criteria for anxiety compared to 5% of the untreated group. At long follow-up (2-5 years) these gains were maintained. In 1997, Kendall showed statistically significant clinical improvement with one-year maintenance of gains in another group of children (1 -1). This positive effect has been produced in group cognitive behavioral therapy as well as with individuals (12). We have incorporated within our program a parents group that runs simultaneously but separately from the adolescent group. Adding family anxiety management training has been shown to enhance the efficacy of CBT (1 3).

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ON TRAC (Taking Responsibility for Adolescent/ Adult Care) a Transition Service for Youth With Chronic Health Conditions

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ON TRAC began as a project in 1995 at British Columbia's Children's Hospital (now part of Children's & Women's Health Centre of British Columbia - C&W) to support the 1200 youth who transfer into the adult health care system annually. The ON TRAC Project was created with the support of private funding to begin to explore the needs of youth with diverse chronic health conditions as they reach the age of adulthood and prepare to leave Children's Hospital. Many youth and families had begun to voice their concerns that their transfer to the adult setting was neither prepared nor smooth. Pediatric staff were bothered by the lack of preparation yet unsure how or when to begin the process. Adult care providers also felt youth were being transferred without preparation and with few skills required by the adult system. The pediatric centre, beginning to look at the quality of care being provided to youth, was eager to support an initiative to create a pathway and process to ensure comprehensive, coordinated, continuous care.

Defining Transition Issues for Youth with Chronic Health Conditions

Transition, as a general term, describes movement from one state or place to another, a process of change or a passage from one life phase to another (*Chick & Meleis, 1986*). Transition for youth with chronic health conditions encompasses the health concerns and issues that affect youth as they prepare to move from pediatric health care services to adult health care services.

Transition has been defined as the "purposeful, planned movement of adolescents with chronic medical conditions from child-oriented to adult-oriented health care." *(Blum, Garell, Hogman, Jorissen, Okinow, Orr & Slap, 1993, p. 570)*. The goal of transition is to provide health care that is uninterrupted, coordinated, developmentally-appropriate and psychologically sound prior to and throughout the transfer into the adult system *(Blum et al, 1993)*. Transition care then, needs to be much more than a well-organized transfer of care *(Sawyer, Blair & Bowes, 1997)*. In order to assist youth in a comprehensive, coordinated transition, preparation needs to begin early on in the adolescent's life, to ensure he/she develops the skills and knowledge necessary for adulthood and the adult health care system. This entire process, called '*transition',* involves developmentally-appropriate care within an environment that supports the unique needs of youth with chronic health conditions and their families.

Youth with chronic health conditions can be described as facing many simultaneous transitions:

Developmental Transitions

- from childhood to adolescence to adulthood
- from school to secondary education or work environments
- from home to independent or community living

Health Care Transitions

- from pediatrician to adult primary care physician
- from pediatric to adult specialists/clinics
- from parent health care benefits/insurance to personal options
- from parental care to possibly attendant care

As well, youth with chronic health conditions may have a third transition from health to ill-

ness superimposed on these transitions dependent on the nature and trajectory of their illness (*Gravelle, 1997*).

Guiding Principles in Developing a Framework for Transition Planning

- The youth, families and specialty health care team members form a unique partnership that requires support and resources throughout the transition process.
- The planning and development of youth-focused, family-centered care requires active participation of the youth, family and health care team members.
- A generic model can be developed and utilized in various clinical settings to ensure developmentally-appropriate care through adolescence and ensure continuous care into the adult health care system and adulthood.
- The need to recognize and understand the existing personnel, cost and time constraints of the current health care system.
- Successful transition planning cannot occur without supporting linkages with other youth and adult programs, agencies and community services.
- A shift in the current health care practices from disease treatment to health promotion and health maintenance is required to facilitate empowerment of youth and families for ongoing health and lifestyle management.
- A system or pathway is necessary to provide documentation of the process to ensure quality standards of care and coordination into the adult system.
- The need to create a process that incorporates evaluation of the interventions, satisfaction of all involved stakeholders and long-term health outcomes for youth with ongoing health care needs.
- Ongoing collaboration and partnerships must be formed between pediatric, adult and community agencies to streamline care of youth with chronic health conditions.

Early Adolescence Ages 10 - 12 Grades 5 - 7 The ***Youth*** and ***Family*** are introduced to the Transition process and the ***Youth*** begins to participate in his/her own care.
Middle Adolescence Ages 13 - 15 Grades 8 - 10 The ***Youth*** and ***Family*** gain understanding of the transition process and the ***Youth*** practices skills, gathers information and sets goals to participate in his/her own care.
Late Adolescence Ages 16 - 18 Grades 11 - Graduation The ***Youth*** and ***Family*** prepare to leave the pediatric setting with confidence and the ***Youth*** uses independent health care behaviors and consumer skills into the adult system.
ò Self-advocacy ò Independent health care behaviors ò Sexual Health ò Social Supports ò Educational/Vocational/Financial planning ò Health & Lifestyle

A Framework for Transition Planning

A model for youth-focused care and transition planning was conceptualized that follows normal adolescent development with early, middle and late transition stages. Within this framework, specific developmentally-appropriate strategies can be placed within six main content areas: self-advocacy, independent health care behaviors, sexual health, psychosocial supports, education/vocation & financial planning, and health and lifestyle choices.

Components of the Transition Framework		
1.	**Self-advocacy & Self-esteem**	
	is empowering youth to learn about their disability or chronic condition, to understand their rights and responsibilities, to understand their medical, physical and social needs and to be able to express those needs to others and the community.	**information teaching practice resources**
2.	**Independent Health Care Behaviors**	
	include adhering to medication and treatment regimes, maintaining ongoing preventative health care, and seeking out health care information and services. The goal is for the youth to move from dependent to independent self-management dependent on his/her medical, physical and cognitive abilities.	**information practice resources**
3.	**Sexual Health**	
	addresses the impact of puberty on the youth's health condition and his/her condition's impact on sexual functioning, genetic considerations, safe choices, and identifying sexual health information in their community.	**information teaching resources**
4.	**Social Supports**	
	includes helping the family acknowledge and cope with their changing roles, identifying issues that are important to each family, linking with peer and parent support groups, recreational opportunities, and resources for ongoing support.	**information support resources**
5.	**Educational/Vocational/Financial Planning**	
	is helping the youth realize his/her abilities and potential, guiding them to resources and services that will assist in their educational/vocational plans for their future, and seeking out health care benefits, insurance, and financial planning.	**information resources**
6.	**Health & Lifestyle**	
	addresses the importance of nutrition, exercise, and taking care of oneself. Through resources and teaching, the risks of drugs, alcohol and smoking are identified and how to prevent accidents and injury to oneself.	**information teaching resources**

Tools to Support the Transition Process
From this framework, many tools, strategies, and initiatives have been developed and are being integrated into clinical practice at Children's & Women's Health Centre. The ON TRAC Project, now within the newly established Youth Health Program, have developed three distinct tools to support youth and their families, as well as care providers and organizations, to initiate and develop youth-focused care practices.

Setting The Trac: A Resource for Health Care is a manual of 250 pages written for health care providers / agencies supporting youth with chronic health conditions and their families interested in integrating transition planning into their care and services. The manual contains over 150 references supporting the design, tools, materials, and evaluation process of the **On Trac Transition Service** at C&W. The manual provides text and handout pages that can be used within various settings to support the initiation, planning, and evaluation of a program designed to support developmentally-appropriate care and transition planning. This resource manual was developed in response to the many inquiries of others wanting to begin integrating youth-focused care and transition planning into their work / organizational environments. It also includes a literature review of over 140 articles, grant proposal outlines, many tools and worksheets to promote group discussions, a **Clinical Pathway for Transition Planning and Adolescent Care** and associated guidelines, and many evaluation tools and strategies. Also included, are guidelines to integrate the use of the *Workbook for Youth* and *Youth Health Planner* into clinical practice.

Your Plan-It – a youth health planner designed for youth with chronic health conditions, was designed by and for youth to assist them in learning about their health condition and participating in their care management. Your Plan-It provides a medium for youth to record, sort and organize health care information they require on a daily basis or when arriving at a new stage in their development; school entry, changing care requirements, new health care personnel, or transitioning to adult care. This bright blue binder with full colour pages and graphics is designed for youth ages 10-18 years. The youth is encouraged to bring the planner to all health care visits and in the event of emergency care. Care providers, teachers and families are encouraged to work with youth at home, in school, and at health care visits to plan for and participate in their health care as they are interested and able. The use of the tool encourages skill and knowledge building required in preparation for the adult world and health care system.

Getting On Trac: A Workbook for Youth contains over 70 exercises for youth living with chronic health conditions to help them learn and practice the skills necessary for adulthood and the adult health care system as outlined in the Clinical Pathway for Transition Planning and Adolescent Care. Through skill development exercises in this workbook, youth are supported and encouraged as they learn to participate in their health care and transition planning. This tool is also an excellent resource for families and persons involved in the youth's health care and/or education. It has been designed for youth to own and use with support, as well as a guide for youth-focused care and education (with pages specifically designed to be photocopied) to be used in private consultation or group workshops, and as a personal support tool.

We now want to pass these tools onto our colleagues working with youth with chronic health conditions. We hope that you find these tools useful in your efforts to involve youth and support their development towards a healthy future. The ON TRAC Service continues to support multi-disciplinary teams in developing and integrating transition planning and health promoting initiatives for youth with chronic health conditions and their families. If you would like any further information, please send your fax number or contact

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Healthy Connections

Connectedness & BC Youth

Connections to family, school, friends, and community are important contributors to good health. Several researchers have found that a young person's sense of caring and connection to others has a strong impact on physical and emotional health.

The Adolescent Health Survey II used a number of questions to assess students' "connectedness," a term used to describe how youth feel about their social environment, including their family and school. Connectedness implies a sense of attachment to others; it is a resource that can be drawn upon in times of stress or in reaction to difficult experiences or decisions.

Connectedness is related to the concept of resilience, which is the ability to cope with and overcome negative events or circumstances. Adolescence is a critical period for the development of resilience. Connectedness to family and school, in addition to certain individual characteristics, seems to promote resilience and to protect against risks during the teenage years.

Results from AHS II indicate that connectedness is related to overall health and to choices about risky behaviour. These results also show that families and schools do make a difference in the health of BC youth.

Defining Connectedness

Questions on connectedness included in AHS II were derived from a major project in the United States, the National Longitudinal Study of Adolescent Health. The survey items on family connectedness assess whether youth:

- feel close to their mothers and fathers.
- feel that their mothers and fathers care about them.
- think their parents are warm and loving are satisfied with their relationships with their parents.
- feel that people in their families understand them.
- feel that they have fun with their families.
- feel that their families pay attention to them

Items related to school connectedness ask youth whether they:

- feel that their teachers **care about them.**
- have trouble getting along with their teachers.
- have trouble getting along with other students.
- feel that they are a part of their schools.
- are happy to be at their schools.
- think that teachers at their schools treat students fairly.
- feel safe at their schools.

Responses on each set of questions were compiled to give each student a relative "score" that identifies them as having high, medium, or low levels of family and school connectedness. (Connectedness to one parent or to both parents was scored equally.) Students' responses to items about their health status and risk behaviours were then compared on the basis of their connectedness scores for family and school.

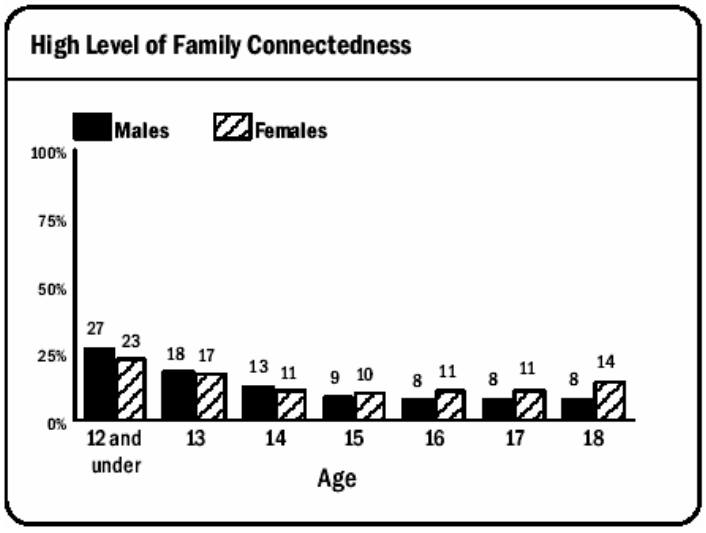
About three-quarters (72%) of BC students are classified as having a medium level of connectedness with family, and 15% are highly connected. A similar percentage (74°%) has a medium level of connectedness to school, and 13% are highly connected. Younger students feel more connected than older students: 25% of 12 yearolds are highly connected to family compared with only 9% of 17 year-olds (see figure). Connectedness to school drops between Grades 7 and 10, then tends to rise slightly in Grade 11 (see figure).

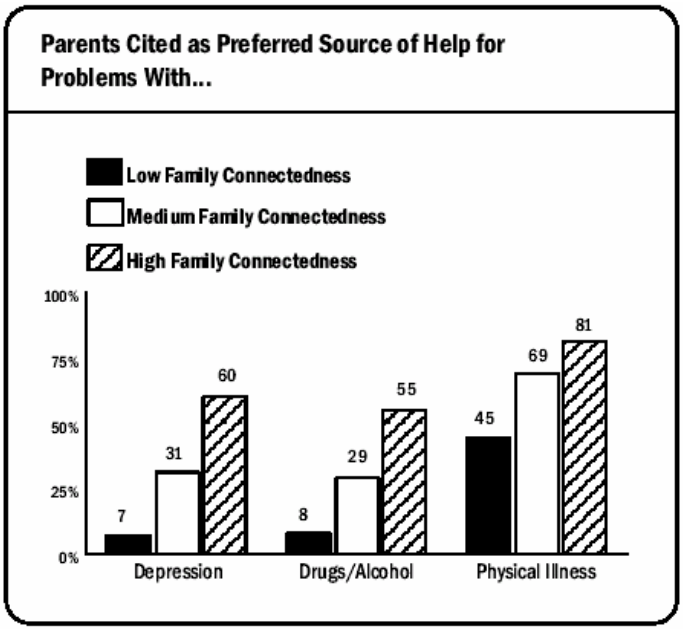
Youth who are highly connected to their families and schools also seem to have more connections to others in their communities. Highly connected youth are more likely to participate

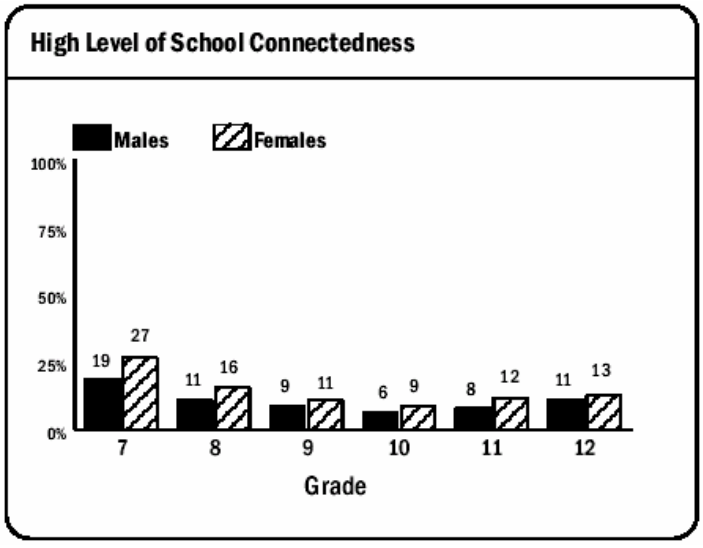
in organized extracurricular activities, such as supervised sports; dance or aerobic classes; art, drama or music lessons; or community groups and clubs. They also are more likely to be involved in volunteer activities, such as supporting a cause, fund raising, helping in the community, helping neighbours or relatives, or volunteering at school. Highly connected youth are more likely than youth with low levels of connectedness to be involved in more than just one extra-curricular or volunteer activity.

As might be expected, youth *who* are less connected to their families are less likely to report going to parents first if they have a problem (see figure below). Instead, they tend to turn to their friends, or to health professionals in the case of health-related concerns such as physical illness, STD's, or needing birth control

Family and school connectedness do not always go hand-in-hand, although two thirds of youth do have similar levels of family and school connectedness. Only about 1% of students reported low levels of family connectedness and high levels of school connectedness; another 1% reported high levels of family connectedness and low levels of school connectedness.







Less-Connected Youth

Compared to youth with a high level of connectedness, youth who are less connected to family and school are:

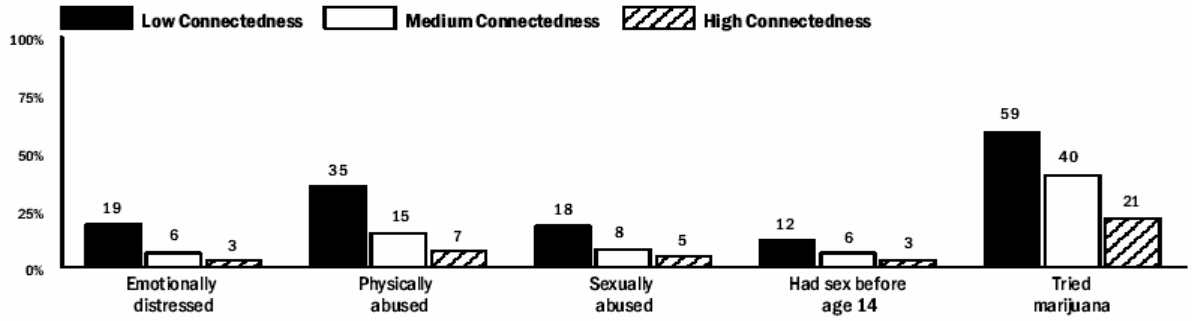
- less likely to live with both parents, and more likely to live only with their mothers
- less likely to have parents with a college or university education, fathers who are employed full-time, and mothers who are full-time homemakers
- more likely to have parents who have received income assistance from the government
- more likely not to be spiritual or religious
- more likely to have a chronic illness or disability.

Connectedness and Risky Behaviour

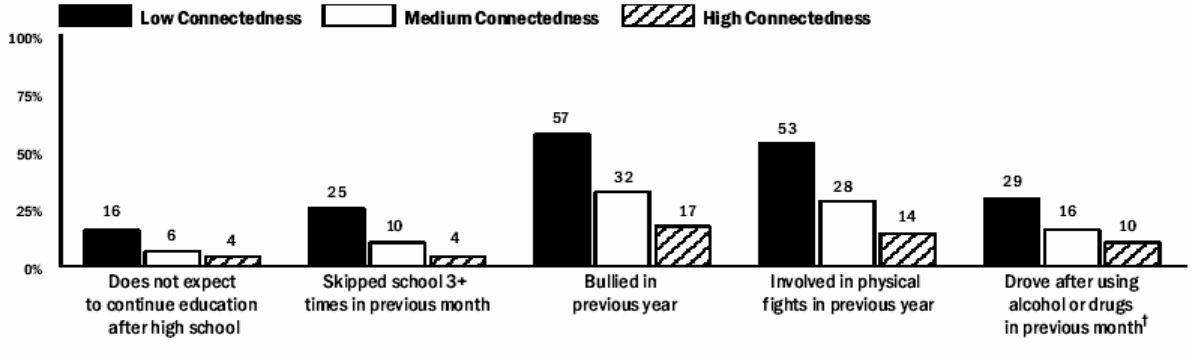
Some behavioural patterns established during adolescence may have life-long consequences. The sense of connectedness that youth feel to those around them may play a role in whether or not they make healthy decisions (see figures). AHS II results indicate that students with high levels of connectedness to family and school are less likely to engage in a range of risk behaviours, including early sexual activity, smoking, alcohol and substance use, drinking and driving, or suicide attempts. They also are less likely to experience emotional distress or abuse.

Students with high levels of connectedness are more likely to attend school regularly and to have plans to continue their education. Relationships among connectedness, health and risk behaviour are present at all age and grade levels.

Family Connectedness and Risk



School Connectedness and Risk



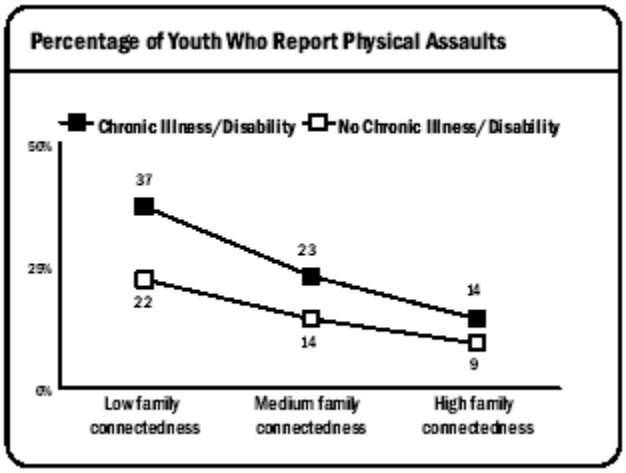
† of licensed drivers

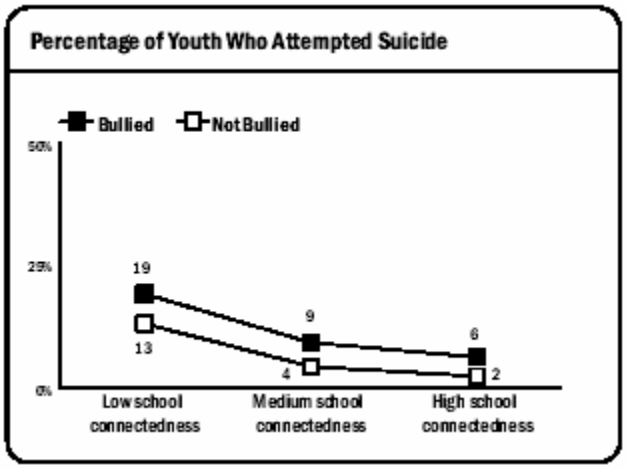
Connectedness and Resillience

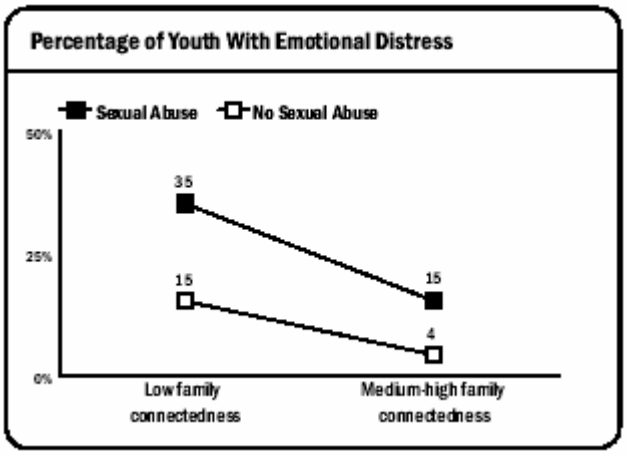
Resilience enables individuals to cope with problems resulting from life circumstances- including abuse, illness, family conflict or poverty- or as a result of experimenting with risky behaviours. Once exposed to such stresses, some youth appear to be at higher risk for further negative outcomes, while others manage to function well despite these challenges.

AHS II results show that adolescents who have been bullied, abused, or who have a chronic illness or disability are at greater risk for negative health status and risky behaviour. However, this risk is reduced for those youth with higher levels of connectedness.

For example, although sexually abused youth are generally more likely to be emotionally distressed than non-abused youth (20% vs. 6%), those sexually abused youth who are more highly connected to their families are at lower risk for experiencing emotional distress (see figure). Thirty-five percent of sexually abused youth who have low family connectedness report being emotionally distressed, compared to 15% of sexually abused youth who have medium-high family connectedness. Similarly, youth who have a chronic illness or disability have a higher likelihood of being physically assaulted (25% vs, 15%). However, the difference between physical assaults in youth with a chronic illness/disability as compared to those without, is smaller in highly connected youth. The AHS also shows that youth who are bullied at school are more likely to attempt suicide (11% vs. 4%). The proportion of youth who have been bullied who have also attempted suicide, is lower for youth who are more highly connected to school. These and other findings from the AHS results suggest that high levels of connectedness promote resilience and enable youth to cope with challenges and negative experiences.







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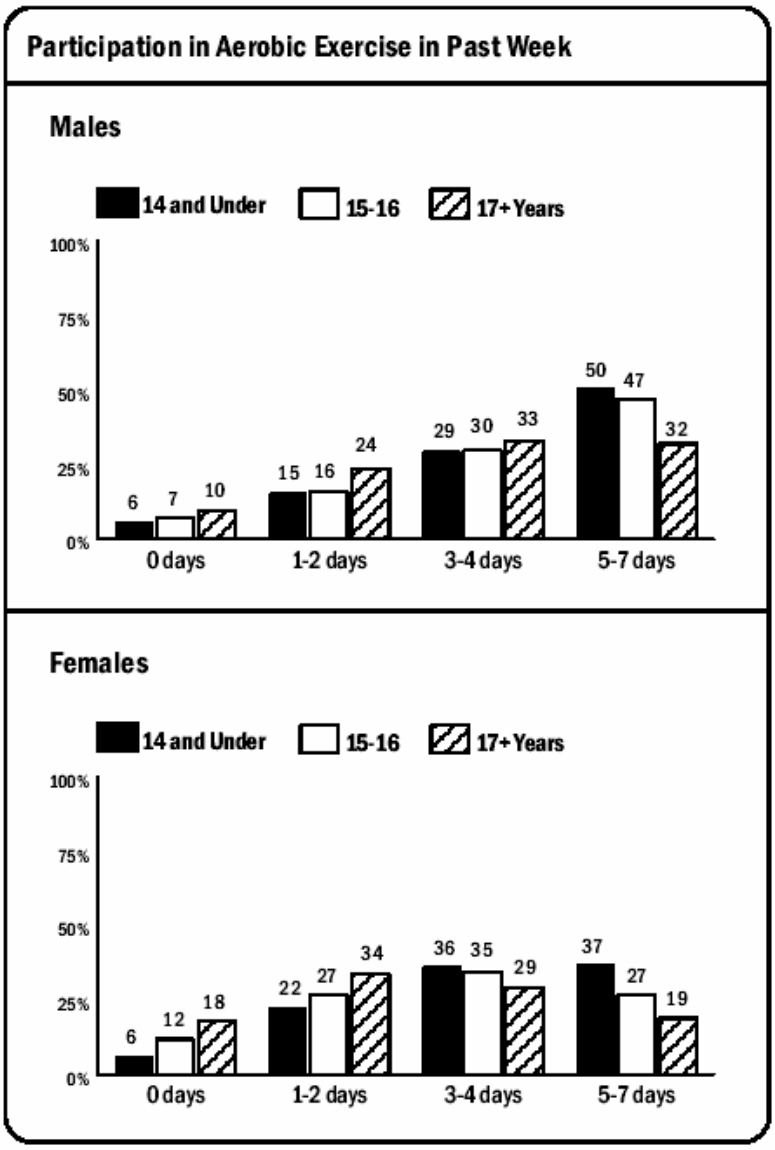
Keeping Fit

Physical Activity among BC Youth



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Participation in regular exercise is widely considered to form part of a healthy lifestyle. A recent province-wide survey shows that most BC students in Grades 7-12 are involved in a variety of physical activities. Responses to a question included in the Adolescent Health Survey about aerobic exercise (defined as exercise or participation in physical activities "that made you sweat or breathe hard") show that 69% of youth exercised regularly (on three or more days) in the previous week. Only 9% of youth had not exercised at all in the past week.

The frequency of aerobic exercise varies according to gender and age. Generally, girls and older youth are less likely to take part in regular aerobic activities than boys and younger youth (see figure). Those adolescents who do not exercise regularly are slightly more likely than others their age to speak a language other than English more than half the time at home, to be less connected to their family, and to be in a lower socioeconomic group.

Girls and older youth are also less likely to take physical education (PE) classes. While nearly all youth under the age of 15 take PE class, about half of boys and a quarter of girls 17 and older take PE. Of those who do take part in PE class, 73% of boys and 64% of girls exercise more than 30 minutes during an average class. Younger teens tend to be less likely to exercise this often in their PE classes.

Two-thirds of youth across the province indicate that they take part at least weekly in activities, such as biking or rollerblading, which are not part of an organized sports activity. Sixty percent of youth say they participate in weekly sports activities supervised by a coach or instructor, including school teams, swimming lessons, dance classes, or other sports instruction (see figure).

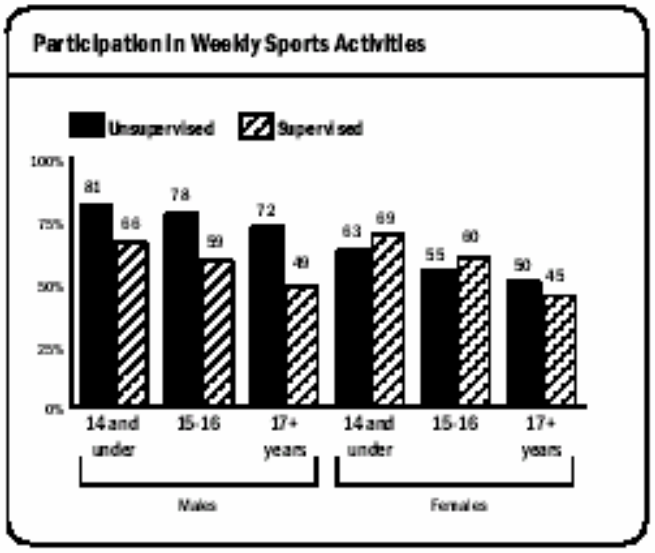
Exercise and Body Image

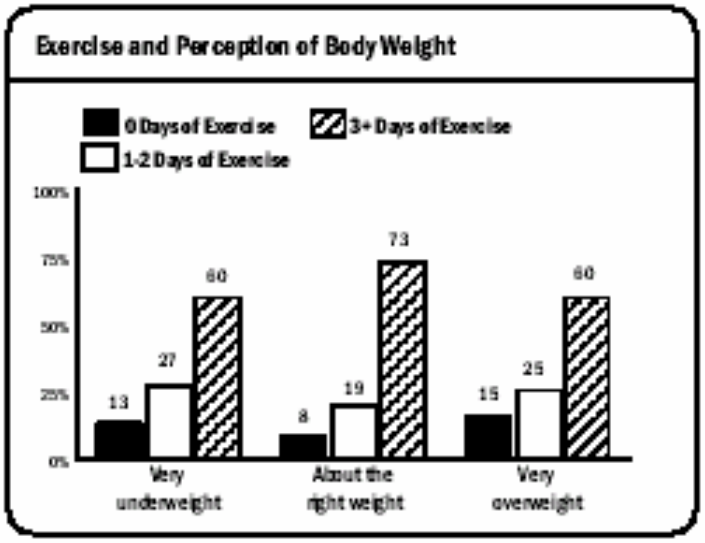
Participation in regular aerobic activity is related to how an individual feels about his or her body. Three-quarters of youth who are very satisfied with their looks say they exercise three or more times a week. By contrast, 60% of youth who are dissatisfied with their body exercise this frequently. The relationship between body image and exercise is especially apparent for boys (see figure).

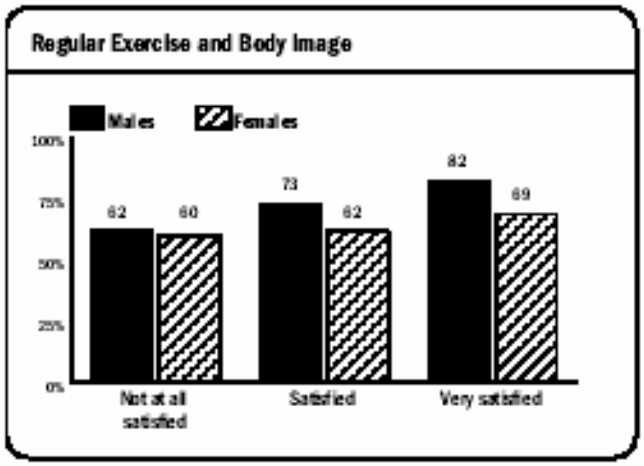
Exercise also is strongly related to youths' perceptions of weight. Forty percent of students who think they are either very underweight or very overweight exercised less than three times the previous week, compared to 27% of those who see themselves as being about the right weight (see figure). Youth who exercise to lose weight are more likely to exercise almost every day of the week. However, teens who use dieting to lose weight are no more likely to take part in regular aerobic exercise.

Exercise and Other Health and Risk Behaviours

Youth who exercise regularly are less likely than inactive students to be regular smokers or to experience physical or emotional health difficulties. Regular exercisers are also more likely to eat breakfast every day. However, they are equally likely to be current users of either alcohol or marijuana. Not surprisingly, those teens who exercise more often are more likely to experience injuries; these injuries are usually sports-related (see table).







Health, Risk and Exercise

	0 Days of Exercise	1-2 Days of Exercise	3+ Days of Exercise
Regular Smoker	16%	13%	9%
Current alcohol user	65%	69%	68%
Current marijuana user	53%	54%	51%
Had physical health problems in previous 6 months	45%	43%	38%
Had emotional health problems in previous 6 months	53%	48%	44%
Experienced injury in previous year	22%	29%	44%
Eat breakfast every day	45%	47%	52%

Safe & Sound

Injury issues among BC Youth

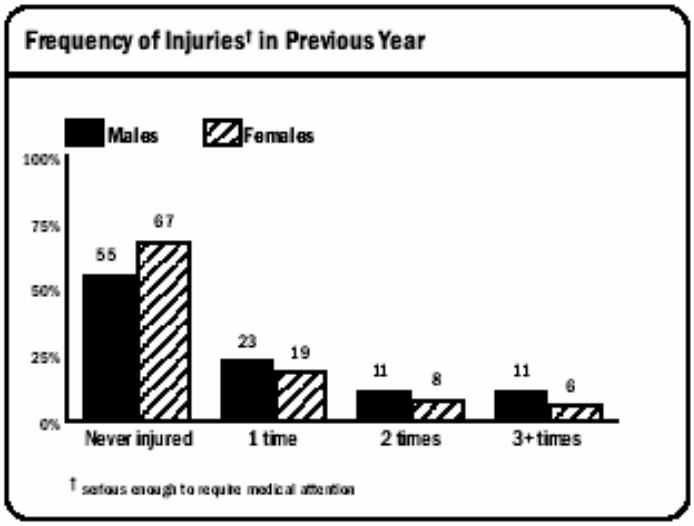
Most adolescents enjoy excellent health. However, youth are much more likely than other age groups to have serious injuries, especially in motor vehicle accidents, sports or recreational activities. Unintentional injuries are the leading cause of death during the teen years. Not surprisingly, the risk of injury increases with behaviours such as driving after the use of drugs or alcohol.

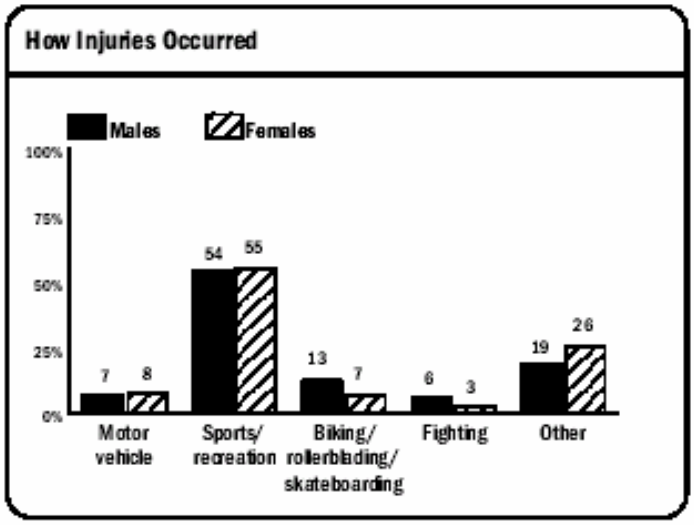
Because most injuries result from predictable and preventable circumstances, effective injury prevention programs could significantly reduce the toll of injury in the adolescent age group.

The Adolescent Health Survey shows that, in the previous year, 40% of youth had at least one injury serious enough to require medical attention. Males are more likely than females to report at least one serious injury.

Injuries among youth in Grades 7-12 are most common at ages 14 and 15, while youth aged 13 years or 18 years are least likely to report having been injured seriously in the past year.

Of youth who were injured, 22% of BC youth say their most serious injury occurred in a home or yard. Nineteen percent experienced their worst injury at school, 18% were injured in a recreation centre or arena, 13% in a park or recreation area, and 10% were injured in the street or on a roadway. Only about 2% of all youth were injured at work. (Fourteen percent were injured somewhere other than the above locations.)





Sports Injuries

More than half of all injuries are related to sports or recreational activities. About a tenth of all injuries are related to biking, rollerblading or skate boarding. The vast majority of injuries occurring at school, inside recreation centres or arenas, and in parks are sports related.

Injuries and Fighting

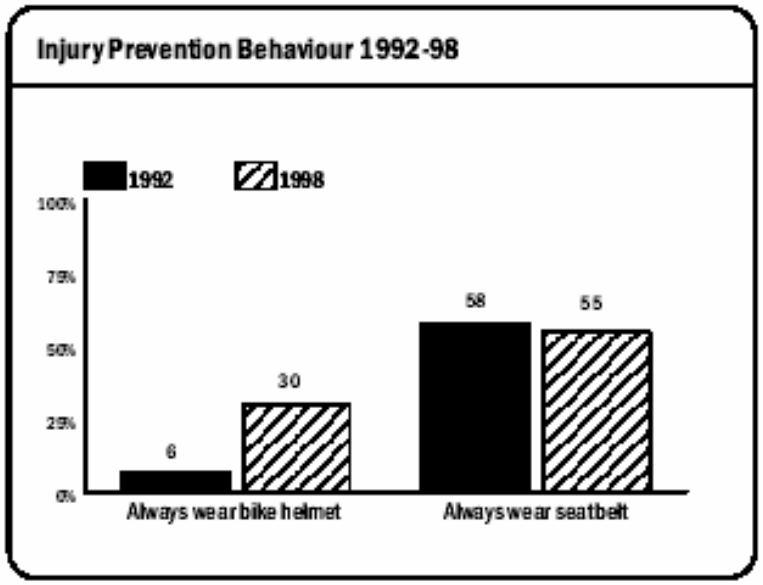
According to the survey, 30% of BC youth aged 12-19 said they were in one or more physical fights in the past year. Of these, 12% were injured seriously enough to require medical attention. As might be expected, students who had been in several fights in the past year were more likely to report having a serious injury due to fighting. Youth who report one or more injuries due to physical fights are more likely than other youth to:

- think they look older than others their age
- use marijuana or alcohol
- report being bullied at school
- carry a weapon to school
- describe their school performance as lower than average

Prevention and Risk Behaviours

More than half of all youth report always wearing a seatbelt when driving or riding in a car, while 8% rarely or never wear a seatbelt. Girls are slightly more likely than boys to wear a seatbelt all the time (57% vs. 53%).
About 16% of licensed drivers participating in the 1998 survey say they drove after using alcohol at least once in the past month. More than a third (41% of boys and 31% of girls) say they drove after drug or alcohol use at least once in their lives, and more than a fifth rode with a drinking driver once or more in the past month. Over 40% of Grade 12 drivers say they have driven after alcohol use. Drinking and driving rates have not changed since 1992.

1998 survey data show that 78% of youth rode a bicycle at least once in the previous year, down from 82% in 1992. Thirty percent of bike riders in 1998 report that they always wear a helmet, up sharply from 6% in 1992. This increase likely reflects 1996 provincial legislation requiring bike helmet use. Of youth injured while riding their bicycle, 25% say they never wear a helmet.



Protecting Youth From Injury

The AHS II survey asked youth to what extent they feel connected to school and families. Strong feelings of "connectedness" have been shown to protect against risky behaviour during adolescence. Compared to youth with low family connectedness, youth who report good relationships (high connectedness) with parents and families are:

- less likely to report one or more injuries (34% vs. 42%)
- more likely to always wear a helmet while riding a bike (46% vs. 17%)
- more likely to wear a seatbelt (72% vs. 32%)
- less likely to drink and drive; 25% of boys and 18% of girls who report low family connectedness drove after alcohol use in the month preceding the survey, compared to 15% of boys and 7% of girls who report high family connectedness.

Youth who feel their teachers care about them, who get along with teachers and school mates and feel involved in school (high levels of school connectedness) are:

- less likely to have been injured than youth who report low connectedness (31% vs. 51%)
- more likely to always wear a seatbelt (76% vs. 38%)
- less likely to drink and drive (29% vs. 47%)
- less likely to be injured in a fight (1% vs. 12%).

For Information:

McCreary Centre Society
Email: mccreary@mcs.bc.ca

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www.acsa-caah.ca

The CAAH new domain name

We have added some interesting documents and we are soon going to add more.

It is the time to renew your membership !

Lighting Up

Tobacco use among BC Youth

Tobacco use is widely recognized as a leading cause of preventable disease, chronic disability and premature death. In Canada, over 20% of all deaths each year are caused by smoking-related cancers, cardio-vascular disease or respiratory diseases. Half of all longterm smokers will die prematurely as a result of smoking; a quarter will die in middle age, losing 20 to 25 years of life

Cigarette smoking among young people remains a serious health issue in BC. Results of the Adolescent Health Survey II (AHS II) show that smoking has not declined since the first survey in 1992. Forty-five percent of students aged 12-18° have tried smoking at least once, and 15% are current (daily or non-daily) cigarette smokers. About a quarter of students in 1992 and in 1998 said they had smoked cigarettes on one or more days in the past month.

Gender And Age

Female students are somewhat more likely than males to be current smokers (17% vs. 13%). Older students, aged 15 to 18 years, are much more likely than younger students to be current smokers (22% vs.7%). The proportion of students who are current cigarette smokers increases consistently from just 29'o at age 12 to 31 % by age 18.

Cigarette Smoking, BC 1992 Versus 1998 AHS

	Ever smoked a cigarette		Smoking cigarettes on 1+ days in the past month	
	1992	1998	1992	1998
Students:				
12-14 years	33%	33%	18%	16%
15-18+	54%	57%	31%	33%
Males	43%	44%	23%	23%
Females	45%	48%	28%	27%
All	44%	46%	25%	25%

Smoking Status By Age And Gender, BC 1998

		Non-smokers	Current Smokers
Males and Females	12-14 years	93%	7%
	15-18+ years	78%	22%
	All ages	85%	15%
Males	12-14 years	94%	6%
	15-18+ years	80%	20%
	All ages	87%	13%
Females	12-14 years	93%	7%
	15-18+ years	77%	23%
	All ages	83%	17%

Starting and Quitting

Most cigarette smokers start smoking at an early age. For students who have ever smoked a whole cigarette, about two-thirds report doing so for the first time when they were between the ages of 11 and 14 years. Twenty-one percent of these students say they smoked their first cigarette at age 10 of younger, while just 12% smoked their first cigarette at age 15 or older.

Over half of current smokers say they have tried to quit smoking. Among all students who smoked cigarettes during the past month in 1992, 49% indicated they had made one or more quit attempts in the past 6 months. In the 1998 survey, this percentage had increased to 57%.

Geography

Cigarette smoking is more popular among adolescents in some parts of the province. The Greater Vancouver area has more students who have never smoked (60%), than the seven other geographic areas (at about 50%). The proportion of students of all ages who are current smokers is lowest in the Greater Vancouver area (at 13%), and highest in the Northwest area of the province (at 23%).

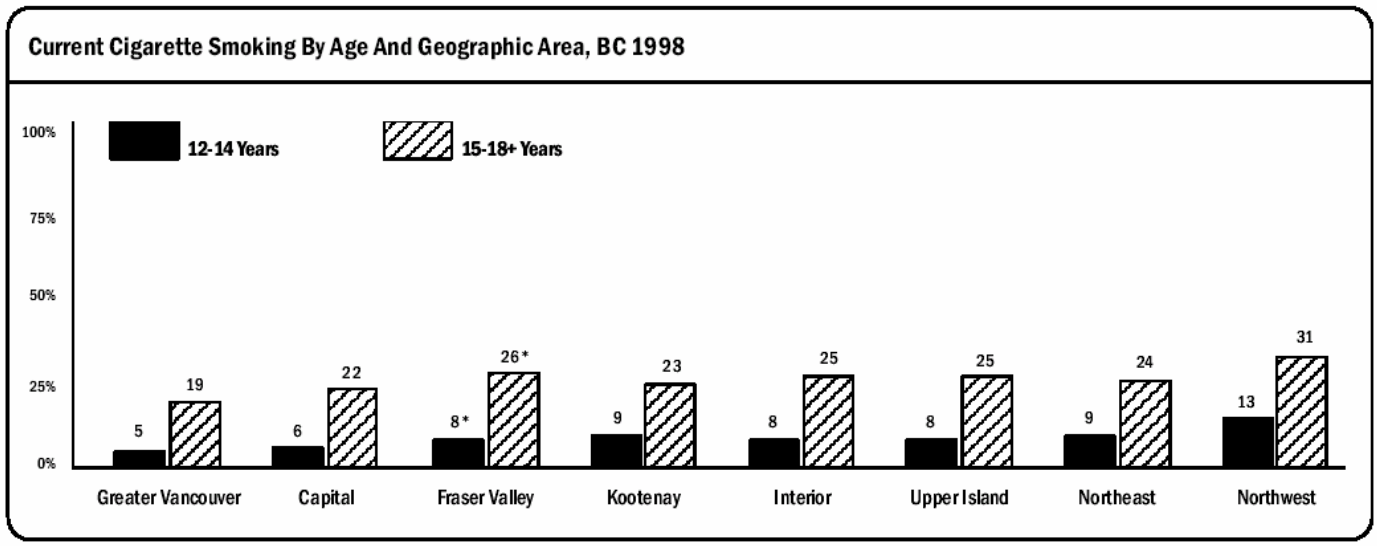
Passive Smoking

Even non-smokering youth often are involuntarily exposed to tobacco smoke in places where they live, work and play. Regular exposure of non-smokers to environmental tobacco smoke (ETS, sometimes called passive smoking) has been shown to cause a variety of illnesses. About 19% of non-smoking students (representing 15% of all students in the province) report that they are exposed to ETS at home every day or almost every day. Combined data on current cigarette smoking (15%) and on exposure to ETS (15%) suggest that the health of about 30% of BC adolescents is presently being threatened by active or passive smoking.

Health Status

Students who are current smokers are considerably more likely than non-smokers to rate their own health status as just fair or poor (28% vs. 10%). They are also more likely to report having one or more physical or emotional health complaints during the past six months.

A much higher percentage of smokers report being emotionally distressed during the past year. Seventeen percent of current smokers compared with just 5% of non-smoking students report that they had made one or more suicide attempts in the past year.



Age At First Cigarette, BC 1998

	Age 10 or under	11-14 years	15+ years
Students who have smoked a whole cigarette:			
12-14 years	33%	67%	N/A
15-18+ years	15%	67%	18%
Males	23%	64%	13%
Females	18%	71%	11%
All	21%	67%	12%

Personal Qualities And Connectedness

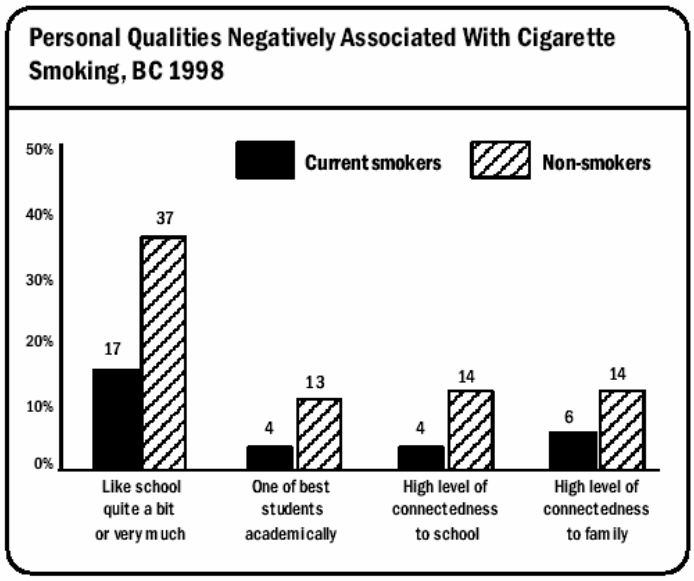
Smoking status appears to be related to a variety of personal qualities. Students who believe they look older than their peers and those who do not plan to pursue a post-secondary education are more likely to smoke. Students who like school and see themselves as being one of the best students in their class are less likely to be smokers

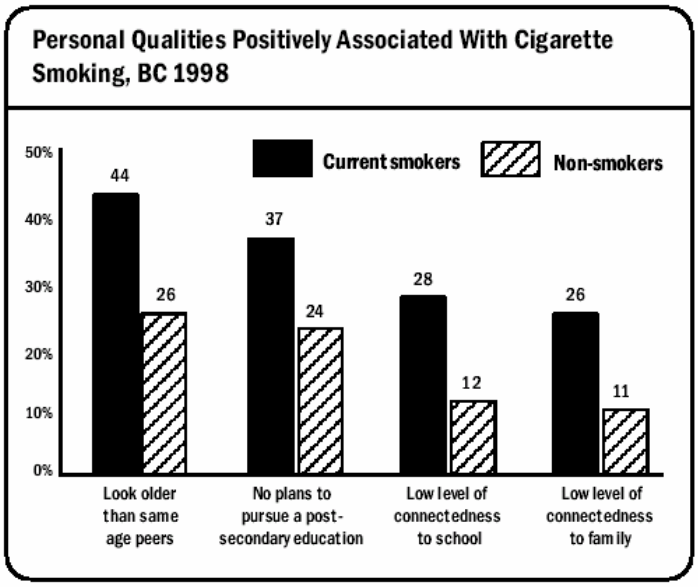
AHS 11 also collected a new category of information through a series of questions about connectedness, a term used to describe how youth feel about their relationships with friends, family and school. Students who report lower levels of connectedness to family and school are more likely to smoke than students who report higher levels of connectedness. Twenty-eight percent of current smokers indicated they had a low level of connectedness to their families, compared to just 12°k of non-smokers. Similarly, 26% of current smokers scored low on connectedness to school, compared to 11% of non-smoking students. Non-smoking students were twice as likely as current smokers to say they would turn to their parents first for help with personal problems.

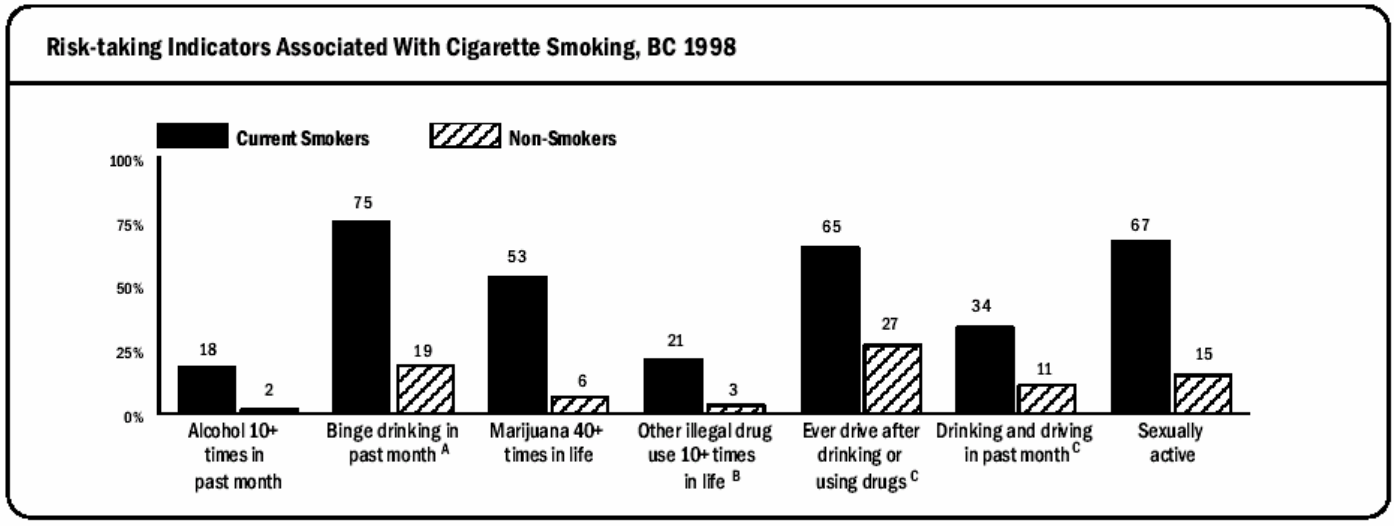
Smoking And Risky Behaviour

Cigarette smoking is also related to various types of risk-taking behaviours. Among BC students, more current smokers than non-smokers report: 1) using alcohol ten or more times in the past month 2) binge drinking on one or more occasions during the past month 3) using marijuana 40 or more times in their life; 4) using other illegal drugs 10 or more times in their life; 5) ever driving after drinking alcohol or using drugs; 6) having driven a vehicle in the past maonth after drinking alcohol; and 7) having ever had sexual intercourse.

It is the time to renew your membership !
Do it now!







Tobacco Sources

AHS II asked current smokers to indicate where they usually obtain their cigarettes. About half of all current smokers aged 12 to 18 years report that they usually get cigarettes from their friends, either through purchase or simply being given cigarettes. About 15% of all current smokers are given cigarettes by their parents, and another 15% sneak them from their parents

While sale of tobacco to minors is illegal in BC, these restrictions do not seem to be very effective. It appears easy for teen smokers to purchase cigarettes directly from virtually every type of retailer. Convenience stores and gas stations are favourite sources for younger and older students alike. Forty-five percent of current smokers aged 12 to 14 and 67% of smokers aged 15 to 18 report purchasing their cigarettes from convenience stores. About a quarter of 12 to 14 year olds and 45% of 15 to 18 year olds usually purchase cigarettes from gas stations. Cleary, BC needs to improve enforcement of laws prohibiting the sale of cigarettes to minors.

Prevention That Works

Most young people are already aware of the health risks associated with smoking, yet too many teens still choose to smoke. Smoking

prevention programs appear to have had limited success in reducing smoking rates in this age group. New data on smoking from AHS II suggests that tobacco education programs for youth may be doomed to ineffectiveness when they do not take into account the social environments of adolescents.

To positively influence youth choices about smoking, tobacco control initiatives must consider the inter-relationships between home and school environments, as well as the influence of peers. Smoking prevention programs for youth may need to focus more on enhancing open and meaningful communication, creating supportive home and school environments that discourage tobacco use.

A better understanding of the social context of adolescent smoking behaviour is essential for the development of smoking prevention and cessation methods that can achieve long-term positive outcomes in the future.

For Information:

McCreary Centre Society
Email: mccreary@mcs.bc.ca

Current Smokers Usual Sources For Obtaining Cigarettes By Age Group, BC 1998

	Age 12-14 years	Age 15-18 years
Parents give them to me	12%	18%
I sneak them from parents	27%*	11%
Friends give them to me	58%*	51%
I purchase from friends	53%*	38%
I purchase from convenience store	45%*	67%
I purchase from supermarket	10%	18%
I purchase from restaurant	6%	11%
I purchase from gas station	23%	45%
I purchase from drug store	5%	10%
I purchase from hotel/motel	#	4%
I purchase from smoke shop	12%	19%
I purchase from pub/lounge	5%	11%

Publications

Metis Gazette a big hit

Youth get forum for culture, ideas

Although it has all the features of a larger daily -politics, sports, arts, travel, culture and human interest -there's something that sets Canada's newest newspaper apart from the competition.

Its focus is on Métis youth.

This summer, the *Metis National Youth Advisory Gazette* was launched with hoopla and excitement from its. North Battleford, Sask., headquarters.

The *Gazette,* which can also be read online at www.metisnation.ca, provides a voice for thousands of young people across the country. In its first week, there were 9,000 "hits" on its Internet site alone.

Not only does it give youth a forum to publish their thoughts, experiences, artwork and poetry, it also provides strong links to their culture - teaching them everything from the basics of the, Métis's *Machif* language to the history of leaders Gabriel Dumont and Louis Riel.

The *Gazette,* which is funded by the Métis National Council, also features profile stories on Métis youth who are role models for others their own age.

Co-editors Trevor Kennedy and Jennifer Brown say it has been a learning experience to put the issue together.

"The first one is always the hardest," says Mr. Kennedy, who is also president of the Métis Nation of Saskatchewan Youth Council.

The next issue comes out in December.

Stores ideas are gathered at youth conferences and through the Métis National Youth Council. "We listen and talk to the youth and see what they think will benefit them," Mr. Kennedy says.

Take Five

In order to meet the requirements of the Ministry of Health's 1997 Mandatory Health Programs and Services Guidelines sexual health component, the *Take Five* information newsletter, focusing on sexual health issues for youth, was developed. The Sexual Health Network of Eastern Ontario, a collaborative health unit committee with membership from six health units in Eastern Ontario, developed the *Take Five* newsletter. The purpose of the newsletter is to:

- Provide parents and other adults who work with youth with information on an on-going basis that will assist them in their role as the primary sexuality educators of their children
- Promote awareness about youth sexuality to parents, caregivers and those persons who work with youth
- Promote communication between parents/ caregivers and youth.

To order back issues call:

Cheryl Howe
Tel: (613) 345-5685
Ext: 2266
Fax: (613) 345-7038
You can find past issues of *Take Five* on our web site at www.rmoc.on.ca/healthsante/en/public.htm#takefive

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The Health of Canada's Children : A CICH Profile Third Edition

The Health of Canada's Children : ACICH Profile Third Edition is a product of consultation throughout our country, drawing on resources and advise from a wide range of experts in many fields. It provides a relevant and clear picture of where our children are today, and gives some direction for where we might assist them as they explore their futures.

The Health of Canada's Children : ACICH Profile Third Edition is a source of reliable, relevant and concise information on the health of children and youth. This signature publication covers a broad range of community health indicators in a reader-friendly format and includes graphs and chapters focusing on:

- Pregnancy, birth and Infancy
- Pre-School Children
- School-aged Children
- Youth
- Income Inequity
- Mental Health and Well-being
- Children and Youth with disabilities
- Aboriginal Children and Youth
- Children's Environmental Health

To order contact:

Canadian Institute of Child Health
374 Bank Street, Suite 300
Ottawa, Ontario, K2P 1Y4
Tel: (613) 230-8838; Fax: (613) 230-6654
e-mail:cich@cich.ca
Internet: www.cich.ca

Your Plan-it

Your Plan-It has been created for youth to enable them to take an active role in their health care planning and health promotion. It was designed as a tool to assist youth in their task of sorting and organizing the enormous amounts of information presented to them during health care visits. It will also provide a medium of recording and finding pertinent information as needed – on a daily basis or when arriving at a new stage in development: school entry, changing care requirements, new medical/school personnel, or transitioning to adult care.
Your Plan-it was developed for youth to:

- Communicate their needs more effectively to health care providers, family members, and others;
- Improve their understanding of their health conditions and health care services available to them; and,
- Provide youth with the opportunity to learn and develop the skills necessary for health management and navigating the adult health care system.

Individual copies are available from:

The Family Resource Library
Third Floor, Room 3D24
B.C.'s Children's Hospital

Volume copies (over 5) are available from:

On Trac- A Transition Service
For Youth, Families and Health Care Providers
Children's & Women's Health Centre
of British Columbia
4500 Oak Street, Room B426
Vancouver, BC
V6H 3N1
Tel : (604) 875-3472
Fax : (604) 875-2388
Email : mpaone@cw.bc.ca

Getting on Trac – A Workbook for Youth

On Trac, a transition service at Children's & Women's Health Centre of British Columbia, has produced a workbook for youth to support and encourage their participation in their own health and transition planning. The workbook offers youth exercises for skill development and information.

This 123-page workbook is divided in eight sections:

1. About me
2. Doing It!
3. The S(ex) Word
4. Feeling Connected
5. About My Future
6. Healthy Choices
7. Making the Move
8. More Stuff

To order contact:
Mary Paone, CNS
On Trac Transition Service
Tel: (604) 875-3472
Fax: (604) 875-2388
Email: mpaone@cw.bc.ca

The Progress of Canada's Children Into the Millennium

The Progress of Canada's Children 1999/2000: Into the Millennium is the fourth in a series of annual reports from the Canadian Council on Social Development that monitors the well-being of children, youth and families. This 72-page report presents a wealth of data and information about children and youth, organized into two main sections. The first section assesses important inputs into child and youth well-being such as economic security, physical safety and community resources. The second section reviews how children and youth are faring by assessing outcomes such as learning achievements, health status and youth employment.

The long-term goal of *The Progress of Canada's Children* is to measure changes in children's well-being from year to year. This year's millennium issue reviews trends over the 1990s and it looks forward, to areas deserving of our attention in the future if we wish to build on our successes in promoting child well-being.

Please send your order to:
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E-mail: publications@ccsd.ca
You can also order on-line at www.ccsd.ca

Style : Questions & Answers on Sexual Health

The document was produced jointly by the Department of Health and Social Services, the Yukon Medical Association and the Yukon Medical Officer of Health. Its purpose is to provide comprehensive yet easy to understand sexual health information to the general public. The book includes chapters focusing on:

- Birth control
- Pregnancy options
- STDS
- Puberty and reproduction
- Gay, lesbian, bisexual
- Rape and abuse

For information:

Reproductive.health@gov.yk.ca

Phone: (867) 667-8393

CAAH 8th National Annual Meeting

Montreal, Fall 2001

The Canadian Association for Adolescent Health will hold its 8th Annual National Meeting in November 2001, at la Maison Notre-Dame (Westmount).
This meeting will present a concomitant French and English program under the theme :

« Adolescence : the teen, the family, the team and the network »

It will be an opportunity to discuss adolescent-parent relationships, health care worker-adolescent relationships, the difficulties to work in team and the problems of networking. Some workshops will focus on intervention for specific problems of adolescents.
The program will be distributed at the end of summer with registration forms.

Please consult the webiste during the summer for incoming information about the Meeting.

Information

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