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Implementation of Routine Screening to Detect Early Cases of Depression and Anxiety in Hispanic Adolescents in the Primary Care Setting

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Executive Summary

This practitioner utilizes the term Hispanic in her project. Hispanic is the preferred term for the population in this quality improvement project. The cited literature uses the terms Latino/a, Latinx, and Hispanic.

Introduction of the Problem

Mental health is an essential part of one's well-being and is important at every stage of life. Many mental illnesses first appear before age 24 and if not addressed, can create long-term morbidity (Blakemore, 2019). Therefore, early identification and treatment are crucial. According to recent statistics, one in seven (14%) 10–19-year-olds experience mental health conditions; however, these health conditions continue to go unrecognized and untreated (World Health Organization [WHO], 2021). In adolescents, depression and anxiety are among the leading causes of illness and disability and are two of the most prevalent mental health conditions in Latino adolescents (WHO, 2021; Potochnick & Perreira, 2010). Between 2015 and 2018, Major Depressive episodes increased from 12.6% to 15.1% in Latinx/Hispanic youth ages 12-17 (Mental Health America, 2022). If not addressed, depression can lead to suicide. Suicide is the fourth leading cause of death in older adolescents ages 15-19; and the second leading cause of death for Hispanics ages 15 to 34 in 2019 (U.S. Department of Health and Human Services [USDHHS], 2021; WHO, 2021). Research supports primary care as the ideal setting for screening. Routine screenings can facilitate early identification and treatment. In the Latinx/Hispanic population, individuals are more likely to seek help for a mental disorder from a primary care provider (10%), than a mental health specialist (five percent) (Mental Health America, 2022; Hispanic Research Center, 2021).

This project is in alignment with the mental health objectives of Healthy People 2030 to (1) increase the proportion of primary care visits where adolescents are screened for depression, (2) increase the proportion of children and adolescents who get appropriate treatment for anxiety and depression, and (3) reduce suicide attempts by adolescents (USDHHS, n.d.). Prior to the implementation of the project, the primary care clinic did not perform routine screenings. Audits revealed that screenings were performed in less than 30% of visits from March through May 2022. Of those cases, several adolescents screened positive for depression and anxiety; however, 70% of the visits were missed, and those adolescents were not screened for depression or anxiety.

Literature Review

The National Alliance on Mental Health (2022) recommends early mental health screening in a primary care doctor's office. Despite evidence-based recommendations for screening, two-thirds of adolescents with depression go unidentified by their primary care provider (Bose et al., 2021). The U.S. Preventive Services Task Force (USPSTF, 2016) recommends routine screening for depression in adolescents aged 12 years and older and recommends the Patient Health Questionnaire-9 (PHQ-9) as the initial screening tool. The PHQ-9 has been shown to be an effective screening tool in adolescent populations and easy to administer in the primary care setting. The PHQ-9 has high sensitivity in adolescents 12 years of age and older. The General Anxiety Disorder (GAD)-7 is well validated and helpful in identifying the presence of anxiety. Findings in the literature do not indicate a different recommendation for screening tools specifically for the Hispanic adolescent population.

According to WHO (2021), the more risk factors adolescents are exposed to, the greater the potential impact on their mental health. Risk factors for Major Depressive Disorder (MDD)

in adolescents include female sex; family history of depression; other mental health or behavioral problems; and in some studies, Hispanic race/ethnicity (Siu, 2016). Ramirez (2017) found Latino adolescents suffer from higher rates of depression and suicidal behavior than their peers, with Latinas having the highest rates of suicidal ideation and suicide attempt of any group. If left untreated, adolescent depression can have negative consequences, including violence, suicidality, and self-injurious behaviors that have also been noted to carry over into adulthood (Bose et al., 2021).

Project Methods

This quality improvement project took place at a primary care clinic located on the Northwest side of Chicago. The goals of this project were to increase routine screening and early identification of depression and anxiety in Hispanic adolescents using evidence-based screening tools and initiate appropriate interventions to lead to better outcomes. Project approval was granted through the Southern Illinois University Edwardsville (SIUE) Institutional Review Board (IRB) and was determined to not be human research. Implementation of this project involved meeting with the medical provider and medical assistant to identify the problem, potential solutions, and agree on the screening tools for utilization. A screening protocol and toolkit of community resources were developed, and a new workflow was implemented. Screenings were provided to all adolescents aged 12-18 years. Those adolescents who did not have a previous diagnosis were included in the data collection.

Kurt Lewin's Three Stage Model Change Theory guided this quality improvement project. The model identifies the phases as creating the perception that change is needed, moving toward the new desired level of behavior, and solidifying the new behavior as the norm (Cummings et al., 2015). Buy-in and sustainment are paramount in achieving better outcomes.

To increase buy-in, staff received education to heighten their awareness on the prevalence of adolescent depression and anxiety, and the impact of the conditions for the population served at the clinic site. Training included a PowerPoint presentation and video. A five-point Likert scale questionnaire was administered to staff pre- and post-implementation to assess their knowledge of the mental health conditions, their comfort level with administering the tools, knowledge level of tools, feasibility of routine screening, and sustainability.

Evaluation

Objectives were measured through quantitative data analysis collected from an audit tool developed by the project leader. The audit tool recorded: (a) the number of adolescent patients who met the criteria for screening with the PHQ-9 and GAD-7 questionnaire; (b) the total number of questionnaires completed; (c) the number of adolescent patients identified for further treatment for depression and anxiety (using scores from screening tools); (d) the number of patients who received referrals to mental health services. Objectives were also measured through responses from the five-point Likert scale pre- and post-questionnaires provided to staff.

The baseline percentage of adolescents who received depression and anxiety screening during the three months pre-implementation was 28.94%. Chart audits indicated that screenings were performed in 11 of 38 visits. During the project implementation period from June through August 2022 routine screenings were performed in 64 of 70 visits using the PHQ-9 and GAD-7, an increase from 28.94% to 91.43%. Mental health referrals were provided/offered in 10 out of 13 positive depression screenings. Three referrals were missed during the first week of implementation, and one patient refused the referral. All nine patients who screened positive for anxiety were provided/offered referrals; three of those patients refused the referral.

Pre- and post-staff surveys results indicated that both the medical provider and medical assistant strongly agreed to all the items assessed which included: understanding the purpose of the screening tools, feeling comfortable administering the tools, ease of use, identifying that there was a need for routine screening, and routine screening would increase early detection and have a positive impact on the delivery of patient care. There was increased awareness on behalf of the medical assistant, in reference to the magnitude of mental health issues in the adolescent population post implementation. Post survey responses from the clinic provider revealed a concern for ensuring adequate mental health referral services that would meet the needs of his patients. Although the toolkit developed by project leader included a list of providers and organizations specific to the Hispanic communities, and those who also accepted public insurance, the medical provider was concerned if his patients would have success with attaining appointments due to having public insurance. Future assessments should examine the management of those adolescents identified as at-risk; to include timeframe from point of referral given to the time of obtaining mental health appointments, compliance with treatment plan, and outcomes. Approaches are also needed in managing adolescents identified as at-risk who refuse mental health services.

There were three significant limitations of this quality improvement project. First, the sample size was small. The project sample consisted of 70 clinic visits, and the timeframe for implementation was two months. It would be difficult to generalize this information to other populations due to the small sample size and limited evaluation period. Next, the auditing tool relied on staff accurately accounting and recording all screenings. Electronic audit reports relied on accurate coding. Lastly, the project leader was not able to assess completion rates of

referrals/management plans (i.e., follow-up with mental health providers) after positive screenings were identified and referred.

Impact on Practice

The immediate impact on the clinical site was the significant increase in screenings and early identification of adolescents at risk. Patients received early interventions as deemed appropriate by the clinic provider. Early identification and treatment can lead to better outcomes for these patients. The long-term potential impact of the project is better outcomes for at risk adolescents through routine screening and early interventions. Symptoms of depression and anxiety, and rates of suicide can be decreased through effective management of these patients, which is in tandem with the mental health objectives for Healthy People 2030.

Conclusion

Standardized screening is vital in identifying adolescents at risk for anxiety and depression. Early detection facilitates early interventions. Current literature supports the implementation of screening to occur in the primary care setting. Screening using the PHQ-9 and GAD-7 were shown to be efficient and the tools ease of use made them practical in the primary care setting. Adolescents with depression have increased health care costs, with reports indicating the estimated overall economic burden to be over \$210 billion/year (Maurer et al., 2018; Sui 2016). Early detection and treatment will lead to better outcomes and ease the economic burden associated with depression. Without routine screenings, many adolescents will continue to go undiagnosed and opportunities for early identification and treatment will be missed.

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