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MULTI-PRONG APPROACH TO IMPROVE OUTCOME OF MANAGING ADOLESCENCE DEPRESSION IN PRIMARY CARE

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ABSTRACT

Depression affects around 4.4 percent of the global population and is the fourth leading cause of illness and disability among adolescents aged 15-19 years. Adolescence is a difficult period with many struggling to develop emotional and mental capabilities to deal with the rising demands of school and family. Some may even have to deal with social triggers such as bullying. In our family physician clinic practice in a polyclinic, we managed a 15-year-old student who was a victim of school bullying which led to her depression. While it is common for polyclinic doctors to prescribe anti-depressants and refer patients with depression to a psychiatrist, we went a step further by collaborating with her family, school and various community health providers and community mental health outreach programme to ensure a positive outcome by providing timely and holistic support and counselling. This also circumvented the stigma and isolation should she be primarily managed in a tertiary care psychiatric unit, thereby minimising the risk of non-compliance with treatment and follow-up.

Keywords: Adolescence, depression, primary care, multidisciplinary

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INTRODUCTION

Globally, over 300 million people are estimated to suffer from depression, which is equivalent to 4.4 percent of the global population.[1] 10-20 percent of children and adolescents worldwide experience mental health conditions, but the majority of them do not seek help or receive care.[2] In their report on adolescent health, the World Health Organisation (WHO) estimated that over half of all cases of mental disorders begin by age 14 and the majority remain untreated well into adulthood. Depression is the fourth leading cause of illness and disability among adolescents aged 15-19 years and fifteenth for those aged 10-14 years globally. Suicide is the third leading cause of death in 15-19 year-olds.[3]

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Adolescence (10-19 years old) is a unique and formative time and is a crucial period for developing and maintaining emotional and social habits important for mental well-being. Recognising and resolving mental health issues such as depression, and their risk factors are essential. The consequences of not addressing mental health and psychosocial development for adolescents extend to adulthood and limit opportunities for leading fulfilling lives. Supportive environments in the family, school and community play a big role in helping adolescents with depression.

This case report highlights the multi-prong approach undertaken by Family Physicians at a polyclinic in improving the outcome of managing an adolescent with depression.

CASE REPORT

Ms N was a 15-year-old Malay female with no previous medical or psychiatric history. She presented with a change in mood for the past three months. She was accompanied by her mother and eldest sister. Ms N was reserved and remained silent during this consultation visit. History had to be obtained first from the accompanying family members.

Ms N had low mood daily for the past three months, with several occasions where she felt that she had hit rock bottom. She had lost interest in hobbies. She used to enjoy engaging social medial platforms such as 'Instagram', but found no joy in doing so lately. She experienced a loss of appetite but without weight loss. Sleep had been affected as well. She headed to bed at 11pm but only managed to fall asleep at 3am daily. While lying on the bed, thoughts of recurring worries flashed in her mind, rendering her unable to have a restful night. She also had interrupted sleep and found it hard to return to sleep once awakened. She experienced high inertia in completing daily tasks and movements seemed to be slower. She had lost focus during classes and spent her time worrying instead. She had confided feelings of helplessness, hopelessness and worthlessness to her eldest sister. She had thoughts of self-harm previously, but these had resolved. She did not have concrete plans of self-harm or left any last words previously. There were no auditory or visual hallucinations.

In order to seek a better understanding of Ms N's situation, the accompanying family members were asked to leave the consultation so that further history could be elicited from the patient. Once they had stepped out of the room, Ms N broke down and cried.

She had been bullied in school and did not want her family members to know about it. She felt 'shameful' that her classmates had bullied her. The bullies had made 'nasty comments' about her and collaborated to 'make her an

outcast'. Her social media accounts were spared. However, she felt that she did not have any friends in school.

She had episodes suggestive of panic attacks once or twice a week, which peaked at 2-3 minutes each time. It could start without a trigger, or occasionally due to excessive worrying, followed by palpitations, shortness of breath, chest discomfort, cold extremities and paraesthesia. These were resolved shortly when she calmed down. However, she was always worried about when the next panic attack would occur.

BACKGROUND

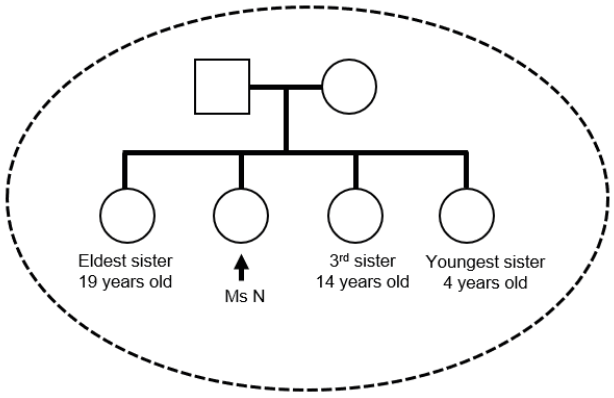
Ms N was a Secondary 4 student in a local school. She was scheduled to take her General Certificate of Education 'N(T)' level examination in 2020. She hoped to enrol in the Institute of Technical Education (ITE) to be an early childhood educator.

She lived in a two-room HDB rental flat with her family of six. Her father was the sole breadwinner who worked as a grocery assistant. Her mother was a housewife. Her sisters were still schooling. Hence, the family was financially strapped.

Ms N had a good relationship with her eldest sister and was able to confide in her about her situation in school. She had fair relationships with her parents but did not feel comfortable sharing her difficulties with them.

There was no family history of depression or other mental health disorders.

Genogram:



CLINICAL EXAMINATION

Ms N was dressed neatly in casual clothes. Her behaviour was appropriate. She was initially reserved but could share her concerns once she felt at ease in the absence of her family members. The conversation was logical but needed much prompting and closed-ended questions. Her mood was low. The content and flow of thought were logical. She did not have delusions or hallucinations. There were no abnormalities of orientation, concentration or memory. Her insight was intact.

A systemic review was conducted to exclude underlying medical conditions. Substance and alcohol abuse was ruled out.

ASSESSMENT

Ms N fulfilled the DSM-V criteria for major depressive disorder[4] and panic disorder.[5] A major contributing factor was the bullying acts in school.

MULTI-PRONG MANAGEMENT

1. **Ensuring adequate social and financial support for subsequent care**

   Ms N's family had financial difficulties, which might deter her compliance with treatment and follow-up. Our Medical Social Worker (MSW) assisted to enrol Ms N's family in the appropriate social assistance programmes. The family was referred to the Social Service Office and put on ComCare assistance, which provided full subsidy for the family's medical care and housing rental. The family was reassured that they would not incur additional financial burden as Ms N began her treatment and recovery with us.

2. **Engaging her family**

   Educating Ms N's family members on her condition enabled them to understand what she was going through and helped them support her during her treatment. It allowed Ms N to feel more accepted. The whole family could then work together to overcome the stigma of depression and monitor her medication's side effects and red flags of her depression.

3. **Collaboration with the school team**

   The school counsellor was contacted, and we managed to formulate a plan for Ms N. She liaised with the school management to start investigations regarding the bullying. She also provided regular counselling sessions for Ms N while psychotherapy services were being arranged. In view of the upcoming major examinations, the school provided provisions for Ms N to be placed in another class, separated from the alleged bullies, during the course of her examinations.

4. **Co-management with REACH team**

   After discussing with Ms N's school counsellor, we felt it was best to enrol her in the REACH (Response, Early intervention and Assessment in Community mental Health) programme. Being a community-based multidisciplinary healthcare service for students with emotional, social and/or behavioural issues, REACH can tap on community resources such as school counsellor, psychotherapy sessions at Family Service Centres (FSCs), and expert opinion from psychiatrists and psychologists from the Institute of Mental Health

(IMH). This allowed Ms N to remain in her comfort zone in the community instead of isolated care in the specialist hospital. The clinical psychologist was contacted and we maintained regular updates on the progress of Ms N. The psychologist had reviewed her and arranged for psychotherapy services at the FSC nearest to her residence.

5. Primary care management by Family Physician

Ms N was started on Fluoxetine 10mg OM, which was subsequently increased to 20mg OM. Possible adverse effects of her medication and potential suicide risk had been discussed with Ms N and her family members. Hydroxyzine 20mg ON was added to alleviate insomnia as needed. Ms N was followed up closely with two-weekly visits to check if she was coping well and to monitor for any medication side effects.

LATEST UPDATE ON THE OUTCOME OF MANAGEMENT

Trust and rapport were gained as the visits grew. Ms N showed improvement in her mood at her second-month visit with us. She had since completed her GCE 'N(T)' examinations successfully and applied for admission to ITE. She was no longer in contact with the school bullies.

Her mood had improved at the most recent visit but dipped slightly as she had stopped taking fluoxetine two weeks ago on her own accord due to an acute episode of dyspepsia. Her dyspepsia had since resolved.

She had no major low mood events since the last visit. She had since found interest in reading novels and watching TV, and was able to help out with the household chores without difficulty. Her sleep and appetite had improved. There were no hallucinations or thoughts of self-harm.

The relationship within her family had improved and she looked forward to their family outings.

She was keen to restart fluoxetine as her mood had dipped initially after stopping it. A lower dose of fluoxetine at 10mg OM was restarted at the latest visit. She was advised to continue taking fluoxetine for at least another six months to prevent relapse of depression.

Currently, she is awaiting her follow-up psychotherapy sessions at Punggol FSC. Meanwhile, she attends regular counselling sessions with her school counsellor. Her next review at the polyclinic will be in four weeks. She is keen to follow up with the polyclinic until she feels well and independent in the community.

CONCLUSION

A multi-prong approach to managing depression is especially rewarding in adolescent depression. It enables the adolescent to understand and cope better with her condition while having support from family, school, and the community. Furthermore, it minimises the need for dedicated treatment in a tertiary medical institution, thereby reducing the stigma and improving compliance with treatment. The combination of help from the family, school counsellor, community psychologist and outreach programme, regular visits with the primary care physician, and input from the psychiatrist if needed are synergistic in improving the outcome for this young patient.

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LEARNING POINTS

- **Mental health disorders, especially in adolescents, are best treated using a multidisciplinary approach.**
- **Physicians should be familiar with and collaborate with the allied health professionals at their clinical institution to ensure that their practices are organised based on best practices for integrated patient care. Such integrated care includes connecting patients with therapists, psychiatrists, case managers and community resources.**
- **If there is a long wait time for mental health services availability, the physician should provide active support and treatment in the interim. Once the patient begins to receive mental services, the physician should stay involved in the patient's care to provide holistic and care continuity.**