Canadian Association for Adolescent Health

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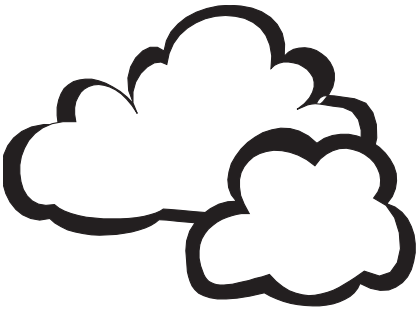

Scientific Events

Articles

Publications

PRO-TEEN

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News from the Association

President's Report 2003

The state of membership in December 2003 is as described in the tables below.

This year, even if it shows that 35% of the members have renewed, in reality, it is a bigger percentages who have paid some dues because many members form 1999 to 2002 have renewed. The members of 1999 and 2000 will probably not renew their membership but many members from 2001 and 2002 will renew in 2004 after several reminders. Sending three reminders per year has proved to be rewarding in terms of membership renewal. Our membership is stable as compare to last year.

We are loosing and gaining 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 National and Regional meetings).

85% of the members are women and 15% are men; 59% of the members want to receive their journal in French, 33% in English, while 8% want both.

49% of the members have a single membership; thus 51% are in a group membership. This includes members who have an institutional membership (185$ for up to 7 members).

22% of the members pay themselves their dues, 77% having their dues paid by their institution or organization; 1% are free members or other kind of payment.

1999	92 (11%)
2000	67 (8%)
2001	93 (11%)
2002	291 (35%)
2003	280 (34%)
2004 (paid subscription since 2003)	51 (7%)
TOTAL	**824**

Meetings

The 2003 annual National Meeting was held in French and English in Montreal November 13 and 14th 2003. It was organized by the Adolescent Medicine Division of Ste-Justine Hospital and of the Montreal Children Hospital. The theme was "Communicating with adolescents" It was well attended with 230 participants who ended up very satisfied according to the evaluation.

Website

The website is visited by an average of 600-900 persons per week, of which about 130 access through the home page while other access indirectly through other links. There are usually more than 7000 hits per week on the site. The time spent on the site is interesting since it is above 5 minutes on average.

PRO-TEEN, PRO-ADO

The journal is still popular. Many of our new members become members to receive the journal. However, publishing the Journal is time consuming and we welcome any articles for publication.

Canadian Health Network

The Canadian Association for Adolescent Health was part of the Consortium acting as the Youth Affiliate of the Canadian health network, a website of health Canada proving health information. The Consortium is in charge of developing the youth centre of the website. The University of Toronto was the coordinator of the Consortium. Last July, CAAH took over the coordination with the same partners in the Consortium. In November, like all Affiliates, CAAH sent a proposal to act as the Youth Affiliate for the years 2004-2007.

Finances

CAAH is still in an uneasy financial situation but with successful meetings, financial situation is improving.

Happy and productive year,

Jean-Yves Frappier
President

Members by province	
Quebec	569 (70%)
Ontario	165 (20%)
British Columbia	37 (4%)
Nova Scotia	10 (1.2%)
Alberta	15 (2%)
Saskatchewan	6 (0.7%)
Manitoba	4 (.5%)
Newfoundland	2
New Brunswick	5 (.6%)
Yukon	1

Workplace (more than one choice)	
CLSC	37%
Private Office	10%
School	31%
Public Health	13%
City Health Department	0.3%
Hospital	17%
University	6%
Community Organization	7%
Youth Centres	6%
Children Aid Society (Youth protection)	2%
Custodial Facilities	3%
Government, Ministries, Governmental Organizations	4%
School Board	2%
Others	4%

Type of work (more than one choice)	
Clinical Intervention	67%
Teaching	36%
Prevention, Promotional Activities	60%
Health Education	42%
Clinical Coordination	13%
Group's animation	28%
Community Work	19%
Public Health	20%
Research	11%
Administration	12%
Documentation, Library	4%
Volunteers	2%
Media	2%
Street work	3%
Program development	16%
Others	4%
Without answer	9%

Profession of Members			
Nurse	33%	Family Doctor	11%
Social Worker	13%	Paediatrician	6%
Psychologist	8%	Gynecologist	1%
Teacher	2%	Other medical specialties	2%
School Counselor	3%	Librarian, Documentalist	2%
Child Life Worker, Occupational Therapist	4%	Nutrionist	2%
Community Worker, Street Worker	2%	Administrator	2%
Sexologist	1%	Others	9%
Coordinator	5%		

Topic of Interest (more than on e choice)	
Parents-adolescents relationships	73%
Behavior problems	62%
Sexuality, pregnancy	70%
Handicaps, chronic diseases	38%
Sexual abuse	61%
Anorexia nervosa and bulimia	65%
Suicide, suicide attempt, depression	70%
STD, AIDS	59%
Drug abuse	65%
General health: growth, dermato, ortho, sports	42%
Rights and Laws	42%
Adolescent development	60%
Learning disorders	42%
Violence	49%
Nutrition and obesity	48%
Psychosomatic complaints	46%
Without answer	9%

Budget 2002 (audited)

Revenues	
Grants	89,716
Membership fees	18,030
QC Regional meeting	36,701
National meeting	17,161
TOTAL Revenues	**161,608**
Expenses	
Administrative support	61,038
Project Assistant	32,357
Journal	6,995
Amortization	1,823
Maintenance	-------
Data entry	1,801
Office supplies	3,305
Representation fees	474
Travel charges	586
Interest and bank fees	328
Tax and permits	30
Professional fees	1,025
Qc Regional meeting	26,730
National meeting	3,925
TOTAL Expenses	**150,017**
Cumulated deficit (dec 2002)	28,023

Scientific Events

Innovative Practices for Suicide Prevention
May 4th-7th 2004

Despite many efforts worldwide, suicide remains an important cause of death. In order to maximize the effects of current suicide prevention initiatives it is crucial that we look for inspiration in the most innovative research and practices developed in different countries.

By sharing innovative experiences we hope to develop a critical understanding of the necesary conditions for developing the most relevant suicide prevention activities. **Innovative Practices for Suicide Prevention** is an unique event both in terms of its content and format. A major emphasis is placed on knowledge transfer and application, we will be holding an international "competition" on winning strategies in suicide prevention and the programme of activities interactions between participants.

The main objective of this congress is to share innovative research and practices in suicide prevention. We will:

- Examine innovative research and practices in suicide prevention in different countries
- Identify new technologies which have been tested, as well as those under development
- Determine conditions which are favourable to the implementation of pertinent innovations in suicide prevention
- Contribute to increased collaboration and information sharing on innovative practices in suicide prevention

The scientific commitee has proposed various topics in contemporary innovative practices. Presentations will be structured around specific themes. Examples of possible themes include:

- Use of media campaigns
- The internet and suicide prevention
- Innovative research methods
- New theories and models for knowledge transfer
- Recent programmes for children bereaved by suicide
- Religion, spirituality and suicide
- Kamikazes and terrorism
- Innovations in therapeutic and intervention methods
- New telephone technologies and their implications
- New evaluation techniques and standards for evaluating practices
- Suicide in micro-environements
- Innovations in the biology and genetics of suicide
- Partnerships and conditions for successful implementation of innovative practices
- Suicide and geography
- The usefulness of methods for controlling access to means for suicide and suicide sites
- New technologies for the surveillance and control of suicide in institutional settings
- Euthanasia and suicide: the same phenomena or distinct problems?

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Articles

Helping boys to find their way

Study by Éric Lacourse, Sylvana Côté, Daniel S. Nagin, Frank Vitaro, Mara Brendgen, and Richard E.Tremblay

How do kindergarten boys develop and grow into antisocial adolescents? Do they move in steady steps, from impulsive behaviour, to fighting, to more serious crimes? Or do they reach early adolescence and, for reasons unknown, resort to antisocial behaviours like fighting, stealing, and vandalism? Can we prevent disruptive kindergarten boys from becoming hard core juvenile delinquents? To answer these questions, researchers looked at a large group of Montreal boys who have been participating in a long-term study.

The researchers began by identifying the different pathways that the boys take. Two groups (more than half the boys in the study) showed little antisocial behaviour from 11 to 17 years of age. Two groups registered levels that declined as the boys matured. The two remaining groups represented a minority, but they had increasing levels: boys with low levels of problem behaviour that rose steadily to relatively high levels, and boys with high levels of antisocial behaviour that increased then decreased their level.

The researchers then decided to see whether, by intervening, they could change the antisocial pathways of the disruptive kindergarten boys. These boys and their families received for two years a parent and social skills training program - and it worked. Compared to boys who had comparable behaviour problems and did not receive treatment – the control group – the boys in the program were far less likely to be physically aggressive or engage in vandalism or theft. In fact, the effect of the program seemed to last throughout adolescence as the boys from the selected group continued to exhibit comparatively less antisocial behaviour than the control group.

By testing the effectiveness of a prevention program, the researchers highlighted an important point, namely that a disruptive or antisocial child is not doomed to become an antisocial adolescent. Interventions can make a difference, allowing boys and young men to find new, less antisocial pathways that can lead them to a productive adult life.

Ref.: Lacourse E, Côté S, Nagin DS, Vitaro F, Brendgen M, Tremblay RE, "A longitudinal-experimental approach to testing theories of antisocial behaviour development" Development and Psychopathology 2002; 14:909-924.

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Overeating Among Adolescents

Ackard D.M. and al

Pediatrics, Vol. 111 N°. 1 January 2003

Overeating is a behavior that begins for many during adolescence, a time at which weight concerns also arise. Studies have found that objective overeating is prevalent among adolescents and has been linked with problematic weight-related behaviors and psychological challenges. The population-based prevalence of binge eating (objective overeating with a sense of loss of control over what or how much one is eating) among youths is as high as nearly 30% for boys and 46% for girls.

Several studies with adults have indicated that the frequency and severity do not yield significantly different results among all individuals who binge eat. Results from these studies revealed that individuals with BED and those with "subclinical" or "subthreshold" levels of binge eating both report significant psychiatric distress compared with those who did not binge eat. However, many individuals report subclinical levels of overeating and binge eating before meeting full criteria for BED.

Methods: Study Population and Design
Participants in this study included a sample of 4746 students (2377 boys and 2357 girls; 12 students had missing data for gender) in public middle and high schools in the greater Minneapolis/St Paul metropolitan area of Minnesota. The study aimed to attract diversity by race and economic status; 31 schools serving socioeconomically and ethnically diverse communities agreed to participate in the study.

Students completed the Project EAT (Eating Among Teens) survey in health, physical education, or science class.

The confidential survey was designed to assess eating and weight-related attitudes and behaviors among adolescents. Height and weight measurements were obtained by trained research staff in a private screened area. Standardized anthropometric procedures were used. Data were collected in compliance with the University of Minnesota's Institutional Review Board and Human Subjects' Committee and with the consent processes for each school district's research board. The student response rate was 81.5%

Results:
Overall, 17.3% of girls and 7.8% of boys reported engaging in overeating (acknowledgment of objective overeating, regardless of loss of control, frequency, or distress). This sum represents 6.3% of girls and 4.5% of boys endorsing items for objective overeating, 7.9% of girls and 2.4% of boys with a subclinical level of binge eating, and 3.1 % of girls and 0.9% of boys meeting criteria for binge eating syndrome.

Overeating was associated with obesity among boys. Boys who overeat were more likely than those who do not to meet the BMI percentile cutoff criteria for obesity. Results for girls were not significant; however, there was a trend that girls who overeat were more likely than those who do not to be obese.

Associations Among Overeating and Body Satisfaction, Depressive Mood, and Self-Esteem:
Overeating was significantly associated with body dissatisfaction. Girls and boys who reported no overeating reported the highest satisfaction for weight and body shape and scored highest on the composite body satisfaction score when compared with their peers who reported any level of overeating. Overeating was associated with depressive mood. Girls and boys who reported no overeating endorsed a lower frequency and severity of depressive mood compared with their peers with objective overeating, subclinical binge eating, or binge eating syndrome. Those who met criteria for binge eating syndrome scored highest on the measure of depressive mood, and those with no overeating scored lowest.

Discussion:
Overall, 3.1% of girls and 0.9% of boys endorsed criteria for binge eating syndrome, and an additional 14.2% of girls and 6.9% of boys reported objective overeating, regardless of loss of control, frequency,

or distress. Results from the current study support the hypothesis that overeating was associated with higher BMI values and obesity status. It is not surprising that overeating and higher BMI values and obesity are associated, in that frequent consumption of large quantities of food is likely to lead to weight gain, notably in the absence of compensatory behaviors typically associated with bulimia nervosa. However, it continues to be unclear how the cycle of dieting, overeating, and obesity starts.

Results from the current study support the hypothesis that overeating was associated with more frequent dieting and greater stress on the importance of weight and shape. The hypothesis that overeating was associated with compromised psychological health was confirmed. Regardless of which symptom (dieting, overeating, weight gain, and/or concerns about weight and shape) presents first, overeating is associated with body dissatisfaction.

Overeating has been found to be associated with body dissatisfaction and drive for thinness among other samples of youths. In fact, desire to be thinner was found to be the significant predictor of binge eating in a study of Australian boys and girls. It is not clear whether individuals who overeat are dissatisfied with their body as a result of a higher BMI value and/or are dissatisfied with their body because of the lack of control over their body and their eating. However, in the current study, post hoc analyses controlling for BMI were still significant, indicating that the association between overeating and body dissatisfaction is not merely attributable to higher BMI values among those who overeat. Future longitudinal research could evaluate the presence of significant body dissatisfaction in relation to the onset of overeating.

Wertheim et al also found that among girls, measures of large current body size, depressed affect, and low self-esteem predicted binge eating. In the current study, girls and boys who reported any level of overeating reported more severe depressive mood and lower self-esteem and were more likely to endorse items about suicidal thoughts and attempts. An unanswered question is whether overeating leads to psychiatric distress, the psychiatric distress precipitates this type of eating, or something else is leading to both overeating and compromised psychological health.

Reproduced from: The Monthly News In Adolescent Medicine

Public opinion and violence prevention

Richard E.Tremblay

Last June, when we invited newspapers to collaborate with the CEECD to conduct an opinion poll on children's aggression (1), Paule Des Rivières (an editorialist at Le Devoir) told us, "It isn't newsworthy." This reaction came as a bit of a surprise since, over the past decade, Le Devoir has covered the progress of Canadian longitudinal studies on child development very well indeed. Des Rivières, in particular, has often recognized the importance of early intervention in her editorials.

Our aim with the opinion poll was to verify to what extent the Canadian public understood (like Des Rivières) that the Canadians who use physical aggression most often are preschoolers, and that preventive interventions during the preschool years are probably the best way to prevent subsequent problems with schoolyard bullying, violent juvenile delinquency, biker gang violence, and spousal violence.

Of course, the CEECD forged ahead with the poll. We asked a random sample of 1,500 Canadians to select the age at which they thought young Canadians used physical aggression most often, and which age category the Canadian government should target if it were to invest $100 million (of new money) into violence prevention. Des Rivières was astonished by the results of the poll and the story made he front page of Le Devoir.

According to the poll, more than 60% of Canadians believe that adolescents resort to physical aggression more frequently than any other category of young Canadian boys (see Figure 1). Only 2% correctly identified preschoolers as being the most frequent

physical aggressors. Des Rivières was especially interested by the fact that no Quebecers (0%) correctly identified preschoolers as the leading age group for frequent physical aggression. So while we know that Le Devoir has been doing its job reporting research results and writing editorials on this subject, its efforts do not appear to have changed public opinion in Quebec - not even by 1%!

Considering that,across the country, most Canadians perceive adolescents as being prone to physical aggression,it is not surprising that 41% wanted to spend the $100 million on preventing physical violence in this age group (Figure 2). No more than 10% of respondents said they would spend the money to help preschool children learn alternatives to physical aggression. These results are disturbing, especially when we consider that politicians often rely on public opinion to decide where to allocate government resources.

There is clearly a long way to go if we want Canadians to understand the results of research on child development and its implications for the prevention of childhood precursors to more serious problems. Results from longitudinal studies indicate that early childhood problems can lead to devastating school performance, social relationships, mental health problems, and increased risk-taking behaviours such as smoking, alcohol abuse, drug use, and reckless driving.

The best way of changing public opinion is most likely to make good use of the resources that are allocated to early childhood development. Once we are able to demonstrate that the programs we have implemented for young children actually prevent school problems and juvenile delinquency, it will be much easier to request further resources. For the time being, our main problem is that we have to convince politicians to invest billions in early childhood development when the short- and long-term effects of the programs are not being adequately evaluated. In 10 years time will we be able to identify which of the early childhood programs did change the life-course of children? Who is keeping score?

For more information:
http://www.excellence-earlychildhood.ca/documents/BulletinVol2No1Avril03ANG.pdf
(1) Opinion Poll Regarding Aggression among Young Children in Canada -Conducted by Léger-Marketing

Figure 1
Age boys resorting most frequently to physical aggression?*

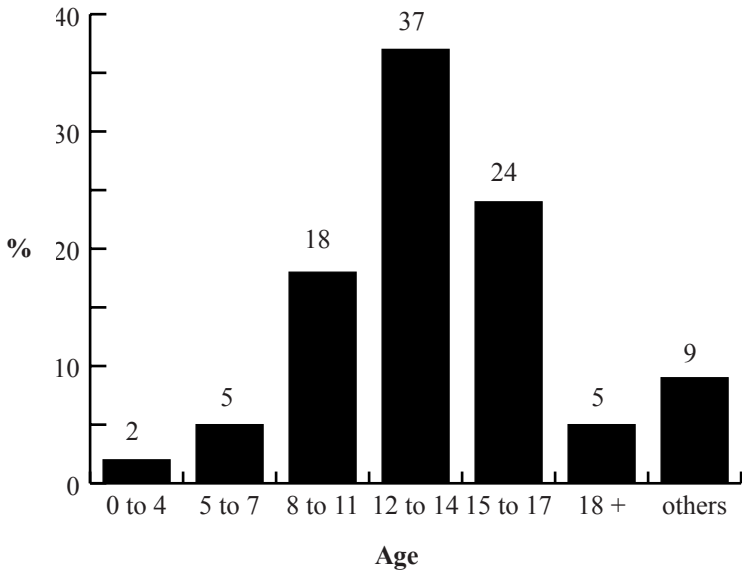
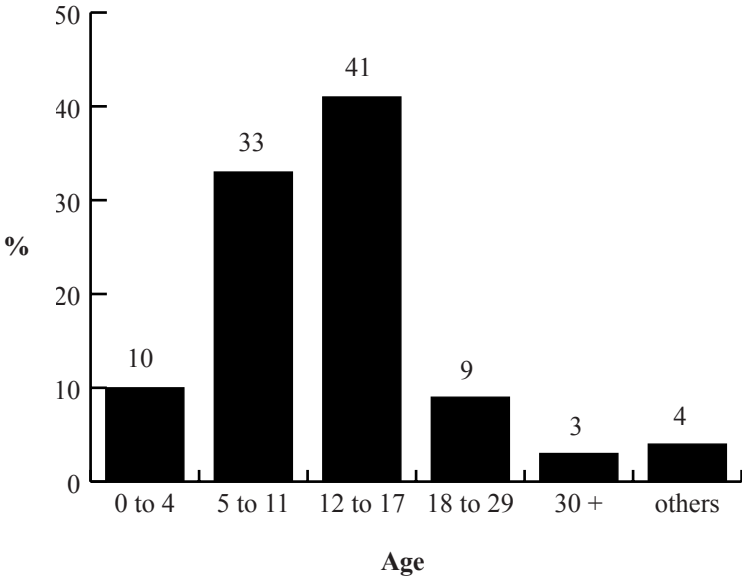


Figure 2
Age in which invest to prevent physical aggression?*



*Poll conducted by Léger-Marketing,
perception of a representative sample of the Canadian population

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Television and Adolescents: Friends or Foes

Claudine Hanna
Fourth Year Medical Student, McGill University
Literature review while on stage at
Hertzl Family Medicine Unit *Jewish General Hospital*

Television and mass media are omnipresent in our life. Adolescents are an attractive target since they spend between 20 and 28 hours per week watching television[1]. In fact, they are particularly vulnerable since they are at the stage of shaping their identity[1]. Television provides role models such as movie stars and athletes[2] that children will be tempted to imitate. The temptation is even stronger when the behavior depicted is rewarded[1]. Mass media are the most powerful conveyors of sociocultural ideas and images and therefore play an important role in adolescents' perception of ideals[3]. However, they often promote standards that are impossible to achieve[3].

The influence of television and media on adolescents' behavior and attitude is often underestimated. Television is certainly the most prominent and influential source of media for adolescents[3]. How much can media influence teenagers? The media wouldn't invest billions of dollars if it weren't profitable[1]. It has been studied for many years and specific behaviors promoted on TV have been of concern. Those include sexual practice, alcohol drinking, distortion of body image, initiation of smoking and use of violence. It is a major problem since initiation of high-risk behavior at a young age is associated with adoption of even more risky activities in the future and severe social and health outcomes[4].

Impact of television on teenagers

Sexual Activity

Television is the leading "sex educator" in America[1]. Unfortunately, more unhealthy information is displayed than healthful one[1]. Each year, adolescents are exposed to 15000 sexual references of which less than 170 deal with birth control, sexually transmitted disease protection, pregnancy prevention and even with abstinence[5]. Sex is promoted mostly as an act of pleasure and it used to sell anything from shampoo to cars. It loses its meaning of love, intimacy and exclusivity. Adolescents who are experiencing their first relationships are vulnerable because of their curiosity to try new activities. The availability of partners renders sexual activity easy to practice.

A few studies have shown how television can influence teenagers' behavior. A study by Brown et al. found that young people who viewed more sexual content on television were more likely to have initiated sexual activity at a younger age[6]. Another study showed that soaps and music videos, which were the most popular TV shows[1], were unfortunately the programs where sex was depicted the most as impersonal and exploitative. Rarely was the birth control pill mentioned[1]. A study from Cleveland showed that adolescents with a preference for music television had increased sexual activities in their mid-teen years[7]. A correlation can therefore be established and we can state that sexuality displayed on TV could possibly incites teenagers to engage into similar behavior.

Alcohol drinking

Beer and wine companies spend about 900 millions dollars per year in advertisement on television[1]. With all that money invested it is tempting to believe that it is profitable to them. Beer is displayed as being sexy, fun, likely to make drinkers more popular. It is usually part of a social activity. However, bad repercussions are often ignored[1]. Advertising exposure seems to influence initial drinking experiences that are in turn correlated with excessive drinking and abuse in the long run[8]. It is thought to stimulate favorable predispositions and therefore is considered more of a contributory factor than a causal factor[5].

Body Image

Media establishes beauty in thin and skinny women. Excessively thin women are shown to be attractive and sexy. Our societal standards emphasize and are obsessed with thinness[3]. However, those standards

are often impossible to achieve[3]. Adolescents are easy to influence since they are shaping their identity and self-esteem and are exploring their sex role[3]. They will be tempted to believe that in order to be attractive and sexy, they need to have a very slim body. The message given by television will lead to lower self-esteem, excessive dieting and the emergence of physical problems[3] because of the desire to resemble the models displayed. Girls are specifically affected by this drive for thinness and are more likely to suffer the detrimental consequences[3].

A study by Tiggemann and Pickering showed that perceived overweight in young women with a BMI around 19.5 was positively correlated with time watching TV[3]. Another study showed that amount of TV watched didn't correlate with body dissatisfaction but the kind of programs did. Soaps, movies and music videos were the most popular but they are the ones that emphasize the most thinness and body dissatisfaction[3]. Young girls with healthy body weights will perceive their body as inadequate when compared to what society considers attractive. TV and media can contribute to women's body dissatisfaction.

Smoking initiation

Smoking is the leading preventable cause of death in the United States[2]. Why are adolescents so attracted to cigarettes? Teenagers are searching for heroes and stars to admire and identify to. On TV, smokers are usually portrayed as attractive, popular and successful[2]. Cigarette smoking is also depicted as a good way to relieve stress. Adolescents will be tempted to imitate such a behavior when it is expected to be rewarded as shown on television. They learn by vicarious reinforcement. Of all smokers, 70% admit becoming regular by age 18[9].

Smoking is very present in Hollywood movies. The American Lung Association Study reviewed 133 movies released from 1994 to 1995. They found that in 77% of them, tobacco use is present[5]. Moreover, 25% of music videos contain images of alcohol and tobacco[5]. A recent study by Gidwani et al. looked at 10-15 years old adolescents and tried to establish a relationship between number of hours of TV watched and smoking initiation. The conclusion was that those who were watching TV 5 hours or more per day were 5.99 times more likely to initiate smoking in the following 2 years than those who were watching less television[2]. This data seems to be consistent with other studies[10-11-12]. On the same note, Villani concluded that TV and media contribute to increased tobacco use in adolescents.

Use of Violence

Teenagers see in average 10000 violent acts per year[13]. The National Television Violence Study examined nearly 10000 hours over 3 years of television and found that 61% contain violence. Paradoxically, programs addressed to children were the richest in violent content[5]. Music videos were also studied and 25% of them portrayed violence[14].
Unfortunately, attractive role models were the aggressors in 80% of violent music videos[15].

Extensive research showed a cause/effect relationship between media violence and real life aggressive behavior and anti social personality[16]. Use of violence to achieve goals is a learned behavior[5-20]. High levels of TV watching could not only cause aggressive behavior but are also contributing to acceptance of violence[17]. The more teenagers are exposed to violence the more they use it and accept it[16]. Children get desensitized[16]. Media may also influence risk perception since the actors seldomly suffer adverse consequences of their risky behavior[18]. Risky behavior is rarely depicted as dangerous on television. Violence is showed as a quick way to solve conflicts without negative consequences[16]. It is even a rewarded behavior[19]. It is unfortunate that media don't show the art of patience, compromise and negotiation[16].

What can adults do?

Role of parents

Now that we've established some positive relationship between media exposure and risky behavior, what is the role of parents? Most parents do not control the media exposure of their children[5]. They also tend to underestimate the number of hours teenagers watch television[5]. Strasburger and Donnerstein recommend co viewing as a protective mechanism[5]. They believe that parents could discuss the program watched and therefore act as a value filter and a media educator[5]. The American Academy of Pediatrics also recommended limiting media use to no more than 1 to 2 hours per day[1]. Other forms of entertainment should be encouraged such as outdoor play, reading, arts and crafts etc.[16]

Role of health professional

Health professionals can help in many ways. When seeing an adolescent, health professionals should ask questions about media viewing[1]. They should specifically ask about time spent watching TV, chatting on the Internet, playing video games etc. They should also recommend limiting the time spent watching TV. Health professionals can provide tricks like finishing all homework before watching television[1] or making a schedule of chosen programs. For adolescents with body dissatisfaction, health professionals can emphasize the importance of maintaining a healthy weight and explain how the media often distort reality.

Health professionals are also encouraged to advocate for improved media. They could pressure television to broadcast more birth control advertisement and less violence or sexuality[5]. In fact, TV can promote good values. For example, an aggressive antismoking campaign in Vermont resulted in a smoking rate 35% lower after 4 years[5].

Conclusion

Television is the most powerful media provider. Adolescents are vulnerable because they are at the stage they are shaping their identity and are looking for role models. Television exposure seems related to high-risk behavior. The possible detrimental consequences include early sexual activity, alcohol abuse, distorted body image, smoking initiation and aggressive behavior. We should also keep in mind that by spending time watching television, teenagers do less outdoor activities and sports and are therefore more prone to suffer from obesity. Parents and health professionals should take an active role in prevention, control and education.

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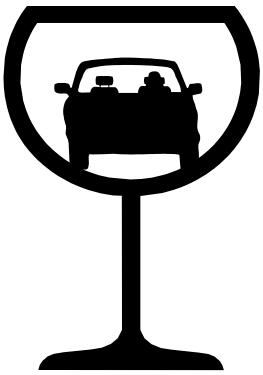
Drinking and Cannabis Use and Driving among Ontario Students

Adlaf E.M. and al

Canadian Medical Association Journal

Alcohol-related motor vehicle collisions are a major source of injury among adolescents. Efforts to reduce the prevalence of drunk driving have been undertaken, with some success. Specific initiatives in Ontario have included the introduction of a zero blood alcohol content (BAC) requirement as part of the province's Graduated Licensing System. Introduced in 1994, this system applies restrictions to all new drivers in the first 2 years of licensing.

Although some research has monitored the prevalence of drinking and driving among adolescents, which is now about 15%, little is known about the risk of injury associated with driving after the use of drugs such as cannabis or with secondary exposure such as being a passenger in a car driven by a drunk driver. These 2 issues are of concern given that US data suggest about one-third of adolescents have ridden with a driver who had been drinking and that about 9% of Ontario drivers aged 18-19 years reported driving after cannabis use. We present here data on these indicators from a representative sample of Ontario students who participated in the Ontario Student Drug Use Survey (OSDUS).



Self-administered questionnaires were administered by staff of the Institute for Social Research, York University, in a classroom setting. The students were asked 3 questions: "How often in the last 12 months did you ride in a car or other vehicle driven by someone who had been drinking alcohol?"; "How often in the last 12 months have you driven within an hour of drinking 2 or more drinks of alcohol?"; and "How often in the last 12 months have you driven within an hour of using marijuana or hashish?"

Our findings are summarized in Table 1. In all, 31.9% of the students reported being a passenger in a car driven by someone who had been drinking. Passenger involvement was unrelated to sex but did differ significantly by grade. Of the students in grades 10 to 13 who had a driver's license, 15.1 % reported driving within an hour after consuming 2 or more drinks; the proportion varied significantly by sex and grade. Of the half sample of drivers, 19.7% reported driving within an hour after using cannabis; the rates varied significantly by sex only.

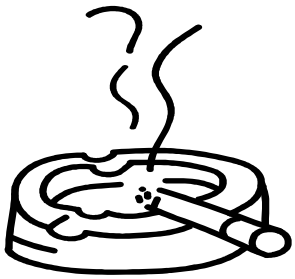
Our study has limitations, the main one being that the data were self-reported and may have been subject to non-response bias. However, this source of bias would most likely serve to underestimate true behaviour. Three of our findings have important public health implications that require further research and monitoring. First, the 15% of students with a driver's license who reported driving after drinking is excessive, particularly since almost all were under the legal drinking age, and most had a graduated license, for which the legal BAC limit is zero. Second, that nearly one-third of the students reported having ridden in a car driven by someone who had been drinking - an exposure associated with the largest risk factor for the leading cause of death among adolescents- is of great concern. Third, driving after cannabis use is a risk behaviour that may be of similar magnitude to driving after drinking. Although there are no earlier data to evaluate trends, the potential exposure may be substantial since a sizeable proportion of adolescent students are drivers (30%) and have used cannabis (30%).

Reproduced from the Monthly News In Adolescent Medicine. July-August 2003

Table 1: Proportion of Ontario students in grades 7 to 13 who reported riding in a car driven by someone who had been drinking, driving after drinking and driving after cannabis use in the year before being surveyed, 2001

	Behavior, % of students*		
Characteristic	Rode in car driven by someone who had been drinking	Drove after having 2 or more drinks †	Drove after using cannabis †
Sex	NS	‡	§
Male	32.6 (889)	20.0 (608)	24.5 (270)
Female	31.2 (957)	8.9 (511)	13.7 (238)
Grade	‡	§	NS
7	17.5 (310)	-	-
8	23.2 (291)	-	-
9	31.5 (316)	-	-
10	36.0 (363)	9.8 (154)	18.9 (72)
11	40.0 (255)	10.7 (374)	18.9 (174)
12	36.2 (182)	20.9 (319)	21.6 (151)
13	43.4 (129)	18.2 (272)	19.0 (111)
All	31.9 (1846)	15.1 (1119)	19.7 (508)

Note: NS = not significant
* Numbers in parentheses are subgroup totals on which the percentages are based.
†Among students in grades 10 to 13 who had a driver's liscence
‡$p < 0.001$
§$p < 0.05$



Smoking Cessation Methods

Adolescent smokers' preferred smoking cessation methods.

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Interventions that are efficacious and appeal to youth are needed to help adolescents quit smoking. High school smokers (N = 585) completed surveys about their smoking cessation preferences. When asked which of 13 quitting options they would most prefer to use, 28.2% selected quit contracts with friends, and 7.6% endorsed self-help programs. Nicotine replacement therapy, group programs and web-based programs were preferred by 4.9%, 3.9%, and 1.0% of respondents, respectively. Most students wanted proof of the intervention's effectiveness. Confidentiality and ease of use were favourably associated with self-help and pharmacological interventions, while social support was associated with group programs. Findings suggest that self-directed interventions, offered as part of a school-wide challenge, with prizes awarded to students who quit, are attractive to youth. More research is needed to determine how to engage adolescent smokers in the quitting process.

Can J Public Health 2001 Nov-Dec;92(6):423-6

Using nicotine replacement therapy in treating nicotine addiction in adolescents.

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Cigarette smoking is the greatest cause of preventable death and disability in the United States. More than 3,000 children in the United States begin smoking each day. Smokers experience withdrawal symptoms that can be ameliorated by pharmacological interventions. These interventions include Zyban (Bupropion HCl), Nicorette gum, Habitrol patch, Nicoderm patch, Nicotrol inhaler, and Nicotrol NS spray, along with their generic counterparts. This article reviews each of these agents, the time course of nicotine withdrawal symptoms, and the Fagerstrom Tolerance Questionnaire and presents a framework for assisting the nicotine-addicted student in smoking cessation.

J Sch Nurs 2001 Oct;17(5):278-82

Nicotine replacement therapy for smoking cessation.

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BACKGROUND: The aim of nicotine replacement therapy (NRT) is to replace nicotine from cigarettes. This reduces withdrawal symptoms associated with smoking cessation thus helping resist the urge to smoke cigarettes. OBJECTIVES: The aims of this review were to determine the effectiveness of the different forms of nicotine replacement therapy (chewing gum, transdermal patches, nasal spray, inhalers and tablets) in achieving abstinence from cigarettes, or a sustained reduction in amount smoked; to determine whether the effect is influenced by the clinical setting in which the smoker is recruited and treated, the dosage and form of the NRT used, or the intensity of additional advice and support offered to the smoker; to determine whether combinations of NRT are more effective than one type alone; and to determine its effectiveness compared to other pharmacotherapies. SEARCH STRATEGY: We searched the Cochrane Tobacco Addiction Group trials register in July 2002. SELECTION CRITERIA: Randomized trials in which NRT was compared to placebo or no treatment, or where different doses of NRT were compared. We excluded trials which did not report cessation rates, and those with follow-up of less than six months. DATA COLLECTION AND ANALYSIS: We extracted data in duplicate on the type of subjects, the dose and duration and form of nicotine therapy, the outcome measures, method of randomization, and completeness of follow-up. The main outcome measure was abstinence from smoking after at least six months of follow-up. We used the most rigorous definition of abstinence for each trial, and biochemically validated rates if available. Where appropriate, we performed meta-analysis using a fixed effects model (Peto). MAIN RESULTS: We identified 110 trials; 96 with a non NRT control group. The odds ratio for abstinence with NRT compared to control was 1.74 (95% confidence interval 1.64 - 1.86), The odds ratios for the different forms of NRT were 1.66 for gum, 1.74 for patches, 2.27 for nasal spray, 2.08 for inhaled nicotine and 2.08 for nicotine sublingual tablet/lozenge. These odds were largely independent of the duration of therapy, the intensity of additional support provided or the setting in which the NRT was offered. In highly dependent smokers there was a significant benefit of 4 mg gum compared with 2mg gum (odds ratio 2.67, 95% confidence interval 1.69 - 4.22). There was weak evidence that combinations of forms of NRT are more effective. Higher doses of nicotine patch may produce small increases in quit rates. Only one study directly compared NRT to another pharmacotherapy, in which bupropion was significantly more effective than nicotine patch or placebo. REVIEWER'S CONCLUSIONS: All of the commercially available forms of NRT (nicotine gum, transdermal patch, the nicotine nasal spray, nicotine inhaler and nicotine sublingual tablets/lozenges) are effective as part of a strategy to promote smoking cessation. They increase quit rates approximately 1.5 to 2 fold regardless of setting. The effectiveness of NRT appears to be largely independent of the intensity of additional support provided to the smoker. Provision of more intense levels of support, although beneficial in facilitating the likelihood of quitting, is not essential to the success of NRT. There is promising evidence that bupropion may be more effective than NRT (either alone or in combination). However, its most appropriate place in the therapeutic armamentarium requires further study and consideration.

Cochrane Database Syst Rev 2002;(4):CD000146

Canadian Health Network

www.canadian-health-network.ca

CHN is a national, non-profit, bilingual web-based health information service. CHN's goal is to help Canadians find the information they're looking for on how to stay healthy and prevent disease. CHN does this through a unique collaboration - one of the most dynamic and comprehensive networks anywhere in the world. This network of health information providers includes Health Canada and national and provincial/territorial non-profit organizations, as well as universities, hospitals, libraries and community organizations.

CHN offers:

- Links to more than 12,000 English and French Canadian web-based resources that pass a rigorous quality assurance process to ensure that the information is timely, accurate, and relevant.
- In-depth information on 26 key health topics and population groups, with resources on how to stay healthy and prevent disease and injury.
- High-quality national health information, and regional resources from Canada's provinces, territories and local communities.
- Information on societal health issues such as violence prevention, environmental health and workplace safety.
- Monthly feature articles on current health issues, special guest columnists, and 'behind the news' information and analysis.

CHN is non-commercial and assures complete privacy and confidentiality.

CHN's mission is to support Canadians in making informed choices about their health, by providing access to multiple sources of credible and practical e-health information.

Its vision is to become "Your preferred choice in Canada for helpful, e-health information you can trust."

CHN's core values are:

- To maintain health information as a public good
- To not recreate existing health information
- To present quality, credible, and practical information from multiple perspectives
- To be socially-inclusive and respectful of diversity
- To exemplify ethics and integrity

CHN offers many search choices to explore its large collection of Canadian health resources in either English or French.

CHN helps users take a critical look at other health web sites, with tools to assess their accuracy, timeliness, relevance and possible bias.

Another checklist aims to show Canadian consumers and health intermediaries what to look for in a health-promoting Web site.

CHN's Advisory Board reflects the diversity that makes CHN a network of health information networks. Members of the Advisory Board come from both within and outside government, and represent a broad cross-section of Canadians in terms of age, language, gender, cultural background, occupation, and geography. The Advisory Board helps to guide the growth and evolution of the network by making recommendations to the Deputy Minister of Health on future strategic directions.

Youth and mental illness

An article from the Youth Centre of the Canadian Health Network

Sound Familiar?

"Nobody could possibly understand how I feel." "If I start to cry I'm sure I'll never stop." "I'm so bad that no one could ever like me." "If I don't hit something I'm going to explode." "If people knew what I was thinking they would say that I'm crazy." "I try as hard as I can but I just don't understand things like I used to." "My family is driving me crazy!" "I just don't enjoy anything anymore." "I wish that I could just stop feeling."

Adolescent Mental Illness

Canadian adolescents, like teens throughout the world, are at high risk for mental illness. Research has shown that in Ontario alone, about one out of five 4 to 16 year olds suffer from some type of psychiatric disorder.

In the U.S., adolescents represent the only age group where there continues to be an increase in mortality rate. Combined, the top three causes of death - accidents, suicide and homicide - account for 75% of the deaths among adolescents.

Professional mental health care resources reach no more than 1 out of 6 children and adolescents in Canada. It is important to better understand what is going on with our youth, why they are at risk, and how we can try to better address the needs of adolescents with psychiatric disorders.

What Is Mental Illness?

Mental illness and mental disorder are not terms easy to define. Misunderstandings lead to misuse and abuse of the terminology and help reinforce myths and even prevent people from getting help when it is really needed.

In general, mental illness refers to clinically significant patterns of behavioural or emotional functioning that are associated with some level or distress, suffering (pain, death), or impairment in one or more areas of functioning (eg., school, work, social and family interactions). At the basis of this impairment is a behavioural, psychological, or biological dysfunction, or a combination of these.

Myths and facts

A number of myths surround child, adolescent and adult mental illness. Society can go a long way to destigmatizing mental illnesses by having a better understanding of the mental health issues.

myth: People with a mental illness are psycho, dangerous and have to be locked away.

fact: Many individuals with a mental illness can have difficulty coping with day to day living. When in great distress, such individuals are at greater risk of harming themselves than others.

myth: People with a mental illness never get better.

fact: With the right kind of help, many people with a mental illness do recover and go on to lead healthy, productive, and satisfying lives.

myth: You can tell if someone has a mental illness by looking in their eyes.

fact: Although there are many signs and symptoms for when someone may be developing a mental illness, diagnosis is a difficult task best undertaken by health professionals. Quick judgements and stereotypes are poor substitutes for comprehensive assessments by professionals.

myth: Only crazy people see shrinks.

fact: People of all ages and all walks of life seek help from a variety of mental health professionals including psychiatrists. Seeking out and accepting help are signs of coping and of preventing situations from getting worse.

myth: If you talk about suicide, you won't attempt it.

fact: Suicidal comments have to be taken seriously as they often lead to plans, attempts, or completions.

Youth And Mental Illness

There are different kinds of mental illness that are commonly seen in adolescence, all of which have significant effects on a teen's day to day living. Some of these include:

Adolescents and depression:

Many teens feel down and blue at times, but for some these feelings do not seem to go away. The symptoms can be there day and night and life can become a chore. These teens may not realize that what they are experiencing are symptoms of a potentially treatable disease.

Adolescents and suicide:

Suicidal thinking and behaviour often go hand in hand with depression in adolescence. Suicide is the second most common killer of Canadian teens. While some suicidal behaviour may be impulsive, all indicators of suicidal thoughts and actions should be taken seriously.

Adolescents and anxiety:

Many physical symptoms (eg., headaches, stomach aches, racing heart) can be associated with anxiety in adolescents. Feelings of fear and dread can become so intense that they keep you from going to school, from being in a group, and from many activities that would not be a problem otherwise. Anxiety can be tied to a past trauma (eg., car accident, incident of abuse), an identifiable source (eg., snakes, heights), or present in everything one does.

Adolescents and risk-taking behaviour:

Accidents represent the number one cause of death in Canadian teens and much of this can be traced to different types of risk-taking behaviour. Risk taking is a broad category of behaviours that includes among others: alcohol and substance abuse, unprotected sex, thrill seeking, and delinquent behaviours. Such behaviours are often symptomatic of various mental illnesses and may result in some of the real tragedies of adolescence. As well, if a person engages in one risk-taking behaviour they are likely to engage in more than one.

Adolescents and eating disorders:

Two psychiatric eating disorders, anorexia nervosa and bulimia, are on the increase among Canadian teenage girls. They also occur in boys but much less often. Both disorders are characterized by a preoccupation with food, and a feeling of lack of control over aspects of one's life. The teenager with anorexia nervosa is often perfectionistic but suffers from low self-esteem and an irrational belief of being overweight, regardless of how thin he or she becomes. Teenagers with bulimia binge on huge quantities of food and then purge their bodies of dreaded calories by self-induced vomiting, laxative use, and often excessive exercising.

Eating disorders can have fatal consequences, and adolescents with these disorders are typically very good at avoiding being discovered. Denying the presence of their problem delays much needed help.

Adolescents and conduct disorders:

Conduct disorders are a complicated group of behavioural and emotional problems in adolescence. These teens have great difficulty following rules and behaving in a socially acceptable way. The major problem is in the expression of anger. They are often aggressive to peers and adults, and may lie, steal, destroy property and be sexually inappropriate.

Risk-taking behaviours are common in this group, including the full range of suicidal behaviour. They frequently have other contributing problems including school failure and negative family and social experiences. Conduct disorders can co-occur with adolescent depression and attention deficit disorder.

Mental Illness Is A Family Affair

Many of the major psychiatric illnesses commonly seen in adults surface during adolescence. Although not directly linked, there is a strong predisposition for mental illness within families. Some families can also operate in such ways as to trigger mental illness within its members, especially those more vulnerable members.

Family awareness, early identification and prevention are often the first steps to effective treatments. Relatives can play a key role in the identification and treatment of the teen with a mental illness, with family members themselves often needing help and support.

Don't Ignore The Signs

Parents, teachers, and friends are usually the first to recognize that an adolescent may be having significant problems with emotions or behaviour. The following are a few signs to look for in your teen, student, brother, sister, classmate, or friend that may indicate that a psychiatric evaluation will be useful.

- marked drop in school performance or increase in absenteeism
- excessive use of alcohol and/or drugs
- marked changes in sleeping and/or eating habits
- many physical complaints (headaches, stomach aches)
- aggressive or non-aggressive consistent violations of rights of others: opposition to authority, truancy, thefts, vandalism, etc.
- withdrawal from friends, family, and regular activities
- depression shown by sustained, prolonged negative mood and attitude, often accompanied by poor appetite, difficulty sleeping or thoughts of death
- frequent outbursts of anger and rage
- low energy level, poor concentration, complaints of boredom
- loss of enjoyment in what used to be favourite activities
- unusual neglect of personal appearance
- intense fear of becoming obese with no relationship to actual body weight
- uncharacteristic delinquent, thrill seeking or promiscuous behaviour
- marked personality change
- comments about feeling rotten inside, wanting to end things, and soon no longer being a problem for others

What Does "Help For Mental Illness" Include

The cornerstone of successful help for a mental illness is a comprehensive assessment by a child or adolescent psychiatrist, and/or other qualified professionals who coordinate information from parents, educators, and other relevant sources.

Treatment can include psychotherapy (individual, family, group), skills programs (learning, social skills, behaviour), and psychiatric medication, and be provided in a variety of inpatient, outpatient, or day treatment settings, including special schools, residential placements, hospitals, private offices, or community clinics.

Effective treatments depend upon the strong partnership between patient, family and professionals.

Where To Go For Help

Research shows that a teen is most likely to tell a friend about concerns that they have regarding symptoms of a mental illness. Unfortunately, that friend may be a great listener but may not be the best person to get help. You can be a better friend by looking for signs and symptoms of mental illnesses and helping someone you know reach out to some of the following people:

- family doctor or paediatrician
- teen health clinic
- school counsellor or teacher
- parent and other family member
- psychologist
- psychiatrist
- social worker
- help line
- emergency department

This brochure was prepared for the Canadian Psychiatric Association by Dr. Simon Davidson and Dr. Ian Manion, Department of Psychiatry, Children's Hospital of Eastern Ontario. The authors wish to acknowledge the "Facts for Families" series, from The American Academy of Child and Adolescent Psychiatry in the document's preparation.

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Publications

Fewer head injuries among helmet wearers

A new study of injured skiers and snowboarders at a British Columbia ski resort found that wearing helmets appeared to decrease the risk of head injury among children.

Authors Andrew Macnab et al studied injuries among young people during the 1998-99 ski season at a major ski resort in B.C. Their results are reported in the most recent issue of Injury Prevention. They note that helmets are generally recommended for skiers and snowboarders but that these recommendations have been based primarily on data from bicycle helmet studies. No study had clearly demonstrated the effectiveness of helmets in head injury prevention for skiers and snowboarders.

They also wanted to investigate whether young children wearing helmets would have an increased risk of cervical spine injury because of the relative weight of the helmet to total body weight and neck strenght.

The medical clinic identified 676 people during the season who suffered head/face/neck injuries, 79 of them being children. (Interestingly, ski patrol records identified a quarter as many as the clinic did.) The authors found there was a decreased risk of head injury for young skiers and snowboarders wearing helmets. Those children experienced no increase in the risk of cervical spine injuries. The authors conclude that there are now grounds for recommending helmets for children who ski and snowboard.

Source: A.J. Macnab et al, "Effect of Helmet Wear on

Six ways to prevent sports injuries

New research reported in the journal Sports Medicine estimates that more than a third of school-aged children in the United States will sustain a sports injury serious enough to need medical treatment.

The researchers, led by T.A. Adirim, note that children may be more vulnerable to injury than adults: they have larger heads proportionately, they may be too small for protective equipment, their growing cartilage may be more vulnerable to stresses and children may not have the complex motor skills needed for certain sports until after puberty.

The most commonly injured areas of the body include the ankle and knee, followed by the hand, wrist, elbow, shin and calf, head, neck and clavicle.

The authors suggest six potential ways to prevent injuries:
- the pre-season physical examination
- medical coverage at sporting events
- proper coaching
- adequate hydration
- proper officiating
- proper equipment and field/surface playing conditions

Source: T.A. Adirim et al, "Overview of injuries in the Young Athlete," Sports Medicine 2003, 33 (1): 75-81

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