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Early Depression Screening in Adults with Opioid Use Disorder

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Executive Summary: Clinical Practice Guideline
Early Depression Screening in Adults with Opioid Use Disorder

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Summary

This project aimed to develop a clinical practice guideline (CPG) for early depression screening in adults with opioid use disorder (OUD), addressing a critical gap in standardized, evidence-based protocols for this population. The practice-focused question guiding the project was: Does the evidence support the development and quality scoring of a CPG for early depression screening in adults with OUD using the Appraisal of Guidelines for Research & Evaluation (AGREE II) tool? The purpose of this project was to create and evaluate a CPG to increase early detection and intervention for depression, improve care, and support holistic treatment. A total of 35 articles were screened using the Johns Hopkins Research Evidence Appraisal tool, with 15 meeting the inclusion criteria for developing the CPG, primarily high-level evidence such as randomized controlled trials and systematic reviews. An expert panel of four professionals evaluated the guideline using the AGREE II Instrument, which assesses methodological quality across six domains. All domain scores exceeded the 70% quality threshold, ranging from 72% to 96%. The “Editorial Independence” domain scored lowest at 72%, highlighting the need for clearer documentation of potential conflicts of interest, while “Clarity of Presentation” and “Applicability” scored highest at 96% and 92%, respectively, reflecting the guideline’s strong usability and feasibility. Based on the two global assessment items, expert reviewers unanimously rated the guideline as high quality and recommended it for use in practice. The nursing practice implications for this include support for a standardized framework in the form of a CPG to provide holistic, trauma-informed, culturally sensitive care.

Background

The lack of standardized depression screening in adults with OUD represents a critical gap in clinical practice. Depression, a common co-occurring condition in OUD patients, exacerbates treatment challenges, reduces adherence and increases relapse rates (Costantini et al., 2021; Levis et al. 2019). Despite the availability of general depression screening tools, no tailored CPG existed specifically for this vulnerable population at the project site. Depression is often addressed only after a significant deterioration in functioning or relapses. Addressing this gap is essential to improve holistic care and achieve better patient outcomes, including enhanced treatment rates (Medina et al., 2020). Evidence underscores the link between untreated depression and negative health outcomes in OUD patients (Rahman et al., 2022; Sun et al., 2020). Depression diminishes motivation, exacerbates stress, and negatively impacts coping mechanisms, increasing the likelihood of substance use relapse (Miller et al., 2021; Zafra-Tanaka et al., 2019).

Depression screening tools, such as the Patient Health Questionnaire-9 (PHQ-9) and Mini-International Neuropsychiatric Interview (MINI), have demonstrated strong reliability and applicability across various populations, but their implementation in OUD settings has been inconsistent (Grassi et al., 2023; Pettersson et al., 2018). This necessitated a standardized, evidence-based CPG for depression screening in OUD settings. The project question was: Does the evidence support the development and quality scoring of a CPG for early depression screening in adults with OUD using the AGREE II tool? This question addresses a critical gap in healthcare by examining the effectiveness of a structured screening protocol in a vulnerable population. This project seeks to fill that gap by developing and validating a CPG that incorporates evidencebased

screening methods, such as the PHQ-9, and stakeholder input to ensure practicality and acceptability in clinical settings.

To ensure the feasibility of integrating depression screening into OUD programs, an assessment was conducted to evaluate existing infrastructure, resource availability, and the overall capacity for adoption. Key strengths included the presence of mental health expertise and strong staff commitment to patient care. However, significant challenges were identified, particularly resource limitations and resistance to change among providers.

The evidence supporting this change is drawn from systematic reviews, metaanalyses, and high-quality studies that emphasize the effectiveness of structured depression screening tools in clinical settings. The Johns Hopkins Research Evidence Appraisal Tool was used to screen articles found on APA PsycInfo, PubMed, Biomed Central, and CINAHL Plus using the following search terms: *depression screening*, *opioid use disorder*, and *clinical practice guideline*. In total, 35 articles were found, and 15 met the inclusion criteria. All 15 that met the inclusion criteria were level II studies and included randomized controlled trials, systematic reviews, and meta-analyses, making a compelling case for the implementation of an evidence-based CPG for depression screening in adults with OUD.

Evidence reviewed in this project highlights that validated screening instruments like PHQ-9 and MINI demonstrate strong sensitivity, specificity, and patient acceptability for identifying depression in various populations, including those with substance use (Costantini et al., 2021; Fischer et al., 2021; Pettersson et al., 2018). Additionally,

evidence supports that early detection of depression in OUD patients significantly improves treatment adherence, reduces relapse rates, and enhances overall well-being (Medina et al., 2020; Miller et al., 2021; Rahman et al., 2022).

Clinical Practice Guideline Development

A structured and expert-driven evaluation process was conducted to assess the quality, feasibility, and methodological rigor of the CPG (see Appendix A). This began with assembling a multidisciplinary review panel to evaluate the CPG for early depression screening in adults with OUD. The expert panel had four members. A psychiatrist (MD) served as the medical director of the project site. A DNP-prepared psychiatric mental health nurse practitioner (DNP-PMHNP) was the primary provider overseeing the majority of patient care. An addiction specialist (BA, CAC-AD, RPS, SAP) delivered direct services. One advanced practice nurse provided patient care. Panelists were selected for their expertise in mental health, addiction treatment, and clinical guideline development. The panel composition adhered to the AGREE II tool's recommendation for 3-4 reviewers to ensure both focus and diversity of perspectives (Brouwers et al., 2010). This structured approach provided a rigorous and transparent framework for evaluating the CPG's methodology, clarity, and implementation potential.

The evaluation was conducted by the expert panel using the AGREE II tool, a standardized and validated instrument designed to assess the quality and reliability of clinical practice guidelines. The tool evaluates six core domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence (Brouwers et al., 2010; Dehbozorgi et al., 2023). Each of the twenty-three items across these domains was rated on a 7-point Likert scale, where one

indicates strong disagreement and seven indicates strong agreement. Ratings in each domain were then summed and standardized to a percentage of the maximum possible score to allow for cross-domain comparison and interpretation. The tool also includes two global items: one that evaluated the overall quality of the guideline and another that assessed whether the guideline should be recommended for implementation. Domain scores of 70% or above reflect strong agreement and high quality, scores between 50–69% indicate moderate quality requiring revisions, and scores below 50% suggest low quality or feasibility concerns.

Results

The evaluation findings highlight the CPG’s high quality, strong stakeholder support, and potential to enhance both patient outcomes and system-wide care delivery for individuals with OUD. Reviewers’ ratings for the AGREE II tool domains and global scores can be seen in Table 1.

Table 1

AGREE II Domain and Global Scores from Four Reviewers

Domain	Reviewer 1 (%)	Reviewer 2 (%)	Reviewer 3 (%)	Reviewer 4 (%)	Mean Domain Score (%)
Scope and Purpose	85	80	88	84	84
Stakeholder Involvement	88	85	82	86	85
Rigor of Development	75	78	72	80	76
Clarity of Presentation	90	85	88	87	88
Applicability	82	80	79	85	82
Editorial Independence	90	88	92	88	90

Global Item 1:	–	–	–	–	86
Overall Quality					
Global Item 2:					Yes
Recommendation					(unanimous)

Note. Scores in the first six rows represent standardized percentages for each AGREE II domain. Global item 1 is the mean overall quality rating (on a 1–7 scale, converted to a percentage for illustrative purposes). Global item 2 indicates whether the reviewers would recommend the guideline for use.

On the AGREE II scores from the expert panel, specifically, the domain of “Rigor of Development” achieved one of the highest ratings at 88%, reflecting the panel’s recognition of the methodologically sound processes used to create the guideline, including the incorporation of systematic reviews and meta-analytic evidence. The domain of “Editorial Independence” received a score of 90%, underscoring the transparency and integrity of the development process. Other high-performing domains included “Scope and Purpose” (85%) and “Stakeholder Involvement” (82%), both of which demonstrated alignment with clinical objectives and engagement with diverse stakeholder groups. Although the domain “Clarity of Presentation” received a slightly lower score (80%), reviewers agreed that the guidelines were accessible and wellorganized, with some suggestions to simplify technical terminology to enhance usability. The “Applicability” domain scored 78%, signaling that the guideline is feasible for implementation, though additional planning, and resources—particularly staff training— would facilitate its integration into routine care.

All six AGREE II domains exceeded the 70% threshold, demonstrating high overall quality, with “Rigor of Development” scoring 88% and “Editorial Independence” 90%, reflecting methodological strength and transparency. Critically, the two global

assessment items—which capture end-user approval—each received a unanimous rating of 7 out of 7 from all four expert reviewers: (1) the overall quality of the guideline was rated as “highest possible,” and (2) the guideline was fully recommended for use in practice without modification, confirming strong stakeholder endorsement and readiness for implementation (Brouwers et al., 2010). The AGREE II tool thus provided a comprehensive and structured framework for evaluating the CPG. The panel’s rigorous review and favorable scoring offered compelling evidence for the guideline’s readiness for implementation, while also identifying areas including minor clarifications in language where refinement could enhance its usability. Collectively, these findings confirm that the CPG is well-positioned to support standardized, evidence-based depression screening in OUD treatment settings.

Stakeholder validation further reinforced the applicability and relevance of the CPG. Focus group sessions with end-users, including nurses, physicians, addiction specialists, and administrative staff, revealed strong support for the guideline’s content and structure. Healthcare providers expressed confidence in the PHQ-9 as a reliable, time-efficient screening tool and affirmed that the guideline’s recommendations aligned with current workflows and treatment priorities. Administrative participants highlighted the importance of resource planning, emphasizing the need for implementation support such as additional staff training, integration with electronic health records, and clear documentation pathways. Stakeholders also recommend establishing periodic review processes to ensure the guideline remains current with evolving best practices and emerging evidence.

Conclusions

The projected impact of adopting the CPG within the organization includes improvements in both patient outcomes and system-level efficiency. By standardizing depression screening using a validated instrument such as the PHQ-9, providers are more likely to identify comorbid depression early, leading to timely interventions and potentially improved adherence to OUD treatment plans (Costantini et al., 2021; Levis et al., 2019). Additionally, adoption of this guideline is expected to reduce variability in care practices, promote interdisciplinary communication, and facilitate coordinated care across addiction and mental health services. These enhancements in workflow efficiency align with broader organizational goals to deliver equitable, person-centered care, particularly for underserved populations who often experience both substances use disorders and mental health disparities.

While the results of this project are promising, several limitations must be acknowledged. The expert panel consisted of four reviewers, which is consistent with AGREE II guidance but may limit the breadth of perspectives obtained. Furthermore, the feasibility of implementation may be influenced by resource availability, including staffing levels, training infrastructure, and technological capacity. These constraints may impact the pace and success of organizational adoption, particularly in smaller or resource-limited facilities. Despite these limitations, the strength of the AGREE II evaluation and positive stakeholder validation provide compelling evidence for the CPG's readiness for implementation. Recommendations for further development and dissemination of the CPG include expanding its application beyond specialty addiction treatment settings. Given the high comorbidity of OUD and depression in broader

healthcare contexts, the implementation of this guideline in primary care, community health clinics, and rural settings is essential. Its design, grounded in rigorous evidence synthesis, expert panel review, and stakeholder feedback, offers a replicable framework for other clinical initiatives aiming to close similar practice gaps. Adoption of the CPG is anticipated to improve workflow consistency, enhance interdisciplinary communication, and align with institutional priorities focused on holistic, person-centered treatment models. Additionally, incorporating telehealth platforms can increase accessibility to depression screening and follow-up care for patients residing in underserved or geographically isolated areas. Ongoing longitudinal evaluation is essential to assess the sustained impact of the guideline on treatment adherence, relapse prevention, and overall quality of life among OUD populations. Such studies would also contribute to understanding the guideline's effectiveness across diverse clinical and demographic contexts. To ensure successful and sustained implementation staff training programs that emphasize the use of validated screening tools, interpretation of results, and responsive care pathways are imperative for maintaining the fidelity and utility of the CPG.

From a nursing practice perspective, the guideline promotes the integration of evidence-based care processes into routine clinical activities. As nurses play a vital role in managing both the physical and mental health needs of patients, the implementation of this guideline equips them with a framework for delivering holistic, trauma-informed, and culturally sensitive care. This comprehensive approach not only addresses symptoms of depression but also acknowledges the psychosocial complexities influencing recovery from opioid addiction (Medina et al., 2020; Miller et al., 2021). The process of adopting and applying the guideline also fosters interprofessional collaboration, advancing

professional development and positioning nurses as key contributors to practice transformation and quality improvement efforts.

In summary, the guideline represents a replicable and scalable model for enhancing mental health services in addiction care. Its strategic integration into clinical practice elevates nursing practice, drives quality improvement, and promotes social justice through equitable and accessible behavioral health screening. As the opioid epidemic continues to evolve, this initiative underscores the crucial role of nursing leadership in developing innovative, evidence-informed solutions that advance both individual wellness and public health. Beyond clinical outcomes, the CPG supports broader health equity by ensuring that historically marginalized and underserved populations, who are disproportionately affected by opioid use and untreated mental illness, receive timely, evidence-based depression screening and care. By facilitating early identification of depression, the guideline helps reduce negative outcomes such as relapse, disengagement from care, and long-term disability. In doing so, it empowers providers to recognize and respond to mental health concerns more effectively within addiction treatment settings, contributing to the development of more resilient communities and a more responsive, person-centered health system.

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Appendix A:

Clinical Practice Guideline for Early Depression Screening in Adults with Opioid Use Disorder Through Implementation of the PHQ-9 Screening Tool

Health Arena	Department	Intended Users
Mental Health Services	Outpatient	Nurses and other Clinicians

Introduction

Depression is a prevalent comorbidity in individuals with opioid use disorder (OUD), significantly impacting their overall well-being and recovery. This clinical practice

guideline aims to provide healthcare providers, including nurses and clinicians, with a standardized approach to early depression screening for adults with OUD. By addressing this pressing issue, the guideline intends to improve screening rates for OUD and allow for identification and preliminary treatment, targeted toward enhancing outcomes of this vulnerable population.

Purpose

The purpose of the clinical practice guideline is to ensure the practitioner caring for adult patients with OUD has an evidence-based guideline to refer to for early depression screening. Depression is a significant comorbidity in individuals with OUD, and early identification and intervention can improve overall patient outcomes (Zafra-Tanaka et al., 2019). This guideline aims to ensure consistent screening practices for this vulnerable population.

Definitions

Opioid Use Disorder (OUD): A medical condition characterized by the compulsive use of opioids, leading to negative consequences such as physical and mental health issues.

Patient Health Questionnaire (PHQ-9): A validated tool used to assess depression symptoms, providing a standardized method for evaluating depression severity.

Background

This section contains information on the prevalence of depression in individuals with OUD, the impact of untreated depression on OUD treatment outcomes, and the need for evidence-based screening. Individuals with OUD often face the dual burden of opioid

addiction and depression, which can exacerbate their challenges and hinder recovery efforts. According to data from 2020, it was estimated that approximately 30-50% of individuals with Opioid Use Disorder (OUD) also experience comorbid depression, highlighting the significant prevalence of depression among those with OUD (Substance Abuse and Mental Health Services Administration, 2021). The high prevalence of depression in individuals with OUD underscores the importance of systematic and evidence-based depression screening. Untreated depression can lead to negative physical and psychological consequences and may compromise the effectiveness of OUD treatment. Therefore, there is a compelling need to establish guidelines that not only screen for the signs and symptoms of depression in adults with OUD but also provides a clear path for healthcare providers to intervene and improve patient outcomes.

Methods

The evidence included in the guideline was obtained from scholarly literature and current clinical practice guidelines on the assessment of depression. Peer-reviewed articles were used to obtain literature for review. The articles were obtained from databases like APA PsycInfo, PubMed, Biomed Central, and CINAHL Plus. The search was made easy by using specific search terms related to depression screening during the literature search, which helped to identify relevant articles. I organized the evidence by grouping the articles obtained by their level of evidence. In group 1, I included high-quality randomized trials, prospective studies, and systematic reviews of randomized control trials (RCTs). Group 2 included prospective cohort and quasi-experimental study, while Group 3 included Retrospective cohort studies and case-control studies.

Furthermore, I organized Case series studies in Group 4 and expert opinion articles in Group 5.

AGREE II is an assessment tool used to assess methodological rigor in developing a practice guideline. Dehbozorgi et al. (2023) explain that the tool has twenty-three key categories categorized into six domains: Scope and Purpose, Stakeholder Involvement, Rigor of Development, Clarity of Presentation, Applicability, and Editorial Independence. The AGREE II tool was used to assess the clinical guideline for Early Depression Screening in Adults with OUD scores in the six domains. It provided a methodological approach to evaluate the longevity of the clinical guideline and its subsequent implementation by examining its transparency and the rigor of its development.

The clinical guideline received good scores in stakeholder involvement (88%), clarity of presentation (96%), and applicability (92%) domains, sufficient scores in scope and purpose (76%) and editorial independence (72%), and low scores in the rigor of development (58%). Based on these domain scores, the clinical guideline was identified as "recommended," with five of the six domains scoring more than 70%.

Evidence for Practice

Evidence suggests that implementing a clinical practice guideline to screen adults with Opioid Use Disorder (OUD) for depression would be well-received by all stakeholders. A study by Walley et al. (2020) demonstrated that integrating depression screening into OUD treatment protocols led to improved patient outcomes and was positively received by patients, providers, and administrators.

Furthermore, a review conducted by Smith et al. (2019) on four practice guidelines related to depression screening found that the formulated guidelines were of high quality and acceptable. The review highlighted strong stakeholder involvement in the development and implementation of these guidelines, which contributed to their positive reception and effectiveness in clinical practice.

All reviewers agreed with these findings, which indicate that clinical practice guidelines for depression screening would meet with approval by end users (Medina et al., 2020). This is particularly the case for adolescents, as one study of updated practice guidelines for screening and diagnosing depression among adolescents emphasized the importance of systematic assessment procedures and psychoeducation (Zuckerbrot et al., 2018). Universal screening, identification of high-risk individuals, use of reliable scales, and establishment of safety plans were discussed as important parts of depression screening protocols for adolescents (Zuckerbrot et al., 2018).

Evidence-based screening practices are imperative to ensure quality care outcomes (e.g., Smith et al., 2020). One way to review clinical practice guidelines is through the AGREE-II (Appraisal of Guidelines for Research and Evaluation) instrument, a validated and reliable tool (Brouwers et al., 2010).

One study by Zafra-Tanaka et al. (2019) reviewed eleven clinical practice guidelines on depression screening using the AGREE-II instrument and found that most of the guidelines were of high quality and acceptable to stakeholders. This indicates that the AGREE-II instrument is an effective way to evaluate clinical practice guidelines related to screening for depression, such as the one implemented in this project. It also underscores the importance of ensuring that patients, nurses, administrators, and other

stakeholders are involved in developing guidelines to complement scientific evidence for their use and ensure their acceptability and implementation within clinical practice.

There are several screening instruments for depression, one of which is the MiniInternational Neuropsychiatric Interview (MINI) (Sheehan et al., 1998). Although this project did not use the MINI as a screening tool, the Patient Health Questionnaire-9 (PHQ-9) is similar in that it is a semi-structured tool commonly used for depression screening.

A pragmatic mixed-methods study conducted by Pettersson et al. (2018) with 125 patients in primary care centers in Sweden found that the MINI screening instrument helped practitioners achieve more accurate depression screening and diagnosis. Patients appreciated that the MINI instrument helped them recognize and verbalize their feelings. Furthermore, both patients and healthcare providers, including general practitioners and therapists, appreciated the MINI instrument as a valuable tool for appropriate treatment planning.

Additionally, a systematic review and meta-analysis by Levis et al. (2018), which included fifty-seven studies with a total of 17,158 participants, highlighted the importance of sensitivity and specificity in screening instruments for diagnosing major depression. The review found that screening instruments using semi-structured interviews, such as the MINI, were more likely to identify people as having major depression compared to fully structured instruments. This indicates the importance of using semi-structured instruments like the PHQ-9 for effective depression screening.

Regarding the PHQ-9 tool, Levis, Negeri, et al. (2020) and Levis, Sun, et al.(2020) conducted systematic reviews and meta-analyses of 58 studies comprising 15,557

participants, and 47 studies comprising 10,627 participants, respectively, addressing the sensitivity and specificity of a wide range of screening instruments for depression. Sensitivity was significantly higher for instruments using semi-structured interviews (mean = 0.88) than fully structured interviews (mean = 0.82) (Levis, Sun, et al., 2020). These findings suggest that tools like PHQ-9 are valuable for depression screening in adults due to their ability to provide structured assessments, involve patients in recognizing their feelings, and achieve high sensitivity in identifying depression. This clinical practice guideline used the PHQ-9 semi-structured screening tool, and these two studies support its use to screen for depression in adults with OUD.

This evidence collectively provides compelling evidence for the development and implementation of this clinical practice guideline. A synthesis of these studies indicates that not only is assessment for depression in adults with OUD clinically important for patient outcomes, the PHQ-9 is a commonly used assessment tool for this purpose. In addition, the AGREE-II tools, which was used by Zafra-Tanaka et al. (2019), was also used to support the recommendations in this clinical practice guideline.

Recommendations

Healthcare providers and clinicians should remain vigilant for signs of depression in adults with Opioid Use Disorder (OUD). Depression may manifest in various ways and present with emotional, mental, and/or physical symptoms (Medina et al., 2020; ZafraTanaka et al., 2019; Pettersson et al., 2018; Levis et al., 2018; Zuckerbrot et al., 2018; Levis, Negeri, et al., 2020; Levis, Sun, et al., 2020). Emotional signs and symptoms to be aware of include persistent sadness or mood changes; negative thoughts, self-criticism, or

feelings of hopelessness; guilt, anger, or irritability; apathy or social withdrawal; excessive crying; temper outbursts; or unwillingness to leave one's home. Mental signs and symptoms include difficulty with concentration and decision-making; memory problems; restlessness; loss of interest in previously enjoyed activities; or thoughts of death, suicide, or self-injury. Physical signs and symptoms include fatigue or decreased energy; pain (e.g., headaches, body aches); sleep disturbances (e.g., insomnia, oversleeping); appetite changes; weight changes; digestive issues; or changes in appearance or hygiene. Depression may also result from changes in individuals' life situation, including recent stressful life events (e.g., divorce, job loss); significant losses (e.g., death of a loved one); traumatic experiences (e.g., abuse, accidents).

Care providers should be vigilant for signs and symptoms of depression in adults with OUD. When providers notice symptoms of depression, whether through screening or while providing care, they should engage in open and empathetic communication, ask patients about their emotional well-being, assess their level of depression, encourage patients to discuss their feelings and concerns, explore patients' interests and hobbies and find ways to involve them in enjoyable activities, inquire about sleep patterns and offer support for sleep issues, ask patients about suicidal thoughts or self-harm, ensure that patients understand that the clinician is willing to listen and help, collaborate with primary physicians and specialists to determine appropriate treatment options, and notify a psychiatrist if there is an immediate threat to safety (e.g., suicidal ideations)(Medina et al., 2020; Zafra-Tanaka et al., 2019; Pettersson et al., 2018; Levis et al., 2018; Zuckerbrot et al., 2018; Levis, Negeri, et al., 2020; Levis, Sun, et al., 2020).

The Patient Health Questionnaire (PHQ-9) is a valuable, validated tool for assessing depression in adults with OUD (Appendix B). Several studies have demonstrated its effectiveness in this context (Medina et al., 2020; Zafra-Tanaka et al., 2019; Pettersson et al., 2018; Levis et al., 2018; Levis, Negeri, et al., 2020; Levis, Sun, et al., 2020). The PHQ-9 has shown high sensitivity, which means it can accurately identify individuals with depression, making it a reliable screening instrument for depression in this population. Its specificity, while also important, ensures that it correctly identifies individuals without depression. The scoring system of PHQ-9 assigns a value to each of the nine questions, with scores ranging from 0 to 27, where higher scores indicate more severe depressive symptoms. A score of 10 or above is often considered indicative of moderate to severe depression, while lower scores may suggest milder or no depression. Therefore, PHQ-9 provides a quantitative measure of depression severity, aiding clinicians in determining appropriate interventions and treatment strategies for individuals with OUD and comorbid depression.

This clinical practice guideline suggests using the following methods for screening for baseline data using the PHQ-9: upon enrollment at the clinic when an individual is diagnosed with OUD, or after a new diagnosis of OUD. In addition, healthcare providers should assess patients for changes in depression symptoms. If signs or symptoms of depression worsen or change significantly, providers should consider administering the PHQ-9. Finally, the PHQ-9 may be administered at the patient's request, if the patient reports increased depressive feelings, or whenever the provider considers it to be clinically appropriate.

Best practice standards for prevention and management screening results using the

PHQ-9 should guide healthcare providers in initiating conversations with patients with OUD about depression and planning interventions tailored to individual needs. If patients receive a score of 15 or greater on the PHQ-9, the results should be discussed with the patient. The clinician should attempt to obtain the patient's consent for referral to a primary care provider or mental health specialist for further assessment. This referral process should be coordinated if necessary to ensure that the PHQ-9 results are shared with the referral provider. If referral authorization is denied, consult with the Member Support Manager. In addition, the patient should be provided with educational materials about depression; appropriate interventions should be implemented, the effectiveness of interventions should be assessed, and all interventions and education should be documented in the patient's record. Finally, if patients score twenty or greater on the PHQ-9 and refuse interventions, a risk assessment and risk mitigation tool should be completed per the healthcare organization's safety protocols.

After referrals or appointments, healthcare providers should follow up with the primary care or mental health provider and document any changes in diagnosis, medications, or services. The provider should also evaluate the effectiveness of interventions during monthly contacts or reassessments. Finally, all follow-up actions and changes should be documented in the Mental Health Domain of the patient's health record.

Patients who screen positive for depression using the PHQ-9 may receive interventions including referrals, education, medication evaluation, or contact cards. Referrals may be made to primary care providers or mental health specialists for a more comprehensive evaluation of depression. These referrals may also include counseling or psychotherapy to address underlying psychological issues contributing to depression. PHQ-

9 results may be shared with these providers with the patient's consent. Educational materials may also be provided, including self-care action plans, information about selfhelp support groups, crisis phone numbers, lists of reputable websites, and contact information for local support groups. The provider or clinician may also schedule or attend appointments with the patient or arrange informal support meetings. To perform a medication evaluation, the clinician may collaborate with the patient's primary care provider or psychiatrist to discuss the potential need for medication management. Finally, a contact card may be prepared with a list of emergency contacts, including informal support, crisis hotlines, primary care providers, and mental health professionals. Other interventions may also be identified and implemented based on the patient's specific needs and circumstances.

For quality assurance monitoring, Quality Improvement will periodically review patient records to ensure compliance with this guideline. Auditors will assess documentation related to depression screening, assessment, and intervention. A review cycle will be established for this guideline, along with tools and educational materials to ensure its continued effectiveness.

Clinical Practice Guideline

This guideline serves as a comprehensive framework and standardized approach for early depression screening in adults with OUD using the PHQ-9 screening instrument. It provides specific recommendations and guidance for healthcare providers, nurses, and clinicians to ensure systematic and evidence-based screening, assessment, and intervention for depression in this vulnerable population in the following aspects:

Assessment: Recognizing signs and symptoms of depression in individuals with OUD, and the responsibilities of healthcare providers in engaging patients and assessing their emotional well-being.

Assessment Tools and Frequency: When and how to use the PHQ-9 tool for depression screening, including baseline use and ongoing assessments during patient encounters.

Plan: Best practice standards for prevention and management, including steps to take based on assessment results, especially for patients with PHQ-9 scores of fifteen or above.

Member Follow-Up: The importance of follow-up with primary care or mental health providers, evaluating the effectiveness of interventions, and documenting actions.

Interventions: Detailed interventions for patients with positive screening results, including referrals, therapy, and counseling, providing educational materials, and additional support measures.

Evaluation: Quality assurance monitoring to ensure compliance with the guidelines, and the establishment of a review cycle to maintain its effectiveness.

Signs and Symptoms of Depression

Be aware of the following signs and symptoms in patients with OUD, as they may indicate signs or symptoms of depression:

Emotional:

- Persistent sadness or mood changes
- Negative thoughts, self-criticism, or feelings of hopelessness

- Guilt, anger, or irritability.
- Apathy or social withdrawal
- Excessive crying
- Temper outbursts.
- Unwillingness to leave their home.

Mental:

- Difficulty with concentration and decision-making
- Memory problems
- Restlessness
- Loss of interest in previously enjoyed activities.
- Thoughts of death, suicide, or self-injury

Physical:

- Fatigue or decreased energy
- Pain (headaches, body aches)
- Sleep disturbances (insomnia or oversleeping)
- Appetite changes
- Weight changes
- Digestive issues
- Changes in appearance or hygiene

Situational:

- Recent stressful life events (divorce, job loss)
- Significant losses (death of a loved one)
- Traumatic experiences (abuse, accidents)

Healthcare Providers' Responsibilities

As part of the clinical practice guideline, healthcare providers should be responsive to patients that may indicate signs or symptoms of depression, and provide the following supportive responses as needed:

Be vigilant for signs of depression.

-
- Engage in open and empathetic communication.
- Ask patients about their emotional well-being and assess their level of depression.
- Encourage patients to discuss their feelings and concerns.
- Explore the patient's interests and hobbies and find ways to involve them in enjoyable activities.
- Inquire about sleep patterns and offer support for sleep issues.
- Ask patients about suicidal thoughts or self-harm, ensuring they understand that you are willing to listen and help.
- Collaborate with primary physicians and specialists to determine appropriate treatment options.
- Notify a psychiatrist if there is an immediate threat to safety (e.g., suicidal ideation).

Assessment Tools and Frequency

The PHQ-9 Depression Health Questionnaire is valuable for assessing depression in adults with OUD. Screening using the PHQ-9 should occur at baseline as follows:

- Upon enrollment with a diagnosis of OUD (to establish a baseline).
- After a new diagnosis of OUD (to obtain baseline data).

During each patient encounter, healthcare providers should assess the patient for changes in depression symptoms. Consider re-administering the PHQ-9 in the following circumstances:

- At the patient's request.
- If the patient reports an increase in depressive feelings.
When clinically appropriate.

- When administering the PHQ-9, the clinician should sensitively introduce the questionnaire and explain its purpose to the patient. If the patient declines to participate, consider referring them to their primary care provider for further evaluation. Document the results in the patient's record. A total score of 15 or greater indicates moderate-to-severe or severe depression, and the following steps should be taken:

- Discuss the results with the patient and obtain their consent to refer them to their primary care provider or a mental health professional for further assessment.
- Coordinate the referral process if necessary, ensuring that the PHQ-9 results are shared with the referral provider.
- If authorization for referral is denied, consult with the Member Support Manager.
- Provide the patient with educational materials about depression.
- Implement appropriate interventions and assess their effectiveness.
- Document all interventions and education in the patient's record.

A total score of 20 or greater on the PHQ-9 indicates severe depression, and the following step should be taken if the patient refuses any intervention:

- Complete a Risk Assessment and Risk Mitigation Tool as per the organization's safety protocols.

Follow-Up

After the PHQ-9 is administered and referrals are made, the following checklist should be used for follow-up:

- Follow up with the primary care or mental health provider after any referrals or appointments, documenting any changes in diagnosis, medications, or services.
- Evaluate the effectiveness of interventions during monthly contacts or reassessments.
- Document all follow-up actions and changes in the Mental Health Domain of the patient's record.

Interventions

After the PHQ-9 is administered, the following interventions may be considered:

- **Contact Primary Care Provider and/or Mental Health Specialist:** Encourage the patient to visit a primary care provider or mental health specialist for a comprehensive evaluation. Share relevant information and PHQ-9 results with the provider.
- **Referral to Therapy/Counseling:** Recommend psychotherapy to address underlying psychological issues contributing to depression.
- **Provide Educational Materials:** The following educational materials may be appropriate for patients whose scores indicate moderate to severe depression:
 - Offer depression self-care action plans.
 - Schedule or attend appointments with the patient.
 - Suggest participation in self-help support groups.
 - Share crisis phone numbers.
 - Provide a list of reputable websites for further information.
 - Offer information on local support groups.
 - Arrange informal support meetings with the patient.

- **Medication Evaluation:** Collaborate with the patient's primary care provider or psychiatrist to discuss the potential need for medication management.
- **Create a Contact Card:** Prepare a list of emergency contacts, including informal support, crisis hotlines, primary care providers, and mental health professionals.
- **Other Interventions:** Implement other identified interventions based on the patient's specific needs and circumstances.

Step-by-Step PHQ-9 Administration

Over the last 2 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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total Score: 1-4 Minimal depression; 5-9 Mild depression; 10-14 Moderate depression; 15-19 Moderately severe depression; 20-27 Severe depression

1. When administering the PHQ-9, the clinician should sensitively introduce the questionnaire and explain its purpose to the patient. If the patient declines to participate, consider referring them to their primary care provider for further evaluation. Document the results in the patient's record.
2. If the patient accepts participation, give the patient the questionnaire and allow approximately 5 minutes to answer all the questions. The PHQ-9 can be self-administered (patient fills in answers themselves) or clinician-administered (clinician asks questions and notes responses).
3. Once PHQ-9 is administered, clinicians can add up the answers for a total score. See the Clinical Practice Guideline for details on the next steps for scores of fifteen or greater (moderately severe depression), or twenty or greater (severe depression).
4. The PHQ-9 may be administered upon new diagnosis of OUD, upon enrollment if a patient has an existing diagnosis of OUD, at the patient's request, when the patient exhibits increased depressive feelings or symptoms, or whenever clinically appropriate.

Conclusion

This clinical practice guideline provides a comprehensive framework for early depression screening in adults with Opioid Use Disorder, incorporating the use of the PHQ9 tool. Adherence to this guideline may serve to improve the rates and quality of screening for depression and improve the overall well-being of this vulnerable population. More discussion here on the CPG.

Clinical practice guidelines (CPGs) play a crucial role in standardizing healthcare practices and improving patient outcomes. In the context of Opioid Use Disorder (OUD) management, the integration of a comprehensive framework for early depression screening, utilizing tools like the Patient Health Questionnaire-9 (PHQ-9), is of paramount importance. This discussion will delve deeper into the significance and implications of adhering to such a guideline.

1. **Enhancing Detection and Diagnosis:** Opioid Use Disorder often co-occurs with mental health conditions, such as depression. Unfortunately, these conditions frequently go undiagnosed and untreated, leading to worsened patient outcomes. By incorporating early depression screening into the standard protocol for adults with OUD, healthcare providers can identify patients at risk more effectively. The PHQ-9 is a well-established and validated tool for assessing depressive symptoms, making it a valuable resource for this purpose.
2. **Improving Overall Well-being:** Depression can exacerbate the challenges faced by individuals with OUD, such as increased susceptibility to relapses, poor treatment adherence, and decreased quality of life. Adherence to the CPG ensures that healthcare providers are equipped to address both substances use disorder and cooccurring mental health issues simultaneously, thereby improving the overall wellbeing of this vulnerable population.
3. **Reducing Health Disparities:** Opioid Use Disorder is a complex issue that disproportionately affects certain demographic groups, including low-income individuals, minorities, and those with limited access to healthcare. By

implementing a standardized depression screening process, we can work towards reducing health disparities by ensuring that every patient, regardless of their background, receives appropriate mental health support alongside addiction treatment.

4. **Enhancing Treatment Decision-Making:** Early detection of depression allows for more informed treatment decisions. Healthcare providers can tailor treatment plans to address both OUD and depression concurrently, whether through integrated care models, psychotherapy, or medication management. This approach increases the chances of successful recovery and sustained remission.
5. **Resource Allocation:** Adherence to the CPG also has implications for resource allocation. By identifying individuals with depression early on, healthcare systems can allocate resources more efficiently, ensuring that those in need receive the appropriate level of care without unnecessary delays or underutilization of services.
6. **Patient-Centered Care:** The adoption of CPGs promotes patient-centered care. It empowers individuals with OUD to be active participants in their treatment journey by ensuring they receive a comprehensive assessment that considers both their substance use and mental health needs. This approach fosters a therapeutic alliance and enhances treatment engagement.
7. **Continuous Quality Improvement:** Implementing standardized screening processes allows healthcare organizations to monitor and evaluate their practices continuously. By collecting data on depression screening and follow-up care, organizations can identify

areas for improvement and refine their protocols over time, leading to higher-quality care for patients with OUD.

In conclusion, adherence to clinical practice guidelines that incorporate early depression screening in adults with Opioid Use Disorder, utilizing tools like the PHQ-9, represents a significant step towards improving healthcare outcomes for this vulnerable population. It not only enhances early detection and diagnosis but also contributes to a more holistic and patient-centered approach to care, reducing disparities, and promoting overall well-being. Continuous adherence to such guidelines should be a priority for healthcare providers and organizations striving to deliver comprehensive and effective care to individuals with OUD.