Training and Evaluation of Nurse Practitioner Students on the Utilization of Patient Health Questionnaire Depression Screening Tool in Adults in a Health Care Setting

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BACKGROUND

- Prevalence of Depression:
  - 322 million affected globally; 21 million in the U.S. (8.3% of adults)
  - Highest in ages 18-25 (33.7%)
- Major Depressive Disorder (MDD) Symptoms:
  - Low mood, lack of interest, changes in sleep/appetite, guilt/worthlessness, low energy, poor concentration, agitation, suicidal thoughts
- Consequences of Untreated Depression:
  - Severe complications and self-destructive behaviors
- Screening Recommendations:
  - Target adolescents (12-18) and pregnant/postpartum women; reassess every 4-6 weeks
  - Use PHQ-2 (2 questions) and PHQ-9 (9 questions) for screening
- Implementation Challenges:
  - Inconsistent PHQ-9 usage among providers
- Barriers:
  - Stigma deterring help-seeking; economic cost of $210 billion annually in the U.S
- Healthcare Providers' Role:
  - Essential for initiating mental health care and addressing concerns during consultations

METHODS

- Design:
  - Quantitative analysis through pretest/posttest questionnaires
- Target Group:
  - NP students at a New York university
- Participation:
  - Voluntary, no compensation, confidentiality assured
- Inclusion Criteria:
  - Attendance for entire session, anonymity maintained
- Data Collection:
  - Anonymous pre-intervention demographic survey
  - 10-question Likert scale pretest and posttest on PHQ-9 knowledge
- Session Duration:
  - 60 minutes (50-minute presentation, 10 minutes for pre/post-questionnaires)
- Analysis Tools:
  - SPSS version 29.0, Wilcoxon Signed Rank Test, McNemar's test

RESULTS

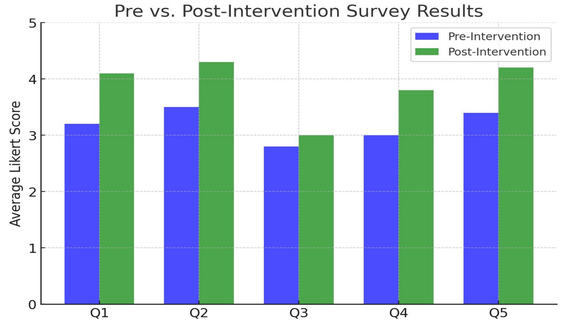
- Study involved 13 female nurse practitioner students aged 30-59
  - Initial findings (pretest):
    - 62% felt adequate knowledge of PHQ-9
    - 62% confident in using PHQ-9 for screening
    - 54% confident in using it for diagnosis
  - Post-intervention findings:
    - 100% reported adequate knowledge (69% agreed, 31% strongly agreed)
    - 85% felt confident using the tool (54% agreed, 31% strongly agreed)
  - Significant improvements in knowledge and confidence were noted through Wilcoxon signed-rank test analysis

OBJECTIVES

- Evaluates training on PHQ-2 and PHQ-9 for nurse practitioner (NP) students.
- Aims to enhance knowledge and proficiency in depression screening.
- Focuses on improving screening skills in healthcare settings.
- Seeks to improve the quality and efficiency of training for NPs.

CONCLUSION

- Educated healthcare providers on the PHQ-9 depression screening tool.
- Enhanced knowledge and confidence in nurse practitioner students.
- Improved knowledge scores observed.
- Study's limitations call for larger, randomized research.
- Need for standardized depression screening practices.



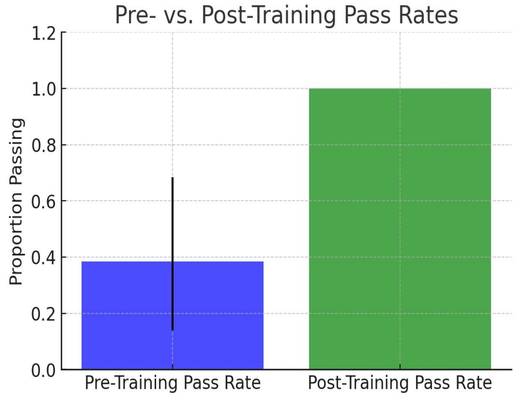


TABLE 2

PHQ-2 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Scoring: A score of 3 or more is considered a positive result. The PHQ-9 (Table 3) or a clinical interview should be completed for patients who screen positive.

PHQ = Patient Health Questionnaire.

Adapted from Patient Health Questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed February 8, 2018.

TABLE 3

PHQ-9 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed; or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Scoring: 1 to 4 points = minimal depression, 5 to 9 points = mild depression, 10 to 14 points = moderate depression, 15 to 19 points = moderately severe depression, 20 to 27 points = severe depression.

PHQ = Patient Health Questionnaire.

Adapted from Patient Health Questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed February 8, 2018.

IMPLICATIONS FOR PRACTICE

- Train NP students on the PHQ-9 tool for improved depression detection.
- Implement routine screenings during patient visits to identify at-risk individuals.
- Focus on early intervention to enhance patient care and outcomes.
- Recognize healthcare settings as vital for patients with behavioral health needs.
- Ensure educated providers utilize screening tools effectively for treatment.
- Aim to improve screening practices and quality of life for those coping with depression.

REFERENCES