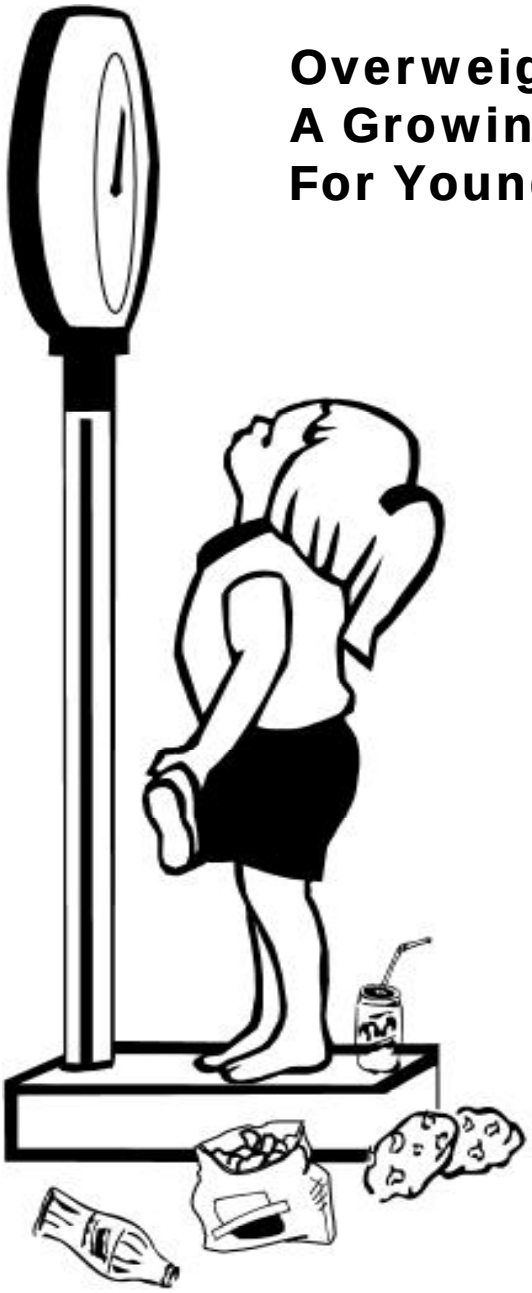
CANADIAN ASSOCIATION
FOR ADOLESCENT HEALTH

December 2001

Volume 10 Number 4

PRO-TEEN

Overweigth... A Growing Problem For Young Canadians!



PRO-TEEN

Publisher: CAAH

Editor in Chief
Dr Jean-Yves Frappier

Associate Editors

André Malo
Philippe Nechkov
John Duong

CAAH

Section médecine de l'adolescence
Hôpital Ste-Justine
3175 Côte Ste-Catherine
Montreal QC H3T 1C5

Tel: (514) 345-9959
Fax: (514) 345-4778
E-mail: acsacaah@globetrotter.net
Web: www.acsa-caah.ca

TABLE OF CONTENTS

Legal Deposit, National Library of Canada ISSN 1201-5474
Canada Post-Convention number 40032438

News from the Association

President's Report 2001

The state of membership in December 2001 is as described in table below.

This year, 66% of our members have paid their dues. The members of 1999 will probably not renew their membership but many members from 2000, probably more than the half will renew in 2002 after several reminders.

We are loosing members each year. Many retire or are not working with adolescents anymore. Also, many organizations were taking a membership for many professionals and are renewing for one only. There are more members in Québec and Ontario because more promotion of CAAH was carried on in those provinces (with more national and regional meetings).

84% of the members are women and 16% are men; 61% of the members want to receive their mail and journal in French, 32% in English, while 7% want both.

47% of the members have a single membership; thus 53% are in a group membership. This includes members who have an institutional membership (185$ for up to 7 members).

23% of the members pay themselves their dues, 75% having their dues paid by their institution or organization; 2% are free members or other kind of payment.

Meetings

The annual meeting, Fall 2001 in Montreal has been cancelled. The meeting will take place the 25th and 26th of april 2002.

Web site

We are slowly developping our web site.

1999	123 (15%)
2000	123 (15%)
2001 (registered and paid in 2001)	529 (66%)
2002 (registered and paid since September 2001)	29 (4%)
TOTAL	**804**

Journal

The journal is very popular. Many of our new members become members to receive the journal. We have to think about the orientation of this publication. Publishing the Journal is time consuming. However, it is encouraging to see that some articles were submitted to the journal by members.

Sections

The committee Section Quebec is in function since three years; their members have developped their third programs for a meeting taking place during april 2002. We find among the members: Danièle Bouchard, nurse; Ginette Ducharme, nurse; Pierre Chartrand, social worker; Yves Lambert, family medicine; Judith gaudet, Ph.D. student in psychology and Jean-Yves Frappier.

Committees

Advocacy

This committee is working with Dr. Leonard chairing this Committee. The Committee has limited financial or support resources. They are active with gun control laws and smoking in adolescents.

Finances

The memberships from the members bring 14,000$ per year. We are still waiting to receive many funds from contracts and work done during 2000 and 2001. We are in deficit because of this.

Future actions

The CAAH is still in financial trouble. The development is slower and harder then expected. The survival depends on each member's efforts.

Happy and productive year,

Jean-Yves Frappier
President

Members per provinces	
Québec	572 (71%)
Ontario	157 (20%)
British Columbia	30 (4%)
Nova Scotia	11 (1.3%)
Alberta	15 (2%)
Saskatchewan	6 (0.7%)
Manitoba	4 (.5%)
Newfoundland	2
New Brunswick	5
Yukon	1

Work Place (more than one choice)	
CLSC	32%
Private Office	9%
School	28%
Public Health	12%
City Health Department	0.2%
Hospital	17%
University	6%
Community Organization	5%
Youth Centres	4%
Children Aid Society (Youth protection)	3%
Custodial Facilities	2%
Governmental Organizations	3%
School Board	2%
Others	4%

Type of Work (more than one choice)	
Clinical Intervention	62%
Teaching	33%
Prevention / Promotion	54%
Health Education	39%
Clinical Coordination	11%
Group's Animation	25%
Community Work	17%
Public Health	20%
Research	9%
Administration	10%
Documentation, library	3%
Benevolent	3%
Media	2%
Street Work	2%
Program Development	15%
Others	3%
Not answered	9%

Professions of members			
Nurses	32%	Paediatrician	6%
Social Workers	12%	Gynecologist	0.12%
Psychologist	7%	Psychiatrist	0.6%
Teachers	1%	Other medical specialties	2%
School Counselors	3%	Dentist	0.12%
Child Life Worker, Occupationa lTherapist	4%	Librarian, Documentalist	2%
Community Workers, Street Worker	2%	Nutritionist	1%
Sexologist	1%	Administrator	2%
Coordinator	4%	Research Agent	0.3%
Family Doctor	11%	Others	8%

Fields of Interest (more than one choice)	
Parents/adolescents Relationships	69%
Behavior Problems	58%
Sexuality, Pregnancy, Contraception	65%
Handicap, Chronic diseases	38%
Sexual Abuse	57%
Anorexia Nervosa, Bulimia	62%
Suicide, Suicide Attempt, Depression	63%
STD and AIDS	55%
Drugs Use and Abuse	60%
General Health: growth, skin, ortho, sport	42%
Rights, Laws	39%
Adolescent Development	40%
Learning Disorders	46%
Violence	45%
Nutrition, obesity	45%
Psychosomatic Diseases	42%
Not Available	9%

Budget: Auditor Report 2000

Revenues	
Subventions	87,253
Membership fees	14,306
National Meeting (2000)	74,660
Regional meeting	1,200
Regional Meeting Ontario	10,285
TOTAL Revenues	**187,704**
Expenses	
Administrative support	41,641
Advertising	500
Project Assistant	44,518
Data entry	1,702
Taxes and permits	294
Journal	13,494
Office supplies	4,244
Maintenance	2,010
Bank charges	316
Travel charges	1,026
Amortization	1,891
Professional fees	1,025
National Meeting	64,404
Regional Meeting	7,806
TOTAL Expenses	**184,872**
In bank, end of year	**(32,882, deficit)**

Please take note...
CAAH new e-mail address

acsacaah@globetrotter.net

Scientific Events

Together Working For and With the Adolescent

12th Quebec Regional Meeting - Montreal, April 25th and 26th 2002

The CAAH will present its 12th Quebec Regional Meeting the 25th and 26th of April 2002 in Montreal at the Maison Notre-Dame. The topic of the Meeting is: "Together Working For and With the Adolescent". It will be presented in both languages, English and French. The objectives of the Meeting will be the following:

- Better understand some issues that adolescent are confronted with, such as the clash between two cultures, parent-adolescent relationship, chronic diseases and motherhood.
- Better understand the relationship between the adolescent and health care workers and educators.
- Improve our intervention with adolescents and their parents.

The meeting will include as usual some guest speakers and workshops. The guest speakers are Mounir Samy who will present "How Can I Not Love My Child? – The Question of Parental Ambivalence"; Jaswant Guzder, "Adolescents Growing Up Between Two Cultures: Conflicts, Competence and Individuation Issues" and Sarah Brandon, "Youth Friendly care and services". There will be two periods of workshops during each day of the meeting, the morning and the afternoon. And the last day the general assembly of the members of the CAAH will take place.

For more information, please contact:

ACSA — CAAH
Section de médecine de l'adolescence
3175 Ch Ste-Catherine,
Montréal QC H3T 1C5
Tel: 514-345-9959
Fax: 514-345-4778
E-mail: acsacaah@globetrotter.net
www.acsa-caah.ca

Articles

New Youth Health Survey Planned for Spring 2002

The McCreary Centre Society has initiated plans for a third round of its Adolescent Health Survey (AHS III), scheduled to begin early next year. The 2002 AHS III survey of students in grades 7-12 will provide up to date in-formation about the physical and emo-tional health of BC youth. Results from the new study also will reveal health trends since the last survey, AHS II, conducted in 1998. McCreary conducted the first BC Adolescent Health Survey in 1992.

AHS uses a pencil and paper questionnaire to record students' responses to questions on health issues including exercise and nutrition, injuries, depression, and risk taking activities such as smoking, and drug and alcohol use. Other questions provide indicators of the youth's social supports and connections with school and family. AHS II showed that young people who have a strong sense of "connectedness" are less likely to engage in risky behaviours.

The questionnaire is administered in classrooms by public health staff and takes about an hour to complete. A sample of students will be selected to reflect the population of students from all regions of the province. The survey is voluntary, and parent and school district permission is required. About 26,000 students from 43 of the provinces 59 school districts agreed to par-ticipate in the 1998 survey. Project Coordinator Aileen Murphy says the research team hopes to increase the level of participation for AHS III to ensure that as many school districts as possible are included.

An Interministry committee and a broadly-based advisory committee with representatives from the provincial government and from youth-serving organizations will guide the development of AHS III.

Funding for the project is provided in part by the BC Ministry of Children and Family Development and the Ministry of Health.

Provincial highlights from AHS II were published in a 1999 report called Healthy Connections: Listening to BC Youth. McCreary also has released a series of 22 regional reports based on the data, as well as summary fact sheets and reports on a number of special population groups and topics. (See full publication list, page 8.) In addition, McCreary sponsored a series of "Next Step" workshops to present the study results and gain feedback from young people.

AHS II reported both positive and negative aspects of youth health in BC. The data showed that teens are waiting longer to begin having sex, fewer girls are experiencing sexual or physical abuse, and more youth are using bike helmets. However, the study indicated that cigarette smoking has not decreased in this age group, and that many sexually-active young people do not take action to prevent unwanted pregnancies or sexually transmitted diseases. The data also showed a significant increase in marijuana use. Results from the survey were widely reported in the media and are used extensively by government and community services to plan health and education programs for adoles-cents.

Prior to beginning administration of the survey during the Spring 2002 school term, McCreary is developing information packages for school districts, parents and youth. The research group also is reviewing items used on the AHS II questionnaire and considering additional questions to generate

new information about youth health status and trends.

In keeping with McCreary's commitment to the involvement of young people in the work of the organization, an AHS III youth advisory committee has been formed. Not only will this group of young people provide valuable input into the AHS III development process but they will also develop additional tools for involving youth in advocating for the survey and in the dissemination of the survey results.

McCreary Centre Society
401 North Esmond Avenue
Burnaby, BC V5C 1S4
Tel: (604) 291-1996
Fax: (604) 291-7308
e-mail: mccreary@mcs.bc.ca
www.mcs.bc.ca

YACshops: Workshops by Youth for Youth

YACshops are for-youth-by-youth work-shops designed to promote youth volunteerism. They were developed, written and tested by members of Mc-Creary's Youth Advisory Council (YAC), with funding from the Involve BC pro-gram. YACshops include:

- So You Wanna YAC...
- Introduction to Leadership
- Taking Leadership to the Next Level
- Team Building
- Communication
- Creativity & YOU!

Whether you're a first time facilitator or seasoned pro, YACshops are easy to use. Included in each manual are instructions on preparing for the workshop; a step by step guide to facilitating the workshop; and all of the handouts and overheads required in the workshop.

Included in the YACshop manual is an "appendix" full of icebreaker activities that can be used at any time during the workshop to keep participants active and interacting with each other.

Through small and large group dis-cussions and interactive activities, participants will be given the opportunity to develop the knowledge and skills required to become more successful youth volunteers. Each YACshop builds on the capacity of young people to network and participate in their own communities. This in turn helps them develop a stronger commitment to the community and improves both peer accountability and intergenerational relationships.

McCreary Centre Society
401 North Esmond Avenue
Burnaby, BC V5C 1S4
Tel: (604) 291-1996
Fax: (604) 291-7308
e-mail: mccreary@mcs.bc.ca
www.mcs.bc.ca

B.C. Youth Health Consortium

The BC Consortium for Youth Health was launched earlier this year, creating a promising new format for research and action on adolescent health issues. The Consortium membership includes about two dozen individuals representing the province's four universities, the provincial ministries of Health and Children & Family Development, plus the Children's Commission, the Provincial Medical Health Officer, and The McCreary Centre Society. Roger Tonkin, Chair of the Board of McCreary, serves as the group's Chair.

Key objectives of the Consortium include:

- encouraging multi-sector, multi-disciplinary (academic/professional/government/ community) collabora-tion on youth health issues
- advancing research and sharing of knowledge about youth health
- enhancing education and training opportunities for professionals working with youth
- providing guidance for the development of sound government policy and programs relating to youth
- developing and evaluating models for health promotion and health service delivery for adolescents
- fostering support for the participation of young people in youth issues

The new Consortium plans to pro vide a means of coordinating interests and efforts related to youth health.

Bringing together individuals from a variety of perspectives is intended to promote new opportunities for research, improved professional training, and more effective policies and services for adolescents. The consortium will fill a critical gap between academic study and service delivery. It also will position BC institutions to take advantage of new funding opportunities, to influence future developments and to emerge as a national leader in youth health.

The consortium's work is supported by contributions from Children's Hospital Foundation, Ministry of Children & Family Development, Canadian Institute for Health Research, Canadian Rural Partnership, Youth in Society Project, and inkind support from University of Victoria, The McCreary Centre Society, and Simon Fraser University.

The Consortium has established four initial areas of focus: research, training, innovation, and youth participation. This November, the Consortium is convening an invitational forum on youth health in BC to discuss these focus areas and plan for future development. Titled "Youth on the Agenda," the forum will be attended by about 100 people from across the province. The forum is designed to help the group set priorities and establish an action plan for ensuring a proper place for youth in policy, legislation and service delivery.

McCreary Centre Society
401 North Esmond Avenue
Burnaby, BC V5C 1S4
Tel: (604) 291-1996
Fax: (604) 291-7308
e-mail: mccreary@mcs.bc.ca
www.mcs.bc.ca

Study Offers Insight On Youth In Custody

On an average day, about 300 young people are residents in BC's nine youth custody centres. These youth have been convicted of a crime and sentenced to a period of time in a custody centre to compensate for their actions and to receive services that may contribute to their rehabilitation. A new McCreary report, Time Out: A Profile of BC Youth in Custody, provides a closer look at the physical and emotional health of these young people, as well as offering information about the youths' perceptions of life in the custody centre.

The 243 youth who participated in the study answered a wide-ranging se-ries of questions about their health, their lives inside and outside the custody centre, their problems and concerns, and their expectations for the future. Results of the research show that this group of young people is at very high risk for health and emotional problems. Many of the young people in custody centres have experienced violence or abuse, and most are lonely and disconnected from their families. Many are dealing with the consequences of early exposure to drugs and alcohol, and many have considered suicide. Most have had more than one encounter with the justice system prior to their confinement in the custody centre.

Highlights of the study include the findings that youth in BC custody centres are much more likely than others in the same age group to:

- have parents with a history of substance use and criminal involvement
- have limited family or social supports
- have a serious health problem, including attention deficit disorder, learning disabilities, depression or Fetal Alcohol Syndrome

Young people in custody centres share many characteristics with street youth. In fact, the study showed that many youth in custody centres have lived on the street at some time.

The report does express some optimism that youth who spend time in custody centres will move on to happier and more productive lives. Despite their difficult circumstances, most of the youth who contributed to the study say that they foresee a personal future that includes education, jobs, family and a home of their own.

The study was done at the request of the Ministry of Children & Family Development (formely the Ministry for Children and Families), which has responsibility for youth custody centres in the province.

McCreary Centre Society
401 North Esmond Avenue
Burnaby, BC V5C 1S4
Tel: (604) 291-1996
Fax: (604) 291-7308
e-mail: mccreary@mcs.bc.ca
www.mcs.bc.ca

Early intervention with an adolescent twist

Roger S Tonkin MD FRCPC, Cabriola Island, British Columbia

Early intervention strategies are among the core prin-ciples of disease prevention and health promotion. The application of these principles during the childhood years has long been a priority for paediatricians. In recent years, the advocates of early childhood development have made a strong case for the importance of early interventions. This emphasis on early intervention is reflected in the National Children's Agenda (1). However, there is concern that this new emphasis may be pursued at the ex-pense of early intervention strategies that are of value in other phases of the life cycle, in particular during adoles-cence (2-5). Both Steinhauer (4) and Henggeler et al (3) provide excellent, evidence-based examples of how interventions in later childhood and early adolescence can have significant benefits in later adolescence.

It is recognized that the main risks to life and future health during adolescence are primarily due to behav-iour (6-8). It is also recognized that strategies to promote healthy lifestyles among Canadian adolescents have met with limited success (9-11). The purpose of the present paper is to focus on the period of early adolescence, and to propose that it presents important challenges and early intervention opportunities. These opportunities may provide paediatricians and other physicians with a chance to have a positive influence on developmental outcomes.

Early Adolescence

Early adolescence begins with the onset of puberty and extends into the early teen years. Because of the variability of the age of onset of puberty among Cana-dian adolescents, it may extend from grades 6 through 9. It is a phase that is characterized by rapid physical changes, emotional lability, strong peer group connections, concrete thinking and experimentation with various lifestyle fads. It is also a period when connectedness to family and school declines, and resistance to adult authority appears to rise. Conflict with family and school, and with the self are commonly experienced by early adolescents. The early adolescent years prompted G Stanley Hall (12) to characterize adolescence as a period of storm and stress. Certainly, it is a time when many adults who are faced with a recalcitrant adolescent are prone to throw up their hands in frustration and say "I give up!". However, Offer and Offer (13) and others (14) have challenged this stereotypical view of early adolescents and espouse the view that not all adolescents experience "storm and stress". Some adolescents are in a state of constant tumult, while others experience surges of tumultuous be-haviour that are followed by periods of quiescence (13,14) Still, other adolescents sail calmly through adolescence and experience it as a continuous, tumult-free developmen-tal phase. Indeed, as shown in Table 1, it is possible to match the differing coping styles (as described by Offer and Offer [13]) with the three phases of adolescence and create a nine-cell matrix that reflects more appropriately the heterogeneity of the adolescent population. This matrix provides a framework that clinicians can use to understand the particular adolescent who they are dealing with; by matching the adolescent's coping style and/or phase with clinical appraisal, they can formulate early intervention strategies that have a better chance of success (15).

Strategic Interventions

To be effective, interventions must be timely, develop-mentally appropriate and have measurable outcomes. They may require a different style (and message) and delivery vehicle during early adolescence than in later adolescence. For example, peer-based, in-school antismoking campaigns may be most effective in the elementary school years, whereas quit smoking strategies delivered in the physician's counselling room may have a significant impact on smokers in the mid to late adolescent years. Interventions may be universal (applied to all early

adolescents) or targeted to specific individuals or groups. For example, immunization against hepatitis B, a sexually transmitted disease, may be provided to high risk street youth or to all grade 6 students. The former strategy has been found to have significant compliance problems, whereas the latter assures better levels of 'herd' immunity. Finally, physicians have long recognized the important opportunity that presents itself during `critical' moments in the office or emergency room. A well timed, short message at the opportune moment often falls on receptive ears and proves to be a major contribution to life change.

Not all interventions will prevent disease or injury, or promote safe adolescent life styles. This failure is not because physicians' interventions are wrong; rather, when talking to adolescents about the risks of being invo-lved in accidents tomorrow, or experiencing cancer or stroke in later life, adolescents are more likely to believe that "it won't happen to me". Despite high profile media messages and in-class programs, far too many adolescents use tobacco, fail to exercise and consume high fat, low fibre foods (16,17). At least a partial explanation of the apparent inability of health promotion messages to affect this age group is related to the early adolescent's cognitive stage (unable to reason abstractly) and the psychology of personal fable (I know better than to let that happen to me). In addition, that which adults see as problems, adolescents see as solutions to their higher priority concerns (eg, weight control or socialization needs).

Indeed, there is growing recognition of the need to pro-mote resilience in adolescence not just as a way of enabling risk avoidance, but as a vehicle for promoting the hardiness necessary to face life's traumas successfully (4,18). A consequence of this type of thinking has been the shift in policy focus away from considering adolescents (especially early adolescents) as problems towards a more positive view of adolescence as a time to experience 'initiative' (19). Thus, early intervention in early adolescence needs to be based on an understanding of what it is that adolescents are trying to solve when they engage in a risky behaviour, and a determination of how to convert the problem into an opportunity to promote individual growth and development.

The Physician's role

The traditional role

Physicians can advocate for proven prevention techniques. The most common reason why adolescents seek medical care is injury. Whenever an adolescent is seen, physicians can use the occasion to offer a targeted inter-vention to promote proper use of safety belts; helmets when on a bicycle, motorcycle or snowboard; protective eye gear and face masks in the various ball sports (hockey, squash, baseball, etc); and safety harnesses when climbing. Universal strategies, such as for immunization, can be applied if, for example, the adolescent patient's immunization status is monitored and physicians ensure that recommended schedules are being followed. The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) (20) provides information on a range of office-based prevention strategies for adolescent patients.

Supplementary activities

Guidelines for Adolescent Preventive Services (GAPS) (20) also recommends that traditional visits are opportunities for physicians to address other less commonly applied health promotion strategies. For example, with the sexually active adolescent, this includes condom use, birth control, knowledge of emergency contraception, or where to go for help to deal with an aggressive or coercive partner. The adolescent who is beginning to smoke may already be experiencing pressure to use alcohol or experiment with other drugs, while the body builder or ballet dancer may be under pressure to use unhealthy diets or nonprescription performance enhancers. When these and other sensitive issues arise in the course of caring for early adolescents, the physician is obligated to respect the adolescent patient's privacy and rights to consent and confidentiality. This can be accomplished, without undermining the parental role, by clearly communicating the boundaries of confidentiality to both the parents and the adolescent.

When asked, early adolescents usually indicate that they wish that their physician would talk to them more about things that are of concern to them (21).

One way to get started is by scheduling a visit with sufficient time to undertake a home, education, activities, drugs, sex and suicide (HEADSS) examination (Table 2). The HEADSS schema for a screening interview of adolescents was developed by the adolescent group at the Children's Hospital in Los Angeles, California and has since proven to be a popular tool that is used by adolescent health clinicians. This type of semidirected counselling session can provide important clues to the what, why and wherefore of an early adolescent's behaviour.

Expanded role

Another way for physicians to intervene during early adolescence is by developing an understanding of the special vulnerabilities that a particular adolescent may face. For example, the tumultuous adolescent may be in constant conflict with family and school, whereas the adolescent with continuous, tumult-free behaviour may face more subtle stress and conflict. The former may manifest itself as delinquency or school failure, whereas the latter may present as anorexia nervosa. An understanding of the unique coping style of an adolescent and his or her family can help guide the physician's prescription when interventions seem in order. Helping adolescents to define clear but flexible boundaries works best in the tumultuous group, whereas stress reduction and redirection of emphasis may help prevent an eating disorder.

Other less obvious opportunities for intervention may present themselves in the examination room. This has always been an important moment in the patient-physician interaction. Depending on the circumstances, it may be a time to ask questions about bodily concerns. After the examination, it is a time to explain the physical findings and explore any special vulnerabilities such as sexual orientation and abuse, and concerns that adolescents may not be aware of their need to voice. For example, adolescents with chronic diseases and those who look older than their age are at greater risk for sexual abuse, substance abuse and suicidal ideation (22,23). These patients are particu-larly in need of a thorough HEADSS assessment during their early adolescent years.

Late recognition of a problem by physicians is an often quoted criticism of parents and adolescents. Adolescents think that physicians already know everything about them or assume that telling physicians about a problem will get them in trouble. Therefore, physicians cannot wait for their adolescent patients to tell them things. Physicians need to learn to ask the right questions and to listen carefully to the answers. Physicians can develop their interviewing or 'asking skills, and be able to understand the answers and how they compare with community norms for early adolescent behaviours (Table 3). Knowing these features and being able to identify patients whose behavior is not compara-ble with that of peers is a useful early recognition tool. Jessor (24) has noted that problem drinking behaviour is more frequent in the presence of low academic expectations, low religiosity and poor relations with parents. A history of earlier age of onset of problem drinking, cigarette use or first sexual intercourse is strongly associated with subsequent engagement in multiple risky behaviours (15). Adolescents with low connectedness to family and school are at higher risk for serious sub-stance abuse, high risk sexual activity and violence (23).

Supportive role

There are adolescents who are at risk because of circumstances beyond their control. They are in need of more individualized interventions and, where possible, the opportunity to connect, in a continuous way, to a nonfamily, caring adult (which may or may not be their personal physician). These are adolescents with chronic physical and emotional conditions, abused adolescents, adolescents who have issues of sexual orientation, some Aboriginal adolescents, early school leavers, etc (22,25, 26). These are groups of patients who enter adolescence with a history that will affect their normal adolescent growth and development, and may put them off track. Finding ways of connecting with them is an essential element in any early intervention and can be the most rewarding of professional experi-ences.

Adolescents with recognized chronic conditions, such as renal disease, diabetes or cystic fibrosis, and those who have recovered from neonatal disorders or cancer often enter adulthood

inadequately prepared. Often, they have become dependent on the paediatric model of care, and rely on parents to take responsibility for their life and health care. The process of transition of care and per-sonal responsibility needs to be introduced to them in early adolescence (27).

Specialized role

Another group of early adolescents to consider are those who are at extremely high risk. They are on the streets and may be homeless, in the justice or foster care systems, or not in school. They drift through their early adolescence and move towards the often deadly environment of the streets of the inner cities. Once there, they consume vast amounts of time, energy and resources. Often, they are beyond the reach of services and have sad, short lives. But they are not always beyond hope and benefit greatly from humane services de-livered through multidisciplinary models of alternative care (3,4,11,27,28). However, the best possible early intervention is to recognize that they are at risk before they leave their small towns and cities (29). Upstream care is most likely to work best and be more cost effec-tive.

Conclusions

Early adolescence provides a range of opportunities for physicians to play a role in interventions that are in-tended to prevent disease and injury, and to optimize health in the later adolescent and adult years. This fact has recently been highlighted in the federal document The Opportunity ofAdolescence: The Health Sector Contribution (30). The strategies outlined in the present paper are in keeping with the best principles of health care, but their implementation requires a shift in priorities and program funding. Establishing mechanisms for enhancing practitioner skills, enabling more time for adolescent-physician interaction, having a willingness to work in col-laborative, interdisciplinary models of care, promoting an expansion of biopsychosocial research on early adolescence, and funding of research needed to support evidence-based practice are but a few of the challenges physicians should agree to face.

Acknowledgement

Input from members of the Adolescent Medicine Committee of the Canadian Paediatric Society and Lionel Dibden, Head of the Adolescent Health Section of the Canadian Paediatric Society, is gratefully acknowledged.

References

1. Federal-Provincial-Territorial Council on Social Policy Renewal.
A National Children's Agenda: Developing a Shared Vision. Ottawa: Government of Canada, 1999.
2. Rutter M, Maughan B. Mortimer P, Ouston J. Fifteen Thousand Hours: Secondary Schools and Their Effects on Children. Cambridge: Harvard University Press, 1979.
3. Henggeler SW, Melton GB, Smith LA, Schoenwald SK, Hanley JH. Family preservation using multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. J Child Fam Stud 1993;2:283-93.
4. Steinhauer P. Clinical and service applications of the theory of resiliency with particular reference to adolescents. Int J Adol Med Health 2001;13:53-73.
5. Bruer JT. The Myth of the First Three Years. New York: The Free Press, 1999.
6. Tonkin RS, Frappier J-Y, Goldberg E, Westwood M. The health status of adolescents in Canada. Int Pediatr 1995;10:277-82.
7. Peters L, Tonkin RS. Measuring adolescent health status. Bailheres Clin Pediatr 1994;2:385-408.
8. Plan of Action for Health and Development of Adolescents and Youth in the Americas 1998-2001. Washington: Pan American Health Organization, 1998.
9. Youth Health: For a Change. New York: UNICEF, 1997.
10. Kidder K, Stein J, Fraser J. The Health of Canada's Children: A CICH Profile, 3rd edn. Ottawa: Canadian Institute for Child Health, 2000.
11. Tonkin R. The Future Needs of Canada's Youth. Child and Youth Health Care in the 21st Century. Report of the 11th Ross Conference on Paediatrics. Canadian Paediatric Society, 1997.
12. Hall GS. Adolescence: Its Psychology and Its Relation to Physiology, Anthroplogy, Sociology, Sex,

Crime, Religion, and Education, vols I & II. Englewood Cliffs: Prentice-Hall. 1904.
13. Offer D. Offer JB. From Teenage to Young Manhood. New York: Basic Books, 1975.
14. Arnett JJ. Adolescent storm and stress, reconsidered. Amer Psychol 1999;54:317-26.
15. Tonkin RS. Youth Needs and Problems in Adolescent Medicine: The Challenge of the 1990s. In: Frappier J-Y, Westwood M, eds. In: Report of the 8th Canadian Ross Conference on Paediatrics. Canadian Paediatric Society, 1991.
16. King AJC, Boyce WK King MA. Trends in the Health of Canadian Youth. Ottawa: Health Canada, 1999.
17. Adolescent Health Survey: Province of British Columbia. Vancouver: The McCreary Center Society. 1993.
18. Burt MR. Why Should We Invest in Adolescence? Washington: Pan American Health Organization, 1998.
19. Larson RW. Toward a psychology of positive youth development. Am Psychol 2000;55:170-83.
20. Elster AB, Kuznets NJ. AMA Guidelines for Adolescent Preventive Services (GAPS). Chicago: Williams and Wilkins, 1994.
21. Malus M, LaChance PA, Lamy L, Macaulay A, Vanasse M. Priorities in adolescent health care: The teenager's viewpoint. J Fam Pract 1987;25:159-62.
22. Adolescent Health Survey: Chronic Illness and Disability Among Youth in BC. Vancouver: The McCreary Center Society, 1994. 23. Healthy Connections: Listening to BC Youth. Burnaby: The McCreary Center Society, 1999.
24. Jessor R. Risk behavior in adolescence: A psychological framework for understanding and action. J Adolesc Health 1991;12:597-605.
25. Being Out: Lesbian, Gay, Bisexual & Transgender Youth in BC. Burnaby: The McCreary Center Society, 1999.
26. Raven's Children. Burnaby: The McCreary Center Society, 2001. 27. Suris J-C. Issues and concerns for adolescents with chronic disease and disability. Bailheres Clin Pediatr 1994;2:345-57.
28. MacKenzie RG. Considerations in developing a system of health care for adolescents. Baillieres Clin Pediatr 1994;2:215-26. 29. Our Kids Too: Sexually Exploited Youth in British Columbia. Burnaby: The McCreary Centre Society, 1999.
30. Federal-Provincial-Territorial Advisory Committee on Population Health. The Opportunity of Adolescence: The Health Sector Contribution. Ottawa: Government of Canada, 2000.

Reproduced from: Paediatr Child Health Vol 6 No 7 September 2001, 424-428.

Table 1: Heterogeneity of the adolescent population of British Columbia

	Stage of adolescence		
	Early	Middle	Late
Coping style			
Constant state of tumult	10%	10%	7%
Surges of tumult behaviour	16%	16%	10%
Continuous, tumult-free behaviour	11%	11%	9%
Approximate age group (years)	12 to 14	15 to 17	18 to 19

Table 2: The psychosocial adolescent history based on home, education, activities, drugs, sex and suicide (HEADSS)	
H = Home	Who lives there, how do they relate, what are the conflicts, recent losses or stresses
E = Education	What grade, enjoyment, accomplishments, attendance, plans for future
A = Activities	Peer relations, best friends and dating experiences, in and out of school involvement, job, vocational plans, interests, hobbies, skills
D = Drugs	Legal and nonlegal, parental awareness, type, frequency of use, setting where used, age of onset, relation to emotional state
S = Sex	Orientation, age of first experience, safe sex practices, negative experiences, number of partners
S = Suicide	Mood, poor school performance, withdrawal from friends and family, previous attempts, thoughts about suicide, close contact with suicide or death

Table 3: Risky behaviours of nonsmokers versus regular smokers		
	Nonsmoker (%)	Regular smoker (%)
Skips school	17%	65%
Drivers who have ever driven after alcohol consumption	16%	65%
Rode with a drinking driver in past month	12%	51%
Considered suicide	9%	29%
Attempted suicide	3%	17%
Physical fights in past year	23%	47%
Binge drank in past month (of user)	23%	76%
Ever used alcohol	41%	99%
Alcohol users who used alcohol 100 days or more in life	5%	38%
Ever used marijuana	14%	94%
Marijuana users who used marijuana 40 times or more in life	14%	57%
Used harder drugs	14%	72%
Ever had sexual intercourse	9%	67%
First had sex at age 14 years or younger	37%	53%
First tried alcohol at age 14 years or younger	72%	90%
First tried marijuana at age 14 years or younger	61%	86%

Child and Adolescent Bipolar Disorder

Laurence Y Katz MD FRCP, William P Fleisher MD FRCP
LY Katz, WP Fleisher.

Until relatively recently, the concept of diagnosing bipolar affective disorder in children and adolescents was controversial. The prevailing wisdom in the early part of this century was that prepubertal onset of manic depression did not occur (1). Furthermore, according to some psychoanalytic theories, depression was not possible in children because of a lack of the develop-ment of necessary psychological structures. Over the past 20 years, there has been a significant shift toward recognizing the existence of bipolar disorder in children and adolescents. Since 1980, the Diagnostic and Statistical Manual of Mental Disorders, Third Edition: DSM-III, (2), the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised: DSM-III-R (3), and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition: DSM-IV (4) have applied adult criteria to diagnose mania in children, with some modifications to take into account differences in developmental stages (5). Despite the recognition of the existence of bipolar disorder in this age group, difficulty in clearly delineating the clinical characteristics of the presentation of this illness in paediatric patients relative to adult patients continues (6).

There also exists a debate about the relationship be-tween attention deficit/hyperactivity disorder (ADHD) and bipolar disorder in the paediatric population (7). This debate reflects the difficulty in distinguishing bipolar disor-der from other psychiatric disorders. Bipolar disorder has been reported to be underdiagnosed and misdiagnosed (8). These diagnostic difficulties are of clinical sig-nificance because it is critically important to diagnose this disorder as early as possible to prevent the clinical sequelae that occur with untreated bipolar disorder (9). The recognition of the deficiency in clinical knowledge in diagnosing bipolar disorder has prompted the initiation of research to delineate the epidemiology of this illness, its phenomenology in paediatric patients, clinical course and the outcome of various treatment modalities.

Epidemiology

To date, no comprehensive epidemiological study had been conducted to determine the prevalence of paediatric bipolar disorder. Prepubertal onset of mania as defined by DSM-IV (4) is estimated to be rare. If severity and duration criteria are not required for diagnosis, lifetime prevalence estimates rise significantly (10). Thus, when reading the literature, it is important to notice that DSM-III-Revised (3) removed the duration criteria, and, consequently, prevalence estimates using these criteria are substantially higher than those using either DSM-III (2) or DSM-IV (4). The studies that have been conducted, taken together with information gathered from other sources, suggest that the rate of paediatric bipolar disorder is on the rise (6).

The types of studies that have been reported essen-tially consist of retrospective reporting or local, commu-nity-based surveys. Lish et al (11) conducted a retrospec-tive survey of adult patients with bipolar disorder and asked them to report at what age their symptoms began. Fifty-nine per cent of these adults reported that they had the onset of their symptoms in childhood or adolescence. In a local, community-based school survey of adolescents aged 14 to 18 years, Lewinsohn et al (12) found a combined lifetime prevalence rate of approximately 0.8% for bipolar types I and II, with 85% of these adolescents having had bipolar type II. For the patients with bipolar disorder, initial episodes of illness were generally reported to be depression (11), with a relatively high rate of patients (approximately 30%) ‘switching’ to mania during the episode (13,14). In comparison, the lifetime prevalence of adult bipolar disorder

(including both types I and II) is approximately 1.4% of the general population.

Premorbid Characteritics

There appear to be neurodevelopmental antecedents to paediatric bipolar disorder. Sigurdsson et al (15) found that patients with bipolar disorder (compared with those with depression alone) are more likely to have experienced delayed language, social or motor development. As well, patients with paediatric bipolar disorder often have initial manifestations of ADHD and/or conduct disorder (16-18). However, studies have found that, in general, over 90% of patients with paediatric bipolar disorder have normal intelligence quotients (13,16).

Clinical Characteristics

The diagnosis of child and adolescent bipolar disorder is complex, and there is substantial uncertainty and disagreement among child and adolescent psychiatrists as to what constitutes its diagnostic criteria (6,7). This diagnostic uncertainty is especially true for patients with pre-pubertal symptomatology. There are many factors to consider in identifying symptoms and making a diagnosis. The importance of an accurate diagnosis is profound given the consequences of either making a falsely positive diagnosis or missing the diagnosis. An incorrect diagnosis of bipolar disorder can lead to the long term use of medications for which the long-lasting effects on the central nervous system are unknown. However, the lack of treatment of individuals with bipolar disorder may sub-stantially worsen their prognosis (9).

One of the major reasons for difficulties in clearly delineating the clinical characteristics of paediatric bipolar disorder is that the symptoms of the disorder may manifest themselves differently according to the developmen-tal stage of the patient. DSM-IV (4) identifies two types of bipolar disorders. Type I involves patients who have had at least one manic (Table 1) or mixed episode. A mixed episode occurs when a patient meets criteria over a one-week period for both a manic episode and a major depressive episode (Table 1). Type II involves patients who have had at least one episode of major depression and one episode of hypomania, but no manic or mixed episodes. The criteria for hypomania are the same as for mania; the difference in diagnosis depends on the duration and severity of the episode. In a hypomanic episode, symptoms must have been present for at least four days (as opposed to seven days for mania) and be a significant change of functioning from the baseline of the patient. However, the episode does not lead to marked deterioration in functioning, a need for hospitalization or psychotic symptoms; if it does, a manic episode is diagnosed. For a bipolar diagnosis to be made, the manic symptoms must not be due to the direct effects of a substance or to a general medical condition (4).

Children and adolescents with bipolar disorder tend to present with what is considered to be atypical features in adults. Mixed features; rapid (more than four episodes per year), ultrarapid (episodes lasting a few days to a few weeks) or ultradian (variation occurring within a 24 h period) cycling; psychotic features; high rates of comorbidity, especially with disruptive behaviour disorders; and significant psychosocial impairment are common (5).

Geller et al (19), in the first controlled phenomenological study of paediatric bipolar disorder, reported on symptom differences between patients with paediatric bipolar disorder and those with ADHD. Patients with bipolar disorder (age seven to 16 years) had symptoms of grandiosity, elated mood, daredevil acts, a flight of ideas, racing thoughts, hypersexuality, a decreased need for sleep, increased goal-directed activity, increased produc-tivity, irritable mood and accelerated speech at statistically significantly greater rates than matched patients with ADHD. There were no significant differences in the symptoms of being hyperenergetic or distractible. Thus, the symptomatology of paediatric bipolar disorder did not differ substantially from adult bipolar symptoms. However, the paediatric bipolar patients tended to present with a chronic, nonepisodic manic episode (average duration three years) that featured very rapid mood swings multiple times per day (ultradian cycling 75%), and 60% of the patients had psychotic symptoms. The study combined pre- and

postpubertal patients because there were a limited number of differences between the two groups.

In considering the symptomatology of paediatric bipolar disorder, it is critical to recognize that the symptoms manifest in developmentally appropriate ways. In fact, certain authors have proposed that bipolar disorder presents differently in prepubertal and postpubertal patients. It has been proposed that adolescent onset bipolar disorder more closely resembles adult onset bipolar disorder. However, as described above, in the only controlled phenomenological study of paediatric bipolar disorder, there were no significant differences in the clinical presentations between the two age groups. Nevertheless, although the symptoms are the same, they manifest differently at different ages. For example, grandiose delusions in a child may manifest as continual harassment of teachers about how to teach the class or intentionally failing tests because of the firm belief that the material was taught incorrectly (6). Another example is the six-year-old child who is restrained by a 99 kg policeman and firmly believes that when the policeman 'lets go', he is going to `kick his a- - . Alternatively, an adolescent may express grandiose delusions such as the fixed belief that he is the star of the football team, even though he did not make the starting line-up. Furthermore, hypersexuality is expressed according to the cognitive knowledge of the child. It is the preoccupation with sexuality and not the knowledge level that is characteristic of bipolar disorder.

Differential Diagnosis and Comorbidiy

The differential diagnosis of mania is both extensive and complex, consisting of both psychiatric and nonpsychiatric medical conditions. Nonpsychiatric medical con-ditions that can present in a similar manner include the following: neurological disorders, such as brain tumours and central nervous system infections (including human immunodeficiency virus), multiple sclerosis, temporal lobe seizures and Kleine-Levin syndrome; systemic conditions such as hyperthyroidism, uremia, Wilson's disease and porphyria; prescribed medications that lead to bipolar symptoms, including antidepressant agents, sympathomimetics, bromocriptine, stimulants and steroids; and the abuse of substances, including amphetamines, cocaine, phencyclidine, inhalants and 3,4-methylenedioxymethamphetamine (Ecstasy) (1). Consequently, patients presenting with manic symptoms should have a thorough physical examination, including a neurological examination. Decisions regarding further laboratory and neuroimaging examinations should be made based on the clinical findings of the psychiatric, paediatric and neurological examinations (1).

The psychiatric differential diagnosis of manic symptoms varies according to the age of the patient. In children, it is particularly important to ensure that the child is not a victim of sexual abuse (6). This is particularly true if hypersexuality is a part of the clinical presentation. As well, language disorders and disruptive behaviour disorders (ADHD, oppositional-defiant disorder, conduct disorder) are part of the differential diagnosis. As described above, Geller et al's study (19) has begun to delineate the hallmark symptomatology of paediatric bipolar disorder such that distinction between these diagnostic entities should, hopefully, become clearer. The presence of a family history of bipolar disorder in the immediate family is a critical part of considering the diagnosis of prepubertal onset bipolar disorder, and without it, the clinician should be extremely cautious.

In adolescence, with the exception of language disor-ders, the differential diagnosis includes disorders that are present in childhood, but schizophrenia and substance abuse become more prevalent. Substance abuse is an important part of the differential diagnosis but is also frequently comorbid (20).

Wilens et al (20) found that approximately 40% of patients with adolescent onset bipolar disorder had a comorbid substance use disorder and that their risk for substance abuse was 8.8 times greater than those with childhood onset bipolar disorder. In contrast, conduct disorder appears to be more common in bipolar children than in bipolar adolescents (22% versus 18%, respectively) (21). Finally, multiple comorbid anxiety condi-tions are more frequent in prepubertal bipolar children than in bipolar adolescents (33% versus 12%, respectively) (21).

Course and prognosis

To date, there are no systematic follow-up data on pre-school or prepubertal school-aged children with bipolar disorder (5). Strober et al (9), in a five-year, prospective, naturalistic follow-up study of 54 adolescents with bipolar disorder who were admitted to an inpatient service, found that 96% recovered from that episode of the illness sometime during the study. Patients with depressive presentations took significantly longer to recover from the episode than those with manic symptoms only. How-ever, 44% of those who recovered during the study experienced a relapse of a major affective disorder during the five years of the study, and 21% had two episodes. Suicide attempts of sufficient severity as to require medical attention occurred in 20% of participants. Interestingly, among study participants (9), substance use disorders were relatively uncommon (9%) in contrast with the studies mentioned above (19,20).

Treatment

A multimodal treatment plan that combines pharmacological treatments with psychosocial treatments is required (1). The psychosocial treatment consists of psychotherapeutic interventions to address the psychological aspects of bipolar disorder that confound development and biological treatment, and intervention to address the social and culturally relevant consequences of bipolar disorder. This may include the psychoeducation of family and school personnel in the pertinent issues surrounding bipolar disorder, and in particular, addressing the disorder's symptoms and course, treatment options, and potential impact on peer and family functioning. Relapse prevention discussions on the importance of medication compliance and early recognition of symptoms are also an important part of this aspect of treatment (1,22). The goal of these interventions is to ameliorate symptoms and prevent relapse, while also reducing long term morbidity, and promoting normal growth and development (1).

Before initiating pharmacotherapy for the treatment of bipolar disorder, it is necessary to ensure that an adequate premedication work-up has been performed. This includes obtaining informed consent, and addressing the rationale for treatment, as well as the potential risks and benefits of the treatment (1). Furthermore, before initiating medications and after a thorough psychiatric examination, a physical examination that includes any clinically indicated laboratory studies to provide baseline assessments for monitoring specific medications is warranted (1).

The discussion of pharmacotherapy below focuses on the treatment of mania, and readers are referred to Flei-sher and Katz (pages 444 to 448 of the present issue) for a discussion of the treatment of depression. The selection of medications should be based on evidence of efficacy (eg, the Geller et al trial [23, see below] and data from controlled treatment trials of adults with bipolar disorder), the phase of the illness (see below), the presence of confounding presentations (eg, rapid cycling, psychotic symptoms), the agent's side effect spectrum, the patient's history of medication response, and the preferences of the patient and family (1). The paucity of controlled trials of medications for child and adolescent bipolar disorder places the clinician in a very difficult position because extrapolation from adult data is not necessarily valid (eg, children and adolescents with major depressive disorder do not necessarily respond to the same antidepressants as adults).

The treatment of bipolar disorder consists of acute symptom stabilization, maintenance treatment and prophylactic treatment. Acute symptom stabilization for manic symptoms varies, depending on whether psychotic features are a part of the presentation. If psychotic symptoms are present, then antipsychotic medications are frequently a part of the initial medication regimen. This regimen is based on studies from the adult literature and juvenile chart reviews (24,25). Other medications that can be considered include anxiolytics (eg, the benzodi-azepines), and some authors have reported the use of stimulants to address symptoms of ADHD that may be present. The use of stimulants in the treatment of bipolar disorder remains a highly contentious issue because the diagnosis of ADHD in the presence of bipolar disorder is confounded by collinearity, and, at the present time, there are no controlled outcome studies on the use of stimulants in the presence of bipolar disorder.

Although medications, such as antipsychotics, stimulants and anxiolytics, may be a part of acute symptom sta-bilization (24,25), mood stabilizers are the mainstays of treatment of paediatric bipolar disorder (26). This is especially true with regard to maintenance and prophylactic treatment. Although a rapidly growing number of medications are available, three mood stabilizers are commonly prescribed. Lithium, valproic acid and carbamazepine have the most experience supporting their use. Gabapen-tin, lamotrigine and topiramate are on the market, and case reports are beginning to appear. Currently, Geller and colleagues' study (23) on the use of lithium in adoles-cents with bipolar disorder and secondary substance de-pendency is the only controlled study. Geller and colleagues (23) found lithium to be efficacious in reducing substance use (P=0.028) and in improving the overall level of functioning, as assessed on a global assessment of functioning scale (P=0.046). This response occurred in 46% of the treated adolescents. Aside from the study by Geller and colleagues (23), there is a paucity of data ex-amining the efficacy of lithium in early onset bipolar dis-order (1,5,27).

There are no placebo controlled trials of anticonvulsant medications for the treatment of bipolar disorder. The use of valproic acid and carbamazepine is supported by the adult literature; case reports and small series sup-port their use in paediatric bipolar disorder. With regard to valproic acid, a number of worrying side effects war-rant caution in prescribing this medication for bipolar disorder. In addition to concerns regarding hepatotoxic-ity and teratogenicity, recent reports suggest a possible association of valproic acid with polycystic ovarian disease and other endocrinological abnormalities in females with seizure disorders (28,29). All of the mood stabilizing medications carry a significant risk with regard to adverse effects, the potential for toxicity and a significant risk of overdose. A thorough review of the case reports and small series data that inform the psychopharmacology of paedi-atric bipolar disorder is beyond the scope of this review, and the reader is referred elsewhere for more detailed re-views (1,6,23,26,27,30).

Conclusion

Paediatric bipolar disorder is increasingly being recognized as a major health problem that is associated with substantial morbidity and mortality. The evaluation and management of this disorder are multimodal. The early recognition and appropriate management of patients and their families will, hopefully, help to reduce the complications of this chronic disorder. There is a desperate need for further research in almost all aspects of this disorder because there is a paucity of controlled data available for review.

References

1. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry 1997;36:138-57.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Third Edition: DSM-III. Washington: American Psychiatric Association, 1980.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised: DSM-III-R. Washington: American Psychiatric Association, 1987.
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition: DSM-IV. Washington: American Psychiatric Association, 1994.
5. Sanchez L, Hagino O, Weller E, Weller R. Bipolarity in children. Psychiatr Clin North Am 1999;22:629-48.
6. Geller B, Luby J. Child and adolescent bipolar disorder: A review of the past 10 years. J Am Acad Child Adolesc Psychiatry 1997;36:1168-76.
7. Biederman J, Klein RG, Pine DS, Klein DF. Resolved: Mania is mistaken for ADHD in prepubertal children. J Am Acad Child Adolesc Psychiatry 1998;37:1091-9.
8. Carlson GA, Fennig S, Bromet EJ. The confusion between bipolar disorder and schizophrenia in youth: Where does it stand in the 1990's? J Am Acad Child Adolesc Psychiatry 1994;33:453-60.
9. Strober M, Schmidt-Lackner S, Freeman R, Bower S, Lampert C, DeAntonio M. Recovery and relapse in adolescents with bipolar affective illness: A five-year naturalistic, prospective follow-up.
J Am Acad Child Adolesc Psychiatry 1995;34:724-31.
10. Carlson GA, Kasham JH. Manic symptoms in a non-referred adolescent population. J Affect Disord 1988;15:219-26.
11. Lish JD, Dime-Meenan S, Whybrow PC, Price RA, Hirschfeld RM. The national depressive and manic-depressive association (DMDA) survey of bipolar members. J Affect Disord 1994;31:281-94.
12. Lewinsohn PM, Klein DN, Seeley JR. Bipolar disorders in a community sample of older adolescents: Prevalence,

phenomenology, comorbidity and course. J Am Acad Child Adolesc Psychiatry 1995;34:454-63.
13. Geller B, Fox LW, Clark KA. Rate and predictors of prepubertal bipolarity during follow-up of 6- to 12-year-old depressed children. J Am Acad Child Adolesc Psychiatry 1994;33:461-8.
14. Strober M, Carlson G. Bipolar illness in adolescents with major depression: Clinical, genetic, and psychopharmacologic predictors in a three- to four-year prospective follow-up investigation. Arch Gen Psychiatry 1982;39:549-55.
15. Sigurdsson E, Fombonne E, Sayal K, Checkley S. Neurodevelopmental antecedents of early-onset bipolar affective disorder. Br J Psychiatry 1999;174:121-7.
16. Werry JS, McClellan J, Chard L. Early-onset schizophrenia, bipolar and schizoaffective disorders: A clinical and follow-up study.
J Am Acad Child Adolesc Psychiatry 1991;30:457-65.
17. Kovacs M, Pollock M. Bipolar disorder and comorbid conduct disorder in childhood and adolescence. J Am Acad Child Adolesc Psychiatry 1995;34:715-23.
18. Carlson GA. Child and adolescent mania: Diagnostic considerations. J Child Psychol Psychiatry 1990;31:331-42.
19. Geller B, Williams M, Zimerman B, Frazier J, Beringer L,
Warner KL. Prepubertal and early adolescent bipolarity differentiate from ADHD by manic symptoms, grandiose delusions, ultra-rapid or ultradian cycling. J Affect Disord 1998;51:81-91.
20. Wilens TE, Biederman J, Millstein RB, Wozniak J, Hahesy AL, Spencer TJ. Risk for substance use disorders in youths with child-and adolescent-onset bipolar disorder. J Am Acad Child Adolesc Psychiatry 1999;38:680-5.
21. Geller B, Sun K, Zimerman B, Luby J, Frazier J, Williams M. Complex and rapid-cycling in bipolar children and adolescents: A preliminary study. J Affect Disord 1995;34:259-68.
22. Perry A, Tarrier N, Morriss R, McCarthy E, Limb K. Randomized controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment.
BMJ 1999;318:149-53.
23. Geller B, Cooper TB, Sun K, et al. Double-blind and placebo-controlled study of lithium for adolescent bipolar disorders with secondary substance dependency. J Am Acad Child Adolesc Psychiatry 1998;37:171-8.
24. Biederman J, Mick E, Bostic JQ, et al. The naturalistic course of pharmacologic treatment of children with maniclike symptoms: A systematic chart review. J Clin Psychiatry 1998;59:628-37.
25. Frazier JA, Meyer MC, Biederman J, et al. Risperidone treatment for juvenile bipolar disorder: A retrospective chart review.
J Am Acad Child Adolesc Psychiatry 1999;38:960-5.
26. Kowatch RA, Bucci JP. Mood stabilizers and anticonvulsants. Pediatric Clinics of North America 1998;45:1173-85.
27. Kafanteris V. Treatment of bipolar disorder in children and adolescents. J Am Acad Child Adolesc Psychiatry 1995;34:732-41.
28. Iscjarvi JI, Laatikainen TJ, Pakarmen AJ, Juntunen KT, Myllyla VV. Polycystic ovaries and hyperandrogenism in women taking valproate for epilepsy. N Engl J Med 1993;329:1383-8.
29. Isojarvi JI, Laatikainen TJ, Knip M, Pakarinen AJ, Juntunen KT, Myllyla VV. Obesity and endocrine disorders in women taking valproate for epilepsy. Ann Neurol 1996;39:579-84.
30. Davanzo PA, McCracken JT. Mood stabilizers in the treatment ofjuvenile bipolar disorder: Advances and controversies. Child Adolesc Psychiatr Clin North Am 2000;9:159-82

Reproduced from: Paediatr Child Health Vol 6 No 7 September 2001, 439-443

Table 1: Criteria for mania and major depression in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition: DSM-IV* (4)

Manic episode	Major depressive episode
More than a one-week period of an elevated, irritable or expansive mood that represents a significant change in the patient's baseline mental status accompanied by at least three of the following symptome: - inflated self-esteem or grandiosity - decreased need for sleep - pressured speech - racing thoughts or a flight of ideas - increased goal-directed activity - excessive involvement in pleasurable activities that have a high potential for painful consequences - distractibility	More than a two-week period characterized by a depressed or irritable mood, or diminished interest or loss of pleasure in most activities accompanied by at least four of the following: - feelings of worthlessness or inappropriate guilt - sleep disturbance (increased or decreased) - fatigue or loss of energy - decreased concentration - appetite or weight disturbances - psychomotor agitation or retardation - suicidal ideation or thoughts of death

Attitudes of Teens and Professionals Regarding Teen Contraception

Édith Guilbert, MD, MSc, Francine Dufort, PhD, Louise Saint-Laurent, PhD
Department of Obstetrics and Gynaecology,
Laval University, Quebec, School of Psychology, Laval University, Quebec, Department of Sociology, Laval University, Quebec

Introduction

Contraceptive use during adolescent and young adult years remains a challenge in Canada. According to cross-sectional studies (Table 1),1-5 there is no indication that contraceptive use in these age groups has been increasing. The Canadian Fertility Study of 1995 reports that condom use has increased since 1984, while oral contraceptive (OC) use has significantly decreased.5 In the Canadian Contraceptive Study of 1998, only 68 percent of unmarried, sexually active 18- to 24-year-old women report consistent contraceptive use over the past six months prior to the survey.3

In the late 1990s, with increasing numbers of teen pregnancy in Quebec, a qualita-tive research study on pregnancy and contraception in adolescents was planned, using the approach of social representation*. The aim of this study was to understand the social representations of teen pregnancy and its prevention, both from the point of view of teens and of professionals working with youth (physicians, nurses, social workers, teachers). Results on attitudes towards contraceptive methods are presented.

*The term "social representation" can be defined as a structured mental (cognitive, evaluative, affective, and symbolic) content about socially relevant phenomena, which takes the form of images or metaphors, and which is consciously shared with other members of a social group.7

Methods

The study took place in the region of Quebec City between October 1997 and March 1998. Ten focus groups were done with adolescent girls, eight with adolescent boys, and 13 with health care and school professionals. A standard interview was used and administered by trained interviewers. Specific questions on contraceptive methods were asked. Focus groups lasted approximately two hours and were video- and audiotaped. Tapes were transcribed and content analysis was done through repeated readings. The research protocol was accepted by the ethics committee of Le Centre Hospitalier Universitaire de Québec and funded by Le Conseil Québécois sur la Recherche Sociale. Consent forms were signed by all participants.

Results

The description of the study population is presented in Table 2.

"In your experience, what are the most frequent contraceptive methods used by adolescents?"

According to the adolescents: the condom and the OC are the methods used most frequently by adolescents. The condom is the most popular because it is widely advertised and much infor-mation is received about it in schools.

According to the professionals: the condom is the most popular method followed by the OC. Some adolescents use both, while some use no contraception at all.

"What are the advantages and disadvantages of the differ-ent contraceptive methods?"

According to the adolescents the condom is the most accessible form of contraception. It is not necessary to see a physician to obtain it. It is affordable, and many teens interviewed knew how to get free condoms. Girls reported that it is easier to use than other contraceptive methods; it is easy to hide and to carry. Adolescent boys and girls are reassured by the double function of condoms: protection against both sexually transmitted diseases (STDs) and pregnancy. They think it is more effective in protecting against STDs than against pregnancy. They are happy with the fact that there are several types and brands of condoms. However, although girls think that condoms offer good protection, they are conscious of potential accidents: some believe they should use OCs combined with the condom to avoid pregnancy. Girls and boys are aware of the risk of tearing and slipping of condoms and some mentioned the risk of allergy to latex. Girls think that the major problem with the condom is that one assumes the partner has a condom. If no condom is available at the time of intercourse, girls believe that it becomes very difficult to refrain from sex. They feel it is the boys' responsibility to have condoms available. Boys dislike this responsibility. Boys also mention that condoms reduce sensation, and may affect the spontaneity of intercourse.

The oral contraceptive pill ("the pill") is a well-known contraceptive method, easy to obtain and inexpensive. However, one disadvantage is the need to take it regularly, every day. Although simple to use, girls must find ways to remember to take it. They know of some positive side effects, such as more regular menstrual cycles and lessening of dysmenorrhea, and unanimously recognize its high contraceptive efficacy. Some add that the actual pills are better than those their mothers were taking. Adolescent girls particularly dislike to see a physician to get it and having to undergo a gynaecological exam. Most adolescents know that the pill does not protect against STDs. Girls mention that it is a chemical; it can cause negative side effects like headaches, nausea, weight gain, loss of body shape, risk of cancer, and that a break after five years of use might be necessary. Boys are also convinced that the pill can cause negative effects on girls such as weight gain or loss, infertility, and mood swings. Some girls believe it can become difficult to take the pill when their parents disagree. Reluctantly, some adolescents mention (with a certain degree of humour) that only abstinence is 100 percent effective!

According to the professionals: the condom is easy for adolescents to use because it is available everywhere, without prescription. Some think that adolescents are now more at ease when buying condoms because of public campaigning, and because they are affordable. Others, however, think that con-doms might be too expensive or that adolescents might be ashamed of buying them. Some of these professionals give free condoms to adolescents. It is noted that certain young people do not know how to use condoms, and that some adolescent girls dislike condoms because of lack of sensation. Professionals mentioned that it is often difficult for a girl to ask her partner to wear a condom, and, if none is available, that they may not use one.

Professionals feel the pill is not easy to obtain it because of the need for a medical consultation. Many professionals have conflicting information about reimbursement for the pill by insurance agencies. Professionals are aware of the way adolescents perceive the pill, some being more conscious of positive and some of negative side effects. They have an important responsibility towards adolescents to give adequate scientific information and support about pill use. It is difficult for girls to integrate regular pill use into their busy lifestyles, especially for those whose parents are not aware that they are using it or who are against it. Professionals encourage adolescent girls to inform their parents about pill use, particularly to receive financial support when buying the pill. According to professionals, the pill is often used by girls who perceive themselves to be in a stable relationship. Apart from depot medroxyprogesterone acetate, other contraceptive methods seem to young people to be either unknown or outdated. The professional opinion is that emergency contraception use is increasing, while absti-nence appears incompatible with today's sexual life.

"Do you think that you must change contraceptive methods according to the kind of relationship you are in (regular or occasional partner)?"

According to the adolescents: contraceptive method use changes with the type of relationship they are in. Girls and boys say that they always use a condom at the beginning of a relationship. They say this is also true if they have occasional partners. In this latter case, the pill is considered too expensive and the risk of STDs too high not to use condoms. Adolescents who fear human immunodeficiency virus (HIV) infection (symbol of death and suffering), or who put more emphasis on STD/HIV prevention than on pregnancy prevention, are also more prone to use condoms. Some boys declare that they prefer to use con-doms all the time, because it offers a dual protection. Those who do not see the importance of using condoms explain that they feel STDs are rare at their age, that they know their partner or that they have confidence in their partner. When in a stable rela-tionship, girls and boys think condoms are not necessary, and that the pill combined with STD screening is the best way to handle the situation. However, a stable relationship is not a well-defined concept, and may be defined as a relationship lasting from a few weeks to a year. Girls explain that a stable relationship implies confidence in the partner and mutual faithfulness. However, some doubt that a faithful relationship during adolescence is possible, and thus use condoms all the time.

According to the professionals adolescent boys and girls do not really adjust their contraceptive methods to their relationship. Professionals think that adolescents do not practice regular contraception because of their perception of personal invulnera-bility at this time in their lives. Professionals think that adolescents do not understand the difference between contraception and STD protection. They believe that adolescents use condoms at the beginning of a relationship or with occasional partners, but that condom use is very quickly abandoned. Professionals believe that adolescents consider a long-term relationship being one that lasts over one month, while professionals consider a long-term relationship as one lasting much longer.

"According to you, is contraception a girl's business?"

According to the adolescents. girls answer spontaneously that contraception is an issue for both girls and boys. But when the interviewer asks them if it applies in "real" life, girls mention that, most of the time, they are the ones in charge. Several of them admit that they prefer to have control over contraception. Others find it unfair. Boys also spontaneously answer that contraception is not only a girl's business. Boys say that girls are responsible for pill use and boys for condom use. Some boys, however, prefer to take charge of contraception. Some mention that they can be fooled by a girl who does not take her pill regularly.

According to the professionals: contraception is a girl's business, because pregnancy is also a girl's business. Several professionals think that it is better managed in this way, while others regret that the contraceptive information given in schools targets most-ly girls. They express the need that adolescent boys be more informed and involved in contraceptive matters. They admit that there have been some positive changes in boys' attitudes towards contraceptive responsibility, although some profes-sionals feel that boys are more preoccupied with protection against STDs. Some professionals feel that girls are not assertive enough with their partners when it comes to contraceptive use.

Discussion

As expected, the adolescents and professionals in our study reported that the most frequently used contraceptive methods were the condom and the pill. Other contraceptive methods were merely mentioned. This confirmed the results of the Canadian Contraceptive Study,3 in which a low level of familiarity and minimal rates of use were reported with contraceptive methods other than the condom and the pill.

Adolescent boys and girls seemed fairly well informed on the two major methods of contraception they use. However, barriers to condom use and misinformation and mispercep-tions about the pill persisted. This was confirmed by the professionals. As many

suggest,349 both counselling and public and school health education have serious deficiencies. First, unless an individual is capable of accepting the fact that he or she is a sexual being with sexual feelings and needs, sexual and reproductive behaviours aimed at preserving health are unlike-ly to take place.$ Health professionals have an important role to play in assessing sexual health during clinical consultations with adolescents, as well as promoting sexual self-concept in sex-education programs. Moreover, when professionals provide contraceptive counselling, they have the opportunity not only to describe different contraceptive methods, but also to dispel negative attitudes towards contraceptive methods. This is achieved by emphasizing any non-contraceptive benefits, by reinforcing assertiveness of the adolescent, by developing his or her negotiating and communication skills, by identifying barriers to regular use, and by facilitating daily compliance.

Our study shows that contraceptive use and protection against STD/HIV varies according to the type of relationship an adolescent has. Condom use seems to be confined to recent relationships or relationships with multiple partners, while pill use occurs when the relationship is defined as stable. Among heterosexual adolescents, it is thus clear that dual protection is still a very unclear concept, and that "stable relationship" has a very unsta-ble definition. Some have suggested that interventions for STD/HIV prevention may be improved by addressing the characteristics of a relationship, particularly the length of a dating relationship.'° Although this may be useful on an individual basis, it is important to develop general behavioural guidelines. From our study and others on contraceptive effectiveness, we suggest that simple slogans could be developed on these particular issues, such as "Double or quits!": use dual protection (condom and pill, or condom and long-acting contraceptives) or do not engage in sexual intercourse. A stable relationship does not last three hours, three days, or three weeks ... It's at least three months!': use condoms for at least three months before having screening tests. Check the results of your screening tests before stopping condom use. `Prefer quality to quantity': with fewer sexual partners, there are fewer STDs.

Finally, our study shows that adolescent boys are willing to take contraceptive responsibility. The message that contraception is both boys' and girls' business, although not new, is still a very important message. In view of the perception by health and school professionals that adolescent boys are concerned with preventive behaviours for reproductive health, some new strategies could be developed and tried. For example, when adolescent boys were confronted in roleplaying with the possibility that, if an unplanned pregnancy occurs, paternity could be identified and that they would have to support the child's education, they reacted very intensely and intended to develop contraceptive behaviours. Involving adolescent boys in reproductive health pre-ventive behaviours is still an area to develop.

In conclusion, counselling teens about contraception and STD/HIV protection remains an extraordinary challenge. Listening to teens gives us clues to reinvent our approaches and answer their needs in better ways.

References

1. Boroditsky R, Fisher W, Sand M. The Canadian contraception study. J Obstet Gynaecol Can 1995;17(7):1-32.
2. Boroditsky R, FisherW, Sand M. The 1995 Canadian contraceptive study. J Obstet Gynaecol Can 1996;18(12):1-31.
3. Fisher WA, Boroditsky R, Bridges ML. The 1998 Canadian contracep-tive study. Can J Hum Sex 1999;8(3):151-220.
4. Balakrishnan TR, Krotki K, Lapierre-Adamcyk E. Contraceptive use in Canada. Fam Plan Perspect 1984;17(5):209-15.
5. Martin K,Wu Z. Contraceptive use in Canada: 1984-1995. Fam Plan Perspect 2000;32(2):65-73.
6. Rochon M. Service de la recherché, Direction générale de la Planifica-tion et de l'évaluation, Ministère de la Santé et des Services sociaux 2000 (personal communication).
7. WagnerW Field of research and socio-genesis of social representations: a discussion of criteria and diagnostics. Soc Sci Inform 1994;33(2):200.
8. Fisher WA, Fisher JD. Understanding and Promoting Sexual and Repro-ductive Health Behavior:Theory and Method. ln:Rosen RC, Davis CM, Ruppel HJ Jr, Davis SL (eds). Annual Review of Sex Research. Vol 9. Mason City 10: Society for Scientific Study of Sex 1998;pp.39-76.
9. Kirby K, Short L, Collins J, et al. School-based programs to reduce sex-ual risk behaviors: a review of effectiveness. Publ Health Rep 1994;109(3):339-60.

10. Civic D. The association between characteristics of dating relationships and condom use among heterosexual young adults. AIDS Educ Prev 1999; 11(4):434-52.

Reproduced from:Journal SOGC Volume 23, number 4 April 2001, 329-333.

Table 1: Percentage Distribution of Women Age 15 to 17 years and 18 to 24 years, by current Contraceptive Practice, According to survey and year

Status	15-17 years	15-17 years	15-17 years	18-24 years	18-24 years
Study group	CCS 1994 (n = 165)	CCS 1995 (n = 124)	CCS 1998 (n = 91)	CFS 1984 (n = 91)	CFS 1995 (n = 600)
Pill	32	23	21	43,7	38,0
Condom	29	25	10	4,6	12,6
IUD				3,5	0,8
Diaphragm				0,4	0,0
Foam		4	1	0,2	0,4
Rhytm	2		1	1,0	0,3
Withdrawal	5	2	3	0,9	0,2
Other				0,5	0,9
Sterilization	1			2,6	3,6
Pregnant or not using contraceptive method*	51	65	66	42,8	43,4

* The proportion of sexually active women is not known in these studies except for CCS 1998 (64%).

Table 2: Description of the study population

Characteristics	Adolescents n = 150	Health care and school professionals n = 90
Female	62%	77%
Mean age (yrs)	16.2	39.3
Relligious affiliation (yes)	82%	80%
Religious practice (yes)	22%	29%
Low socioeconomic background	59%	48%
High socioeconomic background	14%	32%
Sexually active (yes)	71%	N/A
Type of professional	N/A	
- physician or nurse		55%
- social worker		28%
- teacher		17%

Teen Pregnancy and Substance Use

Diane Francoeur, MD, Hôpital Ste-Justine, Université de Montréal, Montréal QC

Methods

A Medline search was done for French and English articles dating from 1995 to the present, using the terms "adolescent sexuality," "pregnancy," "substance abuse," and "contraceptive use." Searches were extended earlier than 1995 as needed to assure a good representation of the issue and a good methodology. Abstracts were reviewed and articles selected.

Predictors of use of tobacco, alcohol and illicit drugs in adolescents

Estimated rates of substance use among pregnant adolescents, including tobacco, alcohol, and illicit drugs, range from 11 percent to as high as 52 percent,(1) similar to the rates of use in nonpregnant female adolescents. Cigarettes and alcohol are the most common substances used.(2) Substance use is highly correlated with use by family and friends(3) and is more common in white adolescent girls than in other ethnic groups.(4) The mean age at which adolescents first try cigarettes is before their 13th birthday.(2)

In the 1998 study by Teagle and Brindis,(2) 49 percent of pregnant adolescents reported the use of at least one substance during their pregnancy, and 80 percent had experience with at least one substance in the six months prior to pregnancy. The mean age for progression of substance use follows the pattern observed in previous research,(5) beginning with cigarette smoking (mean age 12.4 years), progressing to alcohol consumption (mean age 13.8 years), to marijuana (mean age 14.3 years), and finally to other drugs (mean age 15.2 years).

Fortunately, the majority of subjects (approximately 64%) in the study by Teagle and Brindis discontinued substance use during the first trimester of pregnancy.

Family and siblings were reported to be substance abusers in one-third of the group. Alcohol and tobacco use was more common in parents, whereas marijuana and other drugs were more commonly used by siblings and the father of the baby.(2)

The prevalence of smoking in adolescent girls was 20 percent, 2 comparable to most other studies.(6,7) Caucasian females have the highest prevalence of tobacco use among adolescent subgroups. Minority groups tend to use less and initiate later than white youths.5 Adolescent girls report that they smoke to limit weight gain, to have smaller babies and an easier delivery, and to decrease their anxiety. There is a strong correlation between age at first intercourse and the level of cigarette smoking.5 Factors associated with cigarette smoking during pregnancy were multiparity, unmarried status, alcohol use, and parental smoking.

The estimated rate of alcohol use within the teen population varies from 20 to 60 percent.(8) Most studies show a rate of approximately 20 percent during pregnancy. Alcohol use is more common within the Caucasian population.(8)

In the Teagle and Brindis study, the rate of marijuana use in the first trimester was less than the prepregnancy rate (14 and 20 percent respectively).(2) No ethnic differences were found in marijuana use. Alcohol and marijuana use was more common in unwanted pregnancies, in older adolescents, and in multiparas.2 Unfortunately, most of this information comes from self-reported analysis and is subject to reporting bias. Pregnant adolescents worry that they will be judged by the interviewer and that their babies will be taken from them, and thus may be inaccurate in their reporting.

The Youth Risk Behavior Survey ,(9) 1995 survey of Amer-ican students from grades nine to 12, demonstrated that the rates, frequency, and amounts

of use of illicit substances, espe cially cocaine, heroin, and opiates, had fallen slightly over the preceding decade. Alcohol and marijuana use remained stable, while the use of cigarettes increased slightly.

Pregnancy as an opportunity for intervention

The prenatal care setting represents a unique opportunity for education regarding prevention of substance abuse with highest-risk adolescents, or intervention with teens already substance users, especially helping adolescents realize the consequences of substance abuse in pregnancy. Many of these pregnant teens drop out of school, thereby foregoing one of the only institutions that focuses primarily on positive intervention related to the adolescent. For these pregnant teens, the prenatal clinic may be their only opportunity to discuss behavioural change. The importance of the child the pregnant teen has chosen to carry affords a greater incentive to make positive lifetime changes dur-ing pregnancy, perhaps a greater opportunity than at any other time of her life.

Sexual abuse is a common antecedent of adolescent pregnancy, with up to 66 percent of teens reporting histories of abuse.(10) Child abuse, both physical and emotional, seems to be a risk factor for early pregnancy. This is probably related to high-risk behaviours that may lead to unplanned pregnancy, such as early onset of sexual activity, prostitution, substance abuse, and multiple partner relationships.(10) These adolescents engage in more relationships that are violent, and they have the highest rates of sexual victimization after the age of 16 years, including both sexual assault and reports of rape.(11) They may have an increased desire to conceive in order to have something positive happen to them.(11)

Gilchrist et al. (12) examined the use of drugs among adoles-cent mothers up to 18 months postpartum. They observed that use of all substances decreased substantially during pregnancy, but increased steadily in the 18 months after delivery. This increase in use was associated with depression, stress, and a per-ceived need for social support.(12) It is imperative that those who provide care for these young women are aware of both this possibility and the possible association with sexual abuse.

Screening for drug abuse and intervention strategies

Even if drug use is suspected, it is not always easy to obtain the information needed to confirm this suspicion. Horrigan et al. (13) demonstrated, in both adult and teen populations, that a psy-chological questionnaire on substance abuse is probably far more specific than a urine screening test. Screening tests were able to identify only 15 percent of the 57 percent who self-reported use of a substance. This may be in part because drugs are mostly detectable in urine only for a short time, approximately four days, although cannabis may be detectable for two to four weeks. Alcohol can only be detected with a blood sample. (13)

Little has been published on interventions to stop the use of substances during pregnancy. The most popular model is probably the Minnesota Model, based on the 12 steps of Alco holics Anonymous. (14) The program relies on group support, self-help, and professional staff to help parents deal with asso-ciated drug abuse and law problems and emphasizes the importance of going back to school.

The therapeutic community is based on an adult treatment approach that views alcohol and drugs as deviant, and abuse as representative of a disorder of the whole person. (15) This approach is based on group tasks and responsibilities, includ-ing one-on-one counselling.

The third major treatment approach for teens is family therapy, where difficult family relationships are revised and families are given assistance to review the limits and responsi-bilities of the individuals.(16)

Finally, cognitive therapy focuses on maladaptive thoughts and behaviours.(17)

The goals of all treatment approaches are to increase stress-management behaviour, establish a drug-free environment, increase academic performance, and emphasize that drugs are not the solution to problems.

To achieve these goals requires true commitment on the part of care providers. The ideal is for all teens not to use substances during pregnancy. Fortunately, most do not.

References

1. Cornelius MD, Day NL, Cornelius JR, Geva D,Taylor PM, Richardson GA. Drinking patterns and correlates of drinking among pregnant teenagers.Alcohol Clin Exp Res 1993;17:290-4.
2. Teagle SE, Brindis CD. Substance use among pregnant adolescents: a comparison of self reported use and provider perception. J Adolesc Health 1998;22:229-38.
3. Lohr MJ, Gillmore MR, Gilchrist LID. Factors related to substance use by pregnant, school-age adolescents. j Adolesc Health 1992; 13:476-82.
4.Wieman CM, BerensonAB,San MiguelVVTobacco,alcohol, and illicit drug use among pregnant women. J Reprod Med 1995;39:769-76.
5. Flanagan P, Kokotailo PAdolescent pregnancy and substance use. Clin Perinatol 1999;26(1):185-200.
6. Bachman JG,Wallace JM, O'Malley PM, Johnston LD, Kurth CL, Neigh-bors HW Racial/ethnic differences in smoking, drinking, and illicit drug use among American high school seniors, 1976-89.Am J Public Health 1991;81:372-7.
7. Arkansas Department of Health. Maternal and Child Health Statistics 1994. Little Rock AR: Office of Comprehensive School Health, 1996.
8. Substance Abuse and Mental Health Services Administration. 1999 National Household Survey on Drug Abuse.Washington DC: Depart-ment of Health and Human Services,2000. http://www.DrugAbuseSta-tistics.samhsa.gov/#RecentReport.
9. Tennessee Department of Education.TheYouth Risk Behavior Survey. Nashville:Tennessee Department of Education, 2000. http://www.State.tn.us/education/ci/yrbs/index.htmi.
10. Fiscella K, Kitzman HJ, Cole RE, Sidora KJ, Olds D. Does child abuse predict adolescent pregnancy? Pediatr 1998;101(4):620-4.
11. Elders MJ,AIbertAE.Adolescent pregnancy and sexual abuse. J Am Med Assoc 1998;280(7):648-9.
12. Gilchrist LD, Hussey JM, Gillmore MR, Lohr MJ, Morrison DM. Drug use among adolescent mothers: prepregnancy to 18 months postpartum. J Adolesc Health 1996;19(5):337-44.
13. Horrigan T, Piazza NJ,Weinstein L.The substance abuse subtle screening inventory is more cost effective and has better selectivity than urine toxicology for the detection of substance abuse in pregnancy. J Perina-tol 1996;16(5):326-30.
14. Gastfriend DR, McLellan ATTreatment matching: theoretic basis and practical implications. Med Clin North Am 1997;81:945-66.
15. Messina M,Wish E, Nemes S. Predictors of treatment outcomes in men and women admitted to a therapeutic community.Am J Drug Alcohol Abuse 2000;26:207-27.
16. CarrA. Positive practice in family therapy. j Marital Fam Ther 1997;23:271-93.
17. Bell DC, Montoya ID, Richard AJ, Dayton CA.The motivation for drug-abuse treatment: testing cognitive and 12-step theories.Am J Drug Alcohol Abuse 1998;24:551-71.

Please take note...
CAAH new e-mail address

acsacaah@globetrotter.net

Time to renew your membership for 2002

The Rights of the Adolescent: The Mature Minor

Victoria J. Davis, MD, Roxanne Mykitiuk, BA, LLB, LLM
Department of Obstetrics and Gynecology, University of Toronto, The Hospital for Sick Children, Toronto ON, Osgoode Hall Law School, York University, Toronto ON

Introduction

Ignorance and misconceptions about adolescent sexuality prevail among adults and ado-lescents themselves. Thus, it is often the role and obligation of adolescent health care providers to dispel myths and to educate their patients about responsible and safer sexual behaviour to ensure sexual health. In addition to providing education, health care providers may also be required to diagnose and treat the reproductive health conditions of minor patients and to facilitate health prevention measures, including contraception and testing for sexually transmitted diseases. Teens who do not want their parents to know about their sexual behaviour may consult a health care provider for reproductive or sexual health care services and treatment without parental knowledge or consent. This may present legal and ethical dilemmas for health care providers who need to ensure a legally valid consent is given for any medical treatment or pro-cedure and who may wonder whether an adolescent below the age of legal majority is able to provide this consent.

While for many purposes the age of majority or a statutor-ily defined age determines when an individual may legally participate in certain activities, there is no legally defined age for consent to medical treatment. Common law recognizes that adolescents under the legal age of majority who are sufficient-ly mature (the mature minor) may have the capacity to con-sent to health care services with the same independence as adults. (1,2) To determine if an adolescent is capable of consent, the health care provider must decide if the adolescent is able to understand and appreciate the nature and consequences of the proposed medical procedure.(3) Maturity is demonstrated when a minor has the intellectual capacity to understand critical information about prospective medical treatment, and the vision to make a responsible decision about her medical care. The key element, therefore, is the minor's competence and capacity to understand and decide, not chronological age.

While adolescents may be able legally to consent to med-ical treatment and many have the decision-making capacities of an adult, (45) determining whether a particular individual has the capacity to consent needs to be assessed on an individual basis. If the health care provider is unsure whether the minor has the requisite capacity, a colleague, bioethicist or psychiatrist could be called upon for a second opinion. Courts have recognized that the decisional capacity of a minor will vary with the gravity of the decision and the degree of understanding and appreciation of the consequences of treatment and its alternatives. Thus the same individual may have the requisite capacity to consent to some medical services, but not others where the decision making process is more complex or the conse-quences more serious. Moreover, while one adolescent may be decisionally capable of consenting to a particular medical ser-vice, another adolescent of the same age may not be. In the context of reproductive health, courts have held that a 15-year-old had the capacity to consent to be fitted with an intrauterine devices and that a pregnant 16-year-old could give a valid consent to have a therapeutic abortion.(7)

Where there is disagreement between a mature minor and her parent about a medical procedure or treatment, the wishes of the adolescent should prevail, as the minor is capable of consenting to her own treatment. Therefore, the parent of a mature minor cannot veto the decision of a mature minor to

have an abortion or to bring a pregnancy to term against the parent's will; choice in this matter belongs with the mature minor.(8) As a general practice, however, the health care provider should discuss with the patient, and document, the importance of involving parents in health decisions, as well as the poten-tial negative consequences of sexual activity and all of the options available (including abstinence).

Where the adolescent is capable of making a decision and understanding its consequences, that adolescent should have equivalent to adult access to all aspects of available reproductive health care. For example, while adolescents are less likely than adults to seek services for infertility, there are some cultures in which early marriage and childbirth are the norm. Consequently, physicians may refer a mature minor for fertil-ity services when pregnancy is not forthcoming. Under law, a married minor is usually treated as having attained majority status; however, fertility services cannot ethically be denied if the unmarried adolescent is found capable and they are required medical services for that individual. Laws also tend to accept that an adolescent below the age of 18 attains majority status on becoming a mother: this facilitates the younger mother in making health care decisions for her child. It would be contradictory for the mother to be able to make health care decisions for her child and not for herself.

In Ontario, statutory law provides that a person is capable, with respect to health treatment, if the person is both able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.(8) The Health Care ConsentAct makes no reference to an "age of consent," following in principle the "mature minor" rule that one's legal right to make health care decisions depends on one's decision-making ability rather than one's age. In some provinces, such as New Brunswick, British Columbia, and Quebec, legislation specifies an age at which an individual may give autonomous consent.(9) These provisions extend the presumption of capacity to consent enjoyed by adults to minors. Even where legislation sets a minimum age for consent to pro-cedures performed in hospitals, as is the case in Ontario, it has been argued that these provisions do not affect the general law of consent to medical treatment, but rather relate to the relationship between the hospital and health care provider and set a bureaucratic requirement to document evidence of consent (3) Therefore, if a mature minor who is under the minimum age specified in the statute consents to treatment in a hospital in the absence of parental consent (a therapeutic abortion for example), the consent will be valid vis-a-vis the treating physician and the hospital.

In the case of adolescents who are incapable of making their own health care decisions, parents or legal guardians generally have the legal authority and responsibility to act as surrogate deci-sion-makers. The surrogate decision-maker is obliged to make treatment decisions in the best interest of the patient. If parental consent was given for medical treatment to an incapable minor who opposed and resisted the proposed treatment, it is possible to contest the parental decision to determine whether parental consent can be imposed in light of the minor's opposition to the treatment. In addition, health care providers who believe that a surrogate's decisions are not in the best interest of the child can appeal to provincial child welfare authorities.(10)

The requirement that health care providers maintain patient confidentiality derives from the Hippocratic oath, and is a legal obligation. Unless assured of confidentiality, sexually active adolescents may forego counselling and contraception, thereby risking pregnancy, sexually transmitted diseases (STDs), and their sequelae. In order to maintain a therapeu-tic bond and ongoing care, the minor must trust the health care provider. Confidentiality is essential. A mature minor is entitled to the same level of medical confidentiality as any other patient. There are, however, certain exceptions to absolute confidentiality. These are: the duty to warn third parties of immi-nent and serious danger (such as a positive HIV test); the disclosure of childbirth when necessary to protect the interests of the newborn child; disclosure when an adolescent requests health services because of sexual or other exploitation or abuse, against which parents may provide protection;(11, 12) and the statutory duty to report

suspected cases of child abuse, including sexual abuse, to a child protection agency.

An additional issue arises when the adolescent is not capa-ble of making decisions about medical treatment, but does not want parents to know about the request for medical services.

Some argue that a health professional who does not dis-close to parents may be acting in the best interest of the patient. Others are of the view that a failure to disclose, especially where the information is important to the welfare of the child, could be regarded as usurping the parent's role as substitute decision-maker to determine what matters are relevant to the health care of the minor. Canadian courts have not determined whether a decisionally incapable minor can bind a health care provider to non-disclosure vis-a-vis parents.(3)

Health care providers need to be aware that it is a criminal offence for a person to involve a child under the age of 14 in any kind of sexual activity even if the child consents to the activ-ity. The Criminal Code of Canada provides a defence where the victim is at least 12 years of age and under 14 and the accused person is at least 12 years of age and under 16, is less than two years older than the victim, and is neither in a position of trust or authority towards the victim nor is a person with whom the victim is in a dependent relationship. This information may be relevant to a health care worker providing contraceptive advice or sex education to a patient who is or is planning on engaging in sexual activity with a consenting partner, whose consent is vitiated by the operation of the Criminal Code.

In conclusion, health care providers need to respect, empow-er, and promote well-being in their patients, especially adoles-cents in the area of reproductive health care. The promotion of well-being includes education in all aspects of sexuality, so that negative sequelae can be reduced or avoided altogether, thus ensuring the right to reproductive health. A failure to discuss sexuality and sexual health means that adolescents often do not acquire the information and skills they need to prevent unin-tended pregnancy and sexually transmitted disease, and the con-sequent psychological impacts of these conditions. In addition to their direct involvement with adolescent patients, health care workers can also work with their local provincial governments to support and adopt policies and programs that respect, pro-tect, and guarantee reproductive rights, including those of minors. This may require the creation of appropriate legislative, administrative, and budgetary measures to realize reproductive rights. However, if established, we can expect to see a decline in unintended pregnancy and STDs, and an increase in the num-ber of youths who are empowered to deal more knowledgeably with their sexuality.

References

1. International Commission of Jurists.The Maastricht Guidelines onViola-tion of Economic, Social and Cultural Rights.A compilation of essential documents. Geneva, 1997.
2. Rozovsky LE, Rozovsky FA.The Canadian law of consent to treatment. Toronto: Butterworth, 1992:53-7.
3. Gilmour JM. Minors. In: Downie J, Caulfield T, Canadian Health Law and Policy.Toronto: Butterworth, 1999:185.
4. Weithorn LA, Campbell SB.The competency of children and adolescents to make informed treatment decisions. Child Dev 1982;53:1589-98.
5. Lewis CC. How adolescents approach decisions; changes over grades seven to twelve and policy implications. Child Dev 1981;52:538-44.
6. Gillick v.West Norfolk and Wisbech Area Health Authority, 11985] 3 All E.R. 402 (H.L.).
7. C. U.S.) v.Wren 11987] 2WWR.669 (Alta. C.A.).
8. Cook R, Dickens BM. Recognizing adolescents"evolving capacities' to exercise choice in reproductive healthcare. Int J Gyn Obs 2000;70:13-21. 9. Etchells E, Sharpe G, Elliot C, Singer PA. Bioethics for clinicians: 3: capacity. Can Med Assoc J 1996; 155:657-61.
10. Harrison C, Kenny NP, Sidarous M, Rowell M. Bioethics for clinicians: 9. Involving children in medical decisions. Can Med Assoc J 1997;156:825-8 11. British Medical Association. Medical ethics today: its practice and philosophy. Br Med J 1993:87-8.
12. Kleinman I, Baylis F, Rodgers S, Singer PA. Bioethics for clinicians: 8. confidentiality. Can Med Assoc 1 1997;156:521-4.

Reproduced from:Journal SOGC Volume 23, number 4 April 2001, 343-345

Publications

Trust for the Study of Adolescence

www.tsa.uk.com

This new site, established by the Trust for the Study of Adolescence (TSA), will be of interest to researchers, journalists, students and all those who work with young people, including those in health, social services, family centres, youth and voluntary organizations, education and prison and youth justice services.

The site will contain full details of:

- Why TSA was founded and what its aims are;
- Current research projects;
- The youth, citizenship and social change ESRC Research Programme;
- Research networks;
- Publications and resources available from TSA;
- Press releases, describing new grant awards and research progress;
- Details on TSA's latest professional development initiatives;
- Details on TSA's latest professional development initiatives;
- Details of upcoming events and conferences;
- Links to other useful web-sites and forums that deals with young people.

Childnet International
www.childnet-int.org

Children International is a non-profit making organization based in London. Childnet works around the world to promote children's interest in understanding and using the internet, promoting media awareness and spreading good practice to those who guide children. Childnet has worked with a number of other agencies to produce publicity and awareness resources, which explain how the internet works and help people understand some of the issues it presents.

The Pelvic Health Centre

At the Women's Health Matters Web site

The Women's Health Matters Web site at Sunnybrook and Women's College Health Sciences Centre is pleased to announce the launch of a new resource focusing on pelvic health. Created in conjunction with women's health experts at the Pelvic Health Centre provides information about:

Cervical Dysplasia
Chronic Pelvic Pain
Endometriosis
Fibroids
Interstitial Cystitis
Ovarian Cysts
Polycystic Ovarian Syndrome
Pelvic Inflammatory Disease
Pelvic Prolapse
Urinary Incontinence
Vulvodynia

The site is intend as a resource for all women and their health care providers who are interested in reliable and trusted health information. Please visit Women's Health Matters at: www.womenshealthmatters.ca

For more information contact
Sheryl Mitchell, Director,
Women's College Health Sciences Centre
(416) 813-4752

Together Working For and With the Adolescent

12th Quebec Regional Meeting

The CAAH will present its 12th Quebec Regional Meeting the 25th and 26th of April 2002 in Montreal at the Maison Notre-Dame. The topic of the Meeting is: "Together Working For and With the Adolescent". It will be presented in both languages, English and French. The objectives of the Meeting will be the following:

- Better understand some issues that adolescent are confronted with, such as the clash between two cultures, parent-adolescent relationship, chronic diseases and motherhood.
- Better understand the relationship between the adolescent and health care workers and educators.
- Improve our intervention with adolescents and their parents.

The meeting will include as usual some guest speakers and workshops. The guest speakers are Mounir Samy who will present "How Can I Not Love My Child? – The Question of Parental Ambivalence"; Jaswant Guzder, "Adolescents Growing Up Between Two Cultures: Conflicts, Competence and Individuation Issues" and Sarah Brandon, "Youth Friendly care and services". There will be two periods of workshops during each day of the meeting, the morning and the afternoon. And the last day the general assembly of the members of the CAAH will take place.

For more information, please contact:

ACSA — CAAH Section de médecine de l'adolescence
3175 Ch Ste-Catherine, Montréal QC H3T 1C5
Tel: 514-345-9959 Fax: 514-345-4778
E-mail: acsacaah@globetrotter.net - www.acsa-caah.ca