

Adolescent Health—A New Perspective in Singapore

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In the past five decades, there have been significant advances in the fields of Paediatrics and Adult Medicine in Singapore. However, the bridging field of Adolescent Health has only recently been recognised to be an important specialty which has not received due emphasis in the medical curriculum for undergraduates, or in the clinical practice of health professionals.

This realisation was accelerated by the increasing affluence and standard of living in Singapore, and the adoption of risky lifestyles and behaviour by this generation of youth, as well as the improved medical standards of care resulting in prolonged survival of children with chronic disorders into adulthood. These factors have fuelled an increasing awareness of the necessity to accommodate the health care concerns of the youth in Singapore. Consequently, this issue is devoted to adolescent health, which we believe will assume increasing significance to practising physicians.

Except for the newborn period and the early infant years, no period of human life span encompasses more dramatic changes than does adolescence. The opening article on “The Perils of Puberty”¹ endeavours to describe this transitional phase, which is marked by a complex inter-relationship of biological, psychological and social changes as the adolescent strives to adjust to new social roles and identities, and to new reproductive capacities.

However, even more important than the physical changes of puberty are the health-risk behaviours and risky environmental factors which often occur together among adolescents,² and may eventually result in morbidity and mortality in adulthood. For example, adolescents who smoke cigarettes are 16 times more likely to report heavy alcohol use than non-smokers.³ Substance abuse and accidental injury or death are strongly linked. Early maturing girls who have been abused are more likely to initiate voluntary sexual activity at a younger age. In fact, one of the most potent predictors of adolescent pregnancy is a history of childhood sexual abuse.⁴

Unfortunately, society tends not to have a sympathetic view of adolescence, preferring to cast them as perpetrators, not as victims, of crime and violence; as pursuers of risk, experimenting with drugs and sex, not as victims of sexually abusive caregivers; as underachievers, not as vulnerable youth suffering from low self-esteem and depression as a result of living with abuse. There is precious little research in this field in Singapore, and a series of articles from local experts addresses issues of adolescent mental health, eating disorders, youth suicide and parasuicide and sexually transmitted diseases in Singapore teenagers,⁵⁻⁸ including an invited review of adolescent alcohol and other substance abuse.⁹

While the normal adolescent encounters societal pressures which may lead to risky unhealthy behaviours, it can be appreciated that the adolescent with a chronic disorder, who lives into adulthood, will have to cope with even greater stresses. There are two articles which address the issues of accommodating the health care needs of an increasing number of youth with chronic conditions who survive into adulthood.^{10,11}

As health professionals manage more adolescent issues, it is becoming increasingly clear that the care of the adolescent is as specific as the care of children and the elderly and, like Paediatrics and Geriatrics, requires special attention. As medical professionals, we need to understand adolescent attitudes, develop the rapport to foster high-risk health behaviour disclosure, develop the skills to counsel appropriately, and promote a healthy lifestyle which will continue throughout adulthood. There is a need to promote health messages which are stronger than those received from their peers, television, movies and magazines.

One problem which may be encountered in an interview with the adolescent is the skill to build a sense of trust between the adolescent and the physician, and yet maximise the ability to collect all pertinent information. Many mnemonics have been developed as a means to remind the physician to survey all pertinent aspects of an adolescent's level of functioning.

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One example is the HEADSS assessment.¹² H—homelife; E—education; A—activities; D—drugs (including alcohol); S—sexuality; and S—suicide (depression). In addition, health professionals should appreciate that confidentiality, which refers to the control and protection of health information shared between the adolescent and the physician, is an essential component of adolescent health care. However, confidentiality cannot be unconditional in that some information such as sexual abuse or suicidality may be of sufficient potential harm to the adolescent that the principle of “first do no harm” supersedes the principle of confidentiality. We are privileged to have contributions from experts in Adolescent Health from Melbourne and Sydney to share their experiences and insight on the clinical management of adolescents.¹³⁻¹⁶

On a broader perspective, adolescent health stems from primary prevention and education programmes, and the final paper addresses the principles in design and delivery of effective education programmes,¹⁷ which will prove to be useful as the field of Adolescent Health in Singapore develops and matures from its current stage of infancy.

In what form can adolescent services be implemented in Singapore? There are three possible models.¹⁸ The first model focuses on adolescents with one particular condition, such as diabetes mellitus. The potential advantage of this model is that patients have in common a condition with a common set of needs, and will work with a consistent paediatric team and, presumably, have an identified care team of adult providers. In the second model, an adolescent health team focuses on an approach to coordinate care and advance the transition process within the context of adolescent health services. The adolescent team would have an approach that is broad in scope, addressing physical, emotional, developmental and social issues. In the third model, a primary care model is hypothesised to use the primary care provider (paediatrician or family physician) to assess and coordinate the health needs of the adolescent and family. Irrespective of which model is implemented in isolation or in combination, it is essential that the adolescent has access to care that is family-centred, continuous, comprehensive, coordinated, compassionate and culturally competent.

I hope that this special issue on Adolescent Health will increase the awareness that adolescence is a time of challenge and promise, in which health professionals can play a significant role.

Lastly, I would like to thank all contributors, editorial staff and the Annals Editorial Board for their kind assistance, without which this issue would not have been possible.

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