CANADIAN ASSOCIATION
FOR ADOLESCENT HEALTH

October 2003
Volume 12 Number 3

PRO-TEEN

Scientific Events

Articles

Adolescent Health - A developping international discipline

Internet Safety

Pathways to Adolescent Health: Sleep Regulation and Behavior

Parent Help Line

Publications

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The CAAH is the Youth Affiliate Partner of the Canadian Health Network

"www.canadian-healh-network.ca"

PRO-TEEN

Publisher: CAAH

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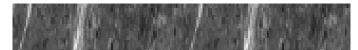
Legal Deposit, National Library of Canada ISSN 1201-5474
Canada Post-Convention number 40032438



Articles

Youth and Health: Generation on the Edge

31st Annual Conference June 1-4 2004, Washington DC

The Global Health Council invites health and development professionals, including providers, community organizers, program managers, policy-makers, researchers, advocates, as well as youth from around the world to submit abstracts for presentation at our 31st Annual Conference.

A Call to Adults Everywhere
They stand on the threshold, nearly two billion strong; a generation of youth stepping hopefully across the edge of childhood, balancing perilously on the edge of new dangers. They have survived birth and infancy, and all the diseases and hazards of the very young that threatened to end what had barely begun. Now, in their second decade of life, the risks and challenges they face easily match those of their earliest years. Your work is not done. As they have in every era, the youth of this generation need your experience, your ideas, your compassion and commitment, to mitigate risks and maximize opportunities. They need respect and inclusion from adults who hold their health — and future - in their hands. Finally, they need the tools and capacities that will set them on their way, and your support for a journey they must ultimately travel on their own.

A Call to Youth Everywhere
A collection of the most dedicated adults in the world cannot adequately capture your unique knowledge of the exhilaration and challenges of your generation. The issues associated with youth health and development are topics of study representing years of effort among experts in the field, but it is your lives and futures that are at stake, and the decisions and approaches to address those issues will color your future. You know the opportunities and obstacles that stand in your path. The spirit of experimentation that fills your journey with risk is also a spirit of energy and innovation that can bring new solutions to intractable problems - if you choose to share them. As the needs of your generation grow more urgent, you stand, full of ideas, at the edge of your elders' vision. Your job is to make them look and listen.

A Call to Everyone Committed to Youth Health and Development...Everywhere
The world's population today holds the largest number of young people between the ages of 10 and 24 that has ever existed: 1.7 billion. Every day, over 6,000 of them become infected with HIV. This year, 25 million will become pregnant for the first time. Tens of millions will smoke their first cigarette, and in coming years one of every three will die as a consequence. By the end of the year, 4 million will have attempted suicide, and 100,000 will have "succeeded." Millions more will be victims of physical and sexual violence, of drugs and of alcohol. And each day adds to the numbers who will become the heads of their family of siblings as a consequence of their parents' death from AIDS and other diseases.

Along with the physical threats to their health and lives, youth also face challenges from inadequate access to education, to health-care information and services, and to employment opportunities. They struggle against numbing poverty, and increasingly they struggle to provide for their families.

The coordinated promotion and improvement of youth health and development is one of the most vital enterprises a global society can undertake to secure its future. Together, we have the means and expertise to do so. The Global Health Council's Annual International Conference for 2004 will serve as a vibrant forum for the exchange of ideas and lessons learned regarding health-related interventions initiated for youth, and increasingly by youth. We therefore invite health and development professionals, including providers, community organizers, program managers, policy-makers, researchers, advocates, as well as youth from around the world to submit abstracts in the following main theme/issue areas for presentation at our 31st Annual Conference, June 1-4, 2004:

Health Risks for Youth
- Sexual/reproductive behaviors: STD/HIV infection, early pregnancy
- Tobacco, alcohol and substance abuse
- Depression/suicide
- Violence: homicide, war and conflict, sexual violence
- Malnutrition/under-nutrition
- Injury and disability
- Infectious disease

Health-related Developmental Issues for Youth
- Access to health information and services
- Access to education
- Employment/vocational training
- Orphanhood/youth-headed households
- Traditional gender roles, cultural and societal norms
- Social relationships, structures and behavioral boundaries
- Participation/inclusion and human rights
- Life skills and leadership skills

The Council also invites general submissions in its key health issue areas
- Child Health and Nutrition
- Women's Health
- HIV/AIDS
- Infectious Diseases
- Disaster and Refugee Health
- Health Systems, Policy and Research
- Health and Human Rights

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2004 National STD Prevention Conference "Sharing Successes and Strategies During an Era of Uncertainty"

March 8-11 2004, Philadelphia, PA

Economic, political, and other societal forces over the last couple of years have influenced the landscape of STD prevention. The focus of public health efforts toward preparedness for bioterrorism and the response to emerging infectious diseases such as SARS has challenged such traditional public health efforts as STD prevention. Simultaneously, STDs remain a public health problem. STD rates are increasing, particularly in certain populations, while public and private healthcare systems suffer resource losses in the face of new legal and management complexities. During this era of uncertainty, STD prevention efforts must remain constant, while evolving in approach with the changing times. We must continue to try to understand the socioeconomic and political dynamics around STD prevention efforts and identify strategies that help maintain and grow STD prevention programs. The interface of science, programs, and policy remains critical to moving STD prevention into the future. Toward that end, the goals of the 2004 National STD Prevention Conference are to:

- Identify practical strategies for effective STD prevention services amidst shrinking resources, adversity, and a growing STD epidemic
- Enhance integration and synergy between STD prevention and other prevention efforts related to HIV, unwanted pregnancies, and substance abuse
- Enhance STD prevention in such settings as primary care clinics, private sector medical practices, HIV services, substance abuse programs, family planning clinics, schools, correctional institutions, and other nontraditional settings
- Expand the understanding of STD prevention into its domestic and global socioeconomic and political context

This conference will bring together delegates from academia, public health departments, nongovernmental organizations, the private health sector, and policy-related organizations to explore these goals, to share successes, to ask new questions, and to seek new answers that will enlighten the movement of STD prevention into the next few years.

The Centers for Disease Control and Prevention is pleased to co-sponsor this conference with the American STD Association (ASTDA), the National Coalition of STD Directors (NCSD), and the American Social Health Association (ASHA).

For more information:
Attn: STD Prevention Conference Registration
2957 Clairmont Road, Suite 480
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Fax: 1 404 633 6477
E-mail: registrationhelp@psava.com
Web: http://www.stdconference.org/

Articles

Chaperone or not

The Society for Adolescent Medicine has a listserv where members and non-members can ask for information or discuss a specific topic. Here are excerpts from the listserv after a comment by one of the member.

I have just received a complaint from a parent of an 18 year old female patient who was seen by one of our male physicians. The parent complained that there was no female nurse in the room during the exam. This was not a gynecologic exam. Does any one have any ideas on how to handle this. Do all male pediatricians have a parent or nurse in the room during a routine or sick visit that does not involve a gynecologic exam?
Nina S. Sanchez, M.D.

My opinion would be that since the patient is 18 and unless mentally challenged or other circumstances would suggest, she (the patient) should be capable of making the decision whether to or not to request another person in the room. Mom, at this time has no business what goes on with the daughter in the physician office again unless the patient circumstances dictate the need. Personally, with an adult (18 +), I'd leave it entirely up to the patient to take the initiative to ask for someone to be in the room with them unless it is a minor or gyn exam. No one at our institution (residents/faculty in the clinics or faculty practices) has a nurse unless either the parent (of a minor) or the patient requests one or a gyn exam is being done. If this were the case we'd have to have supervision on every minor's exam (male or female) no matter the reason. It would be prohibitive in time/cost of personnel.
Russell Bush, M.D. Michigan

This is a not too uncommon problem that is a part of adolescent visits. I feel it is safer for the provider's protection to have female standby when a male provider examines a female. This is especially true for patients with emotional problems. However, also, there are some exceptions when it is in the best interest of the patient not to have someone else in the room out of respect for confidentiality. We make judgments in the office quickly on how to accomplish the exam practically. Problems like these often occur when the provider feels rushed. Also, I feel these events are less likely to occur when the parent knows/ feels comfortable with the provider. Certainly discuss with the parent that seeing teens by themselves is standard of care and why. Sometimes it is best for the provider to explain this to the parent beforehand.
JJ Burns MD, West Virginia University

Under 16 I would like a female in the room—but on occasion the patient has refused. Over 16, one of my nurses ask what the patient prefers, and we do what she wants— some patients just do not want another person in the room. if the patients request that no nurse be present i ask again when I go into the room.
Carl Rosenbloom

This is not just a problem in medicine. The president of a local community college near Princeton is on 30-day leave because he closed his office door while talking to a prospective female student. She accused

him of inappropriate behavior. Personally, I would think for the protection of the physician, a nurse in the room would be appropriate. Also, expecting all 18-year olds to have the courage and savvy to make a demand for a nurse is unrealistic. Let's face it, there are adults who can't make demands of their health care providers. And, if the system does not articulate that the patient has that choice, how can the system expect the patient to intuit that information? I would think the setting is also a factor. My children see the same physician for all their physicals. Consequently, they have a relationship with their physicians. I know my 14-year old would not go into an examining room by herself with a male physician. Finally, is there a religious component to this issue? For example, are Muslim girls allowed in alone with a male physician? Is that a factor to consider? Certainly a topic ripe for discussion.
Sue Ferrara, PhD

The American Academy of Pediatrics has policy on the use of chaperones which was published in Pediatrics, Vol. 98 No. 6 December 1996 (and reaffirmed in 1999). It basically states that "physician judgment and discretion must be paramount in evaluating the needs for a chaperone; however, the highest priority should be given to the requests of the patient and the parent." It goes on to state that, "if the patient is offered and declines the use of a chaperone, the pediatrician should document this fact in the chart."
Joe M. Sanders, Jr., MD

I think all the male physicians for their protection should have a chaperon while examining any female patient whatever is the age, whether is is sick visit, well visit or GYN exam, unless the patient is over 18 and knows the physician well, and requests for no third person to be present. One of our mentors used to say that even we should go to the extent of getting the signature and name of the chaperon documented in the chart. I have heard about a lot of such accusations among private practices, especially false ones, while I was a resident in New York. In this country considering the jury award system and that anyone can sue anyone, even if they can not afford to pay the lawyer, for a few its is sadly some easy way to make money, as there are some "lawyers" who take up cases for no win no fee basis! Pathetic law system!! I have heard about complaints about female physicians by male patients when there was no chaperon during a physical. While I was in England I happen to see a male surgical resident lose his position when he was examining a 7 year old boy after circumcision, when parents were not present in the room, and the child accused him of inappropriate behavior. I think having an appropriate chaperon at appropriate situations is for the protection of both the patient and the physician.
Dr Ram Chandra, MD, FAAP, MRCP(UK)

We had a complaint like that once when I was a fellow. It was a situation where the physician has no protection in case of an allegation. It is best for the physician and the patient.
Keith Ramsey

So is it your recommendation that a nurse be present the entire time a physician, male or female, is in a room alone with a patient regardless of age? One must also remember that females can accuse female doctors of inappropriate behavior as well. Should a female doctor have a male chaperone? That seems like a waste of talent to have a nurse follow you into every exam room each time the door is closed. You could hire a person off the street with no work experience for that I guess. I find this topic interesting as I was just accused recently of being harrassing because a nurse saw me give a hug to another nurse. It was not the nurse that I hugged that complained as we have a friendly relationship but the nurse that saw me hug her that complained. What an interesting world we live in.
Dan Bauer

Do all male pediatricians have a parent or nurse in the room during a routine or sick visit that does not involve a gynecologic exam. I never did, but have not done clinical practice in a few years. The times may have changed. Perhaps asking the girl if she would be more comfortable with another woman in the room would be a good way to go.
Henry S Berman, MD,

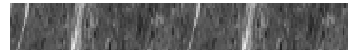
Dr. Sanders reference to the AAP statement is sensitive and appropriate. For me, the question focuses on who best bears responsibility for every need of a patient? A patient's desire for a physician

who is alike (in gender, culture, ethnicity, age, or any other parameter) can generally be sad by shopping around (it's a mighty big country). In medicine, the issue is not sameness, per se, but physician respect, openness, sensitivity, and empathy (all of which may be absent—even with a chaperone present). Practicing medicine to simply protect oneself from lawsuits is plain dishonest, and represents a slippery slope whose bottom serves the profession (at the expense of caring for patients). Those issues notwithstanding, there are real costs associated with meeting every patient desire. Patients who accept financial responsibility for additional staff time could have their needs more easily met. For patients with financial constraints, having a self-appointed chaperone come to non-emergent visits might meet their need. Patients might feel most satisfied in the long run by assuming greater responsibility for their personal needs and comfort. Relying on the system to meet those requirements often sets one up for disappointment. Once that is encouraged, the issue of blaming and complaining may largely go away.
Roger Spingarn, MD

I work in a teen clinic south of San Francisco. When we had a male Family Practice doc working with us it was only with genital exams (for females) that our medical assistant was with him in the room. We've not had a complaint like this, but I would think it might be good to contact the teen and ask her perspective. Did she feel anything untoward happened? What is her relationship with her mother, ie, are there power and control issues? Did the complaint originate with the mother, or was the mother complaining on behalf of the daughter? Sometimes a friendly, non-judgmental interview session with a clinic manager or a senior counselor associated with the clinic with both mother and daughter (and perhaps separately as well) turns up misunderstandings, cultural issues or family background stuff that makes sense of the complaint.
Danamaya Gorham, FNP

Answering the part about muslim girls-I have been practicing in Turkey and have worked (done gynecologic exams) in most all the regions (in various parts of the US as well). Turkey is a 99% muslim secular country. I have found Turkish and muslim girls and their families more open and supportive of a gynecologic exam. One of the reason may be that the respect, trust and dependanceof the family for the physician is more It is always helpful to explain what your are going to do before examining the patient. That provides a guidance for me to assess potential problems. Also too often I have been asked (begged!) by female adolescents not to include nurses during the exams. Then I asked my nurse to stay close to the door as much as she can. (That may be because of the poorer interaction of patients and nurses here). In short I dont think muslim girls should be treated any differently than other girls. You should get a feel for the families sensitivities during the interview. Of course If the family is heavily equipped with religious symbols. I would be cautious whether they are Muslim, Jew or Christian.
Ziya Aras, MD Izmir. Turkey

This issue has been problematic on only rare occasions in the pediatric clinic where I work- a teenaged girl felt the male doctor "leaned too close to her." The resident was quite taken aback. The issue was resolved uneventfully. We have also had one adolescent boy demand that only a female physician examine his genitals because he did not want any male physician to touch his genitals. In our outpatient pediatric clinic we have residents in pediatrics, medicine, emergency medicine, ob-gyn, and medical students rotating through here. So there are numerous perspectives and opinions about the issue of chaperones. My thoughts are that the perspective of residents regarding chaperones has often reflected their discipline. I always stress the need for interviewing teens alone. I personally do not believe a chaperone is always needed. I tell any resident who is uncomfortable being alone with the patient during the physical exam, to obtain a chaperone and ask the patient who he/she would prefer serving as a chaperone. I also tell all residents to offer all patients being examined a choice of having a chaperone, and the choice of person serving as a chaperone (medical professional, parent, family member, friend).



Message on World Population Day

The theme of this year's World Population Day, July 2003, "One billion adolescents: the right to health, information and services", highlighted the need to support young people in their efforts to lead safe, rewarding lives and contribute to the well-being of their families and communities.

Throughout the world, millions of girls and boys are deprived of an education, harming their individual prospects and those of society at large. In some countries, half of all girls are married before the age of 18, often resulting in early childbearing that poses serious health risks to both mother and child. Experience shows that educated women are more likely to marry later, and have healthy and better educated children, who will pass on these benefits from one generation to the next. Education and information also influence how many children they will have. If a woman were to wait until age 23, instead of age 18, to have her first child, that alone could reduce the momentum in population growth by over 40 per cent.

Information and services are also crucial in the fight against AIDS and the broader quest for good health. Young people should know how the HIV virus is transmitted, and how to protect themselves from infection. This is important everywhere but is absolutely critical in countries where infection rates are already high or quickly rising. Reproductive health services and factual information about reproductive health will also help young people to avoid risky behaviour, unwanted pregnancy and poor health in general. And in conflict zones, where levels of sexual violence and abuse are dramatically heightened, young people need appropriate and sensitive services to recover and participate in their country's return to normal life.

If the world is to achieve the Millennium Development Goals and implement the programme of action adopted at the International Conference on Population and Development in Cairo in 1994, the most effective interventions will involve young people themselves. It is they who can best identify their needs, and who must help design the programmes that address them.

One of every six people on earth is an adolescent. In the developing world, more than 40 percent of the population is under age 20. The decisions these young people make will shape our world and the prospects of future generations. On the World Population Day, we recognized their right to the health, information and services they need and deserve.

Adolescent health - A developing international discipline

Roger S Tonkin MD, Jean Yves Frappier MD

Half of the world's population are younger than 25 years of age and it is estimated that youth (10 to 24 years of age) number 1.8 billion. The percentage of the population that is adolescent or youth varies from region to region, and the issues they face vary both quantitatively and qualita-tively (1). The phenomenon of adolescence is a universal one in which major developmental tasks are constants and the impact of risky behaviours and lifestyle overshadow the traditional medical needs of this age group. However, there are youth populations that are at greater risk of communica-ble diseases, malnutrition, complications of pregnancy and the effects of wars.

Adolescence is a challenging phase of the life cycle. It is a phase that begins with a clear biological marker, but which ends within a socially defined, culturally variable context that blurs the boundaries between adolescence and adulthood. In the authors' experiences, adolescents in developing and in developed nations tell similar stories about their issues and concerns. These include their concerns over mental health, substance abuse, violence and dis-crimination, and family disruptions. They seek a greater say in what happens to them, more educational and vocational opportunities, and assurance of safe housing and access to youth-friendly, competent health services. In most regions they must learn to deal with world changes such as globalization, urbanization and emerging technologies. Some must deal with negative experiences such as sexual exploita-tion, abuse and parental illnesses or addictions. Chronic conditions such as asthma or diabetes and the occurrence of injury, addiction and obesity have an impact on adolescent development and can affect the process of transition into adulthood.

On balance, adolescence is a phase of life that has more positives than negatives and youth the world over symbolize the energy and joy of this most precious time. In the present commentary the authors outline the international context within which the field of adolescent health has emerged. A more detailed analysis of the health status and health concerns of adolescents in developing nations will be addressed in a later paper.

Policies and Programs

The United Nations Convention on the Rights of the Child covers up to the 18th birthday but lacks explicit lan-guage about adolescence (2). Similarly, most nations, Canada included, lack formal youth-specific national policies and programs. In separate documents the Pan American Health Organization (PAHO), World Health Organization (WHO), and United Nations Children's Fund (UNICEF) have addressed the possible frameworks for such policies (3-5). At the country level there are adolescent-oriented programs, especially regarding reproductive health care, but the accessibility and quality of these programs varies considerably (especially on the African and Asian continents). Many involve partnerships with external agencies or foundations (eg, Kellogg Foundation has a special interest in working in Latin America or Africa).

Recently the WHO has sponsored a number of initia-tives that have an impact on adolescent health. These include major working groups on tobacco, obesity and the effect of urbanization on substance abuse. Several of these working groups are adolescent-specific and focus on topics such as the needs of boys, adolescent friendly health services and child soldiers. PAHO has taken a particular interest in the role of resiliency in adolescent development while other international agencies have become active in the struggle against child-adolescent sexual exploitation and the concerns and/

or needs of young sex trade workers. Greater attention is now being paid to the adolescent dimensions of global problems such as AIDS, mental health, and chronic illnesses and disabilities. Issues of sexual orientation, as they affect adolescents, remain inade-quately addressed internationally. This increased awareness of adolescent health is encouraging, but it must be acknowledged that direct benefits of these initiatives to individual adolescents remain hit and miss.

In many countries youth health is linked strongly to school health programs. In some instances these programs include direct services, but in most situations they are disease prevention and health promotion entities. School programs are less available in developing countries and fail to reach the many children and youth who are not in school. Where offered, they usually address issues such as eating disorders, sexuality, suicide, bullying, discrimination or abuse. Their effectiveness remains a matter of controversy. In some situations (eg, tobacco use or drinking and driving) the main approach is via media campaigns or legal restrictions. More recently, interest in addressing adolescent health promotion via peer counselling, youth participation and youth empowerment strategies has become more popular.

Research

Adolescent-oriented research has a long history but in most regions it remains under-funded and underdeveloped. Disciplines such as developmental psychology, social psychology, anthropology, and clinical medicine based in academic centres have been the major contributors. Most of these centres are in the developed nations but exciting partnerships between these centres and researchers in developing nations are beginning to appear. WHO has pioneered the use of narrative research techniques in developing nations. These research efforts have emphasized reproductive health issues. Population-based research on adolescents continues to grow as each country awakens to the need for sound epidemiological information on its youth populations (6). In some instances, these efforts include cross-national studies such as those regularly conducted under the auspices of WHO (7).

Adolescent Medicine

The field of adolescent health is multidisciplinary in nature but much of its origins are derived from adolescent medicine in the United States (8,9). Canadian physicians have played a leadership role in this evolution (10-12). In 1987, the International Association for Adolescent Health was founded and both authors of this paper have played important leadership roles in its subsequent development (8). This international body brings together individual adolescent health professionals and national associations for adolescent health from over 30 countries. Its membership strength is in North America, Europe, Oceania and Latin America but new interests are beginning to emerge on the African continent and in a number of countries in Asia. However, there remains a global dearth of adolescent health services and properly trained adolescent care workers.

New Frontier

As the needs of adolescents become better understood and more carefully documented it is clear that our approaches must shift. We must address the realities of poverty, regional conflicts, illiteracy and exploitation that many adolescents confront on a daily basis. However, we must build a foundation that is less reactive, less crisis driven and more developmentally appropriate. We can do this by focusing on asset building, promoting resiliency, and offering programs that are less problem focussed and offer a better balance between risk and protection. We must recognize the importance of paying attention to the real needs of youth and of developing our skills in offering opportunities for them to participate in meaningful ways. Whether in developing nations or the developed ones, we should be encouraging programs that foster adolescents' feelings of strong, healthy connections with family, school, community and caring adults.

The needs of boys, global access to quality reproductive health care, timely intervention in early adolescence, mental health services, provision of youth-friendly health services and access to better training in adolescent care for health professionals are needed in all regions and all countries. The life skills approach being advocated by PAHO holds promise and signals the need to promote healthy child and adolescent development (13). The universality of the basic needs of adolescents is acknowledged and each nation is challenged to make a commitment to make the investments required to meet them (14,15).

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Reproduced from: Paediatrics&Child Health, February 2003, Volume 8, Number 2

Internet safety : Adolescents' Self-report

Christiane Stahl, M.D. and Nancy Fritz, M.D.

Abstract:

We examined the association between adolescents' unsafe experience online, types of Internet activity, and safety practices using a questionnaire returned by 213 private school students (seventh through tenth grades) in spring 1999. One-fourth of respondents reported unsafe experiences. Types of unsafe experience varied with gender, Internet activity, and identity sharing.

Discussion

Recent surveys [4-7], including this study, indicate neither parents nor adolescents have embraced the common-sense recommendations of the American Academy of Pediatrics [1] and the National Center for Missing and Exploited Children [2] for Internet use, especially with respect to computer location, amount of exposure, and parent supervision. In a national cross-sectional survey of youth aged 8-18 years [4], one in five school children has a bedroom computer, which is a higher proportion than children in wealthy neighborhoods who have televisions in their bedrooms. Internet use did not replace other media use; it led to increased media exposure (almost 11 vs. 7 exposure hours daily) [4]. In a Pittsburgh-based longitudinal study of 73 households in which computers with Internet capability were introduced, the amount of Internet use correlated with increasing social isolation and loneliness for teen and adult users. Teens' depression scores, social support, and family communication also showed declines with increasing use [5].

As in our study, less than 10% of seventh to twelfth graders in a 1999 survey reported parent supervision when visiting chat rooms and websites [4]. A majority of youth (69%) in a national survey, which included both parents and 304 youth aged 10-17 years, reported that their parents trusted them completely to do the right thing when it comes to using the Internet [6]. However, in the same survey 41%, of parents and 36% of youth reported incidents of disagreement, worry, or anger in their family over kids' release of information to the web. Almost half the teens in our study reported self-restriction while using the Internet, and two-thirds self-restricted if they had experience feeling unsafe owing to unwanted contact with a person. However, almost all were resistant to the idea of increased adult supervision. Teens did express an interest in blocking technologies to keep out unwanted sites or persons.

These students' self-reliance is consistent with analysis of the Pittsburgh data set showing that teens often became the household expert in computer use, which disrupted the guiding role of parents [8].

Many teens (23%) in our study reported feeling unsafe on the Internet owing to a person or website visit. The amount of online chatting, violation of privacy guidelines, and visits to pornographic websites were associated with feeling unsafe. Exposure to online X-rated content is common; a 1999 poll of 625 youth aged 10-17 years found that 31% (45% of those aged 14-17 years) had seen such content [7].

In a more focused examination of 1501 youths' experience with sexual solicitation online, Mitchell et al. [9] reported that 19% had been targets of unwanted solicitations; one-fourth of these youths suffered high levels of distress afterward. Experiencing sexual solicitation was associated with communicating on-line with strangers. Neither parental supervision nor the use of filtering technology decreased solicitation risk. Most parents and youth were not aware that they could report such episodes to police, the Internet service provider,

or others. Although no one in this study was assaulted as a result of online solicitation, 4% did report attempted or actual offline contact. By comparison, 16% of 856 adult clients at an HIV counseling and testing site reported seeking sex partners online [10].

Borzekowski and Rickert [11] recently explored a more positive aspect of teens' Internet use in their article "Adolescent Cybersurfing for Health Information." They found that half of tenth-graders in a socioeconomically and ethnically diverse suburban New York school system had used the Internet to get health information about sex (sexual activities, contraception, pregnancy, and sexually transmitted diseases), diet, fitness, and exercise. Although the Internet was a valued medium for health information, it generally ranked well behind friends, family members, and health care providers.

Conclusion

Our study suggests a need for increased teen-centered education regarding identity sharing and tools to block unwanted sites or personal contacts. Adult involvement in adolescents' Internet use should include ongoing supervision and research to monitor both negative and positive impacts on safety and development.

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Reproduced from: Journal of Adolescent Health 2002;31:7-10

Young Adults on the Internet : Risk Behaviors for Sexually Transmitted Diseases and HIV

Mary McFarlane, Ph.D., Sheana S. Bull, Ph.D., and Cornelis A. Rietmeijer, M.D., M.P.H.

Purpose

To examine the sexual behaviors and related risk factors for sexually transmitted diseases and HIV among young adults who seek sex partners on the Inter-net.

Methods

Study staff recruited participants in online chat rooms, bulletin boards, and other online venues. A total of 4507 participants responded to a 68-item, self-administered, online survey of Internet sex-seeking practices. The survey solicited information on sexual behavior with partners found on the Internet, in addition, a parallel set of questions addressed sexual behaviors with partners found off the Internet. Of the respondents, 1234 (27.4%) were 18-24 years old. Of the young adults, 61% were male and 75% were white. Responses from young adults were compared to those received from older adults. In addition, responses from young adults who seek sex partners online were compared to responses from young adults who do not seek sex partners online. Analyses, including logistic regression, Chi-square tests, Student's Mests, and analyses of variance, focused on the difference between young and older adults, as well as the differences in sexual behavior with partners located online and offline.

Results: Young adults who seek sex on the Internet report substantially different sexual behavior patterns than young adults who do not seek sex on the Internet. Young adults with online partners reported sexual behaviors similar to older respondents who used the Internet to find sex partners; however, older respondents were more likely than young adults to have been tested for sexually transmitted diseases and HIV.

Conclusions

Young adults who seek sex partners on-line may be at significantly greater risk for sexually transmitted diseases than their peers who do not seek sex partners online. These data point to an urgent need for online sexual health promotion.

Discussion

Anonymous online surveys have several obvious limitations. For example, our survey may have pro-moted false reporting of age, as anyone under the age of 18 years was excluded from participation. In addition, anonymous reporting may have facilitated the purposeful false reporting feared by many online survey researchers. However, data from other studies by these authors [3-5] point to very similar results to those obtained on this Internet survey. The similarity between risk information reported online and risk information reported in person is encouraging evidence for the validity of these data.

The sample reported here is obviously biased, in that it is a sample of Internet users. Most Internet users are Caucasian, educated (high school degree or above), male, and employed. Our goal, then was to obtain a reasonably representative sample of Internet users. We attempted to ensure representation of multiple groups by performing targeted recruitment in chat rooms and on bulletin boards; however, the majority of our data were obtained after national media attention was devoted to the study. Thus, the representative nature of the sample must be called into question

The use of the Internet to initiate risky sexual contact is not a new phenomenon, but our data suggest that

it may be a growing trend. Of particular interest is the demographic makeup of young adults who have sex with Internet partners (young SIPs). In the past, the digital divide has limited access to the Internet on the part of minorities and women. Our data suggest that this is changing, as young adults who have found Internet partners are more likely to be female and Hispanic than their older counterparts. The trend toward a more demographically representative Internet bears watching, particularly from the perspective of epidemiologists studying STDs.

Young SIPS reported having more Internet partners in the past 12 months than non-Internet partners, suggesting that the Internet is the venue where the majority of these individuals' sexual partnerships are initiated. In fact, some young SIPs reported having no non-Internet partners at all in the past 12 months. For people who use the Internet to initiate sexual contacts, this venue may be of great importance to their sex lives. The fact that the average number of 12-month Internet partners is close to the average number of lifetime Internet partners suggests that the Internet may be growing in its importance to young adults' sex lives.

Young adults appear to be more comfortable than older SIPs with finding partners in chat rooms. In addition, they are more ready to exchange identifying or locating information, such as addresses, than are older SIPs. It is possible that the interactive, real-time chat environments allow young adults a (potentially false) sense of security and intimate knowledge of potential sex partners. Their readiness to exchange locating information with potential sex partners brings up safety concerns independent of risk for STDs and HIV.

Our data suggest that people who use the Internet to initiate sexual contact may be having sex with partners who have different characteristics than non -Internet partners. That is, partners found on the Internet were more likely to be same-sex partners than partners found offline. This discrepancy between Internet and non-Internet partner genders suggests that the Internet'may be a tool for exploration of sexual activities that diverge from activities intiated with non-Internet partners. The relative anonymity of the Internet may facilitate sexual experimentation that is considered impossible in traditional venues. This may be especially salient for young adults, many of whom still may be exploring their sexual orientation. However, experimentation with sexual orientations is only one function of the Internet in the sexual lives of young adults, the most important of which is that the Internet apparently increases the efficiency of partner-seeking.

These data point to an urgent need for online STD/HIV prevention interventions targeting young adults. These interventions must be sensitive to issues of privacy and confidentiality, while emphasizing the health benefits of condom use, regular STD screening, and HIV testing. In addition, young adults who seek partners online should be encouraged to discuss STD/HIV status with potential partners, and to negotiate condom use before a face-to-face en-counter. By intervening on these behaviors in the same arena in which risky behavior is initiated, we may be able to effect important changes in risk for STDs and HIV.

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Reproduced from: Journal of Adolescent Health 2002;31:11-16

Sleep Duration From Infancy to Adolescence: Reference Values and Generational Trends

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Objective

The main purpose of the present study was to calculate percentile curves for total sleep duration per 24 hours, for nighttime and for daytime sleep duration from early infancy to late adolescence to illustrate the developmental course and age-specific variability of these variables among subjects.

Methods

A total of 493 subjects from the Zurich Longitudinal Studies were followed using structured sleep-related questionnaires at 1, 3, 6, 9, 12, 18, and 24 months after birth and then at annual intervals until 16 years of age. Gaussian percentiles for ages 3 months to 16 years were calculated for total sleep duration (time in bed) and nighttime and daytime sleep duration. The mean sleep duration for ages 1 to 16 years was estimated by generalized additive models based on the loess smoother; a cohort effect also had to be included. The standard deviation (SD) was estimated from the loess smoothed absolute residuals from the mean curve. For ages 3, 6, and 9 months, an alternative approach with a simple model linear in age was used. For age 1 month, empirical percentiles were calculated.

Results

Total sleep duration decreased from an average of 14.2 hours (SD: 1.9 hours) at 6 months of age to an average of 8.1 hours (SD: 0.8 hours) at 16 years of age. The variance showed the same declining trend: the interquartile range at 6 months after birth was 2.5 hours, whereas at 16 years of age, it was only 1.0 hours. Total sleep duration decreased across the studied cohorts (1974–1993) because of increasingly later bedtime but unchanged wake time across decades. Consolidation of nocturnal sleep occurred during the first 12 months after birth with a decreasing trend of daytime sleep. This resulted in a small increase of nighttime sleep duration by 1 year of age (mean 11.0 ± 1.1 hours at 1 month to 11.7 ± 1.0 hours at 1 year of age). The most prominent decline in napping habits occurred between 1.5 years of age (96.4% of all children) and 4 years of age (35.4%).

Conclusions

Percentile curves provide valuable information on developmental course and age-specific variability of sleep duration for the health care professional who deals with sleep problems in pediatric practice.

Discussion

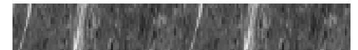
The mean total, sleep duration reported here is in good agreement with values given by others. In a large longitudinal study, Klackenberg found a mean total sleep duration in 1-year-old infants of 13.2 hours (13.9 hours, values in brackets refer to the results of the present study), at 3 years of 12 hours (12.5 hours), at 6 years of 11 hours (11 hours), and at 12 years of 9.5 hours (9.3 hours). In the first year of life, Bamford et al showed the mean total sleep duration to decrease from 14.3 hours (14.2 hours) at 6 months of age to 13.6 hours (13.9 hours) at 1 year of age. In preschool children, Jacklin et al described a total sleep duration of 13.3 hours (13.6 hours) at 18 months, 12.7 hours at

26 months, and 11.8 hours at 33 months of age. Gulliford et al reported an average sleep duration in school-age children of 11.2 hours (11.4 hours) at 5 years and of 10.5 hours (10.4 hours) at 8 years. In the early adolescent age group, we confirmed the study by Szymczak et al, who obtained a total sleep duration of 10.2 hours (9.9 hours) in 10-year-olds and of 8.7 hours (8.7 hours) in 14- year-olds. It is interesting that Laberge et al found mean values from 10 to 14 years of age that were consistently 0.5 hours higher compared with what we found. In our study, the parents were also asked about the duration of daytime sleep and napping habits from the period of birth to 7 years of age. For the most part, our results are in accordance with previous findings of Weissbluth. All of these studies were conducted in countries with similar child-rearing practices and cultural influences (in North America, Continental Europe, and United Kingdom). Therefore, we propose that the percentile curves presented in this study can be applied to children in all Western societies.

The subjects in this longitudinal study were recruited from 1974 until 1993. A comparison of 3 birth cohorts (1974, 1979, and 1986) revealed a decreasing trend of the mean total sleep duration across cohorts. The cohort trend had to be taken into account during the modeling procedure of the percentile curves. It was most pronounced in infants and young children and decreased continuously up to adolescence. During the last decades, young children went to sleep later and later, but wake time remained unchanged. As a consequence, time spent in bed became shorter across cohorts. In preschool children, the parents determine bedtime, whereas with age, bedtime is increasingly self-determined by the child. Therefore, a more liberal parental attitude toward evening bedtime in the past decades is most likely responsible for the bedtime shift and for the decline of sleep duration across cohorts.

For simplicity, the percentile curves and the corresponding tables given in this report apply formally for children born approximately in 1990. Whether bedtime and therefore time spent in bed will continue to change across generations will depend on child-rearing practices in the future.

Reproduced from: PEDIATRICS Vol. 111 No. 2 February 2003, pp. 302-307



Pathways to Adolescent Health: Sleep Regulation and Behavior

Dahl R.E: Journal of Adolescent Health 31(6) 175-184 Dec/02

Sleep: An Overview

Sleep is not simply rest. Sleep is an activity wherein some brain regions show the same (or increased) activity as during wakefulness. Moreover there are several aspects of sleep including the continuity, timing, and patterning of different stages of sleep that are necessary for the restorative process to occur.

For example, if subjects are permitted to sleep ad libitum for 8 to 10 hours but are awakened every 15 minutes for brief periods, the following day they will report tiredness, fatigue, and emotional changes similar to having obtained insufficient amounts of sleep. Similarly, if subjects are permitted ad libitum amounts of sleep but are selectively deprived of one sleep stage, such as Rapid Eye Movement (REM) or delta sleep, they also report daytime consequences.

This restorative function of sleep is essential not only for optimal physical and mental function but also for survival. Sleep is observed in every species of living creature that has ever been studied. Animals deprived of sleep perish; experiments with rats show survival without sleep is comparable to survival without food.

There are, however, a few themes that have emerged from this area of investigation, relevant to clinical issues in Adolescent Health. First, whatever its purpose, sleep seems to be particularly important during periods of brain maturation.

Across species, greater sleep requirements are observed in maturing vs. fully mature individuals. Another central principle about sleep, which may have particular relevance to aspects of adolescent development, is the close link between sleep and perceptions of threat/safety. Sleep, at a behavioral level, involves fundamental loss of awareness and responsiveness to the external environment. During sleep most sensory information stops at the level of the thalamus, preventing perception of (and behavioral response to) potential threats in the environment. As a result, most species have evolved mechanisms to ensure that sleep behavior is limited to safe places (burrows, nests, and temporal niches relatively safe from predators.) Unless one feels safe it is prudent to avoid turning off vigilance and responsiveness. Thus, it also makes sense that any perception of threat and the accompanying increased arousal is antithetical to going to sleep.

Sleep Physiology and Terminology

Sleep stages are defined by the patterns of three electrophysiologic measures; the electroencephalogram (EEG), electromyogram, and electro-oculogram. These measures are used to divide sleep into broad categories of REM sleep and non-REM sleep.

REM sleep is also called paradoxical sleep because it has aspects of deep sleep and light sleep at the same time. On one hand, REM appears deep because the changes in the body, (loss of muscle tone) and subcortical brain systems, such as temperature regulation and control of respiration and heart rate, are more profound than in any other stage of sleep. On the other hand, higher cortical brain functions are quite active and resemble wakefulness. Dreaming is associated closely with REM sleep.

Non-REM sleep is subdivided further into Stages 1, 2 3, and 4. Stages 3 and 4 also called delta or slow-wave sleep represent the deepest sleep in human beings. The length of this deep delta sleep increases in proportion to how long one has been awake. (ie. There is more delta sleep and deeper delta sleep following sleep loss or chronic sleep disturbances). Children experience extremely, large amounts of deep slow-wave sleep, which gradually decreases as they get older. During this deep sleep (usually 1-3 hours after going to sleep) it is extremely difficult to arouse a child, and if aroused, they often appear disoriented, confused and cognitively slow. Confused partial arousals, including sleep walking, talking and night terrors usually emerge from this state.

Biological Changes in Sleep/Circadian Regulation during Pubertal Development: There are four areas of sleep regulation showing changes during adolescent maturation; (a) There is a decrease in duration and depth of non-REM (stages (3 and 4) and REM sleep. (b) A more adult like pattern of REM sleep develops, (c) there are increases in daytime sleepiness and (d) there is a shift in the circadian pattern toward a more owl-like tendency for later bedtimes and wake up times.

Circadian Changes at Puberty

During adolescence there are various alterations in addition to the duration and organization of sleep stages. These include important maturational changes in the timing of sleep and the influence of the biological clock or circadian regulation system. This circadian system is involved not only in the timing of sleep but also the timing of brain hormone release, body temperature regulation, and the architecture within sleep.

The system is largely influenced by the suprachiasmatic nucleus located in the hypothalamus, which is sensitive to light cues and social schedules and plays a modulatory role in the timing of melatonin release.

Psychosocial Influences Contributing to Sleep Problems in Adolescents

In addition to these biological changes leading toward late night schedules, there are extensive psychooocial influences that interfere with adolescent sleep.

Historically there were very few options for late night activities after dark for most adolescents. However in the current era with access to hundreds of cable television channels, telephones, the Internet, video games, and late night social activities, adolescents have innumerable options for stimulating and arousing activity. Access to pharmacological stimulation including caffeine and nicotine, is also common and increasing among adolescents.

Finally, social stresses including fears, anxieties, and emotional arousal can greatly interfere with sleep in adolescents. Extensive physical and emotional change, social turmoil, and novel experiences and challenges occur during adolescence and transiently interfere with going to sleep. It is also important to emphasize that the cognitive components of the ability to fall asleep undergo substantial changes at some point in adolescence (ie, younger children's rumination, worry, and distressing thoughts are much less likely to interfere with going to sleep than those of adolescents.

Reprinted from: The Monthly News in Adolescent Medicine April-May 2003

McCreary Youth Foundation

Our History

The McCreary Youth Foundation was founded in early 2003 by a group of individuals with experience in issues pertaining to youth health, and who had the desire to establish a Foundation that could make a tangible difference in advancing these issues in British Columbia. It is modeled after the Foundation for Young Australians. Her Honor Iona Campagnolo, Lieutenant Governor of the Province of British Columbia serves as Honorary Patron.

The Foundation has received initial funding from the B.C. Ministry of Children and Family Development and will, as a first step, fund projects addressing the sexual exploitation (including at-risk/prevention strategies) of young people in B.C.

Our Mission

Advancing the needs and issues of B.C.'s youth.

Our Vision

To ensure that B.C. youth have an active say in issues pertaining to their lives, and that broader policies include the perspectives and needs of our young people.

Our Values

· Positive Youth Development
· Working in partnerships, across disciplines, sectors and communities
· Youth participation and leadership in our own organization
· Thoughtful community leadership, based on communication, consultation, consensus. rigorous criteria, and high standards

Our Cornerstones (Goals):

As a funder/grantor, our goals are to:

1. Increase knowledge about the risk and protective factors that youth experience and that impact their lives.
2. Assemble evidence that can inform and effect public policy, and communicate this to relevant stakeholders and decision makers.
3. Support initiatives that foster positive youth development, and develop and engage youth leadership.
4. Build world-class research capacity on youth issues in B.C.
5. Identify and support solutions for the issues and concerns of special populations within the broader youth constituency.

Our Strategies

· High-engagement grant-making and awards
· Building an endowment fund for future sustainability
· Youth engagement

NOTE: for more information and regular updates visit www.myfoundation.ca

Publications

New publication offered by ACOG

The American College of Obstetricians and Gynecologists (ACOG) Committee on Adolescent Health Care is pleased to announce the availability of "Health Care for Adolescents". This publication is one of the Committee's recent activities. The document includes all previously published ACOG documents on adolescent health care, many of which have been updated to include new information. It also includes two new documents on eating disorders and screening for chlamydia and gonorrhea. Another publication recently released by the Committee on Adolescent Health Care is the Tool Kit for Teen Care. This kit is designed to help health care providers provide primary and preventive health care to adolescent patients. It includes an adolescent visit record and questionnaire, information on developing an adolescent-friendly office, and protocols for responding to phone calls commonly received by adolescent patients. Other recent ACOG activities pertaining to adolescents include:

1) Adolescent Pregnancy Facts. This document includes the latest statistics on adolescent sexual activity, pregnancy, and childbearing. It also includes the latest statistics on sexually transmitted diseases among adolescents.

2) Strategies for Adolescent Pregnancy Prevention. This document discusses various approaches to preventing adolescent pregnancy; describes models of effective and replicable programs; provides a selection of current literature on teen pregnancy prevention programs and evaluations; and lists relevant publications, other resources available on the subject, and useful Internet sites.

Health Care for Adolescents and Tool Kit for Teen may be ordered through the ACOG distribution center by calling 800-762-ACOG or visiting their web site at http://sales.acog.org. Limited quantities of Adolescent Pregnancy Facts and Strategies for Adolescent Pregnancy Prevention may be obtained at no charge by contacting Lisa Goldstein by phone at (202) 863-2497 or via e-mail at adolhlth@acog.org.

"What to do when your children turn into TEENAGERS " by David Bennett and Leanne Rowe

Published by Doubleday – Sydney – 2003, ISBN 1 86471 077 2.

Reviewed by Roger S Tonkin

This attractive, soft cover 387 page text was recently launched in Australia. Its release is timely as, at about the same time, Iris Litt, editor of JAH penned an editorial to the effect that " Parents are " in " again ". What Bennett and Rowe manage to do is meet Litt's challenge of providing " sufficient information so that they can evolve into the role of a resource person for their children and teens ".

The book includes both an index and a chapter by chapter appendix of footnotes and references. Its formatting is both reader friendly and contemporary in style. I particularly like the frequent use of bullets, sidebars, and inserts. The text is liberally salted with quotes and comments from teens. A useful practice is the inclusion of " What parents can do " inserts in each chapter.

The content and text is very much Australian in focus. Some may find this off putting but the actual information is certainly applicable to any set of western parents. In addition, concepts of asset building and connectedness are included and thereby add to any parent's sense of capacity to cope in a positive manner.

This book is comprehensive and few areas of adolescent health and development are left out. However, it is more of an atlas of adolescent issues than a reference text on specific issues. It is authoritative but does not treat any subject in great detail. It is a book that can start parents off on the process of becoming a " resource person " but requires them to do so from a base of literacy and a western set of values that all readers may not possess. Its appeal to an international audience will be determined by price (not listed) and distribution. I think it is a wonderful text to have in our resource library and applaud the authors for their achievement.

Parent Help Line connects with Parents

Parenting can be one of life's most rewarding experiences. But while it can be fulfilling to raise a child, parents are also faced with lots of challenges and choices. That's why Parent Help Line was launched in 2000.

Staffed by professionally-trained, paid counsellors with backgrounds in fields including social work, psychology and child and youth counselling, Parent Help Line is a toll-free, national, 24-hour, bilingual, anonymous and professional phone counselling, referral and Internet service for parents and caregivers. It offers professional phone counselling and referral at 1-888-603-9100 and a library of more than 300 messages answering typical parenting questions on the phone or at www.parenthelpline.ca. The service is managed and operated by Kids Help Phone. The library of messages is developed and maintained by the child development and parenting experts at Invest in Kids.

"From the moment we launched Kids Help Phone, in 1989 parents started calling," says Chris Simmons-Physick, vice president of Child and Family Services at Kids Help Phone. "They didn't know who else to call. They felt because we were talking to so many kids we might have some insights to help them".

"We felt Parent Help Line completed the circle. It is our prevention arm. If parents, with a child as young as an infant, have the kind of information they need and the kind of support they need to be informed parents, it has a positive impact."

Parents call about a wide range of issues every day, including:

- Discipline and Problem Behaviour: 23% of calls
- Child Development and Health: 20%
- Parent Rooted Problems: 17%
- Divorce and Custody/Step-Families/Adoption: 9%
- Social Skills/School and Academics: 9%
- Eating, Sleeping and Toilet Training: 5%
- Issues of Adolescence: 5%
- Child Abuse:4%
- Child Welfare/Housing/Financial: 3%
- Family Routines: 3%
- Infancy: 2%

Parents can also log on to the Parent Help Line website for information. In fact, traffic to the Parent Help Line site has increased tremendously since 2001, with almost 70, 000 hits to the site recorded in 2002.

- At www.parenthelpline.ca parents can access the same library of messages available on the phone, and exchange messages with other parents in a safe and moderated environment. Parents can check back often and participate in a supportive online community.

To reach Parent Help Line, call 1-888-603-9100 or visit www.parenthelpline.ca