Program_____ Home Visitor_____
Participant Name and/or ID #_____ Date Completed_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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

FOR OFFICE CODING __0__ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

Patient Health Questionnaire-9 (PHQ-9) Scoring

Overview of Tool:
The Patient Health Questionnaire-9 (PHQ-9) is a brief, 9-question screening checklist used to flag potential signs of depression. It is an early warning tool, not a medical diagnosis.

The PHQ-9 is a free, public-domain screening tool that requires no formal training or certification to administer, complete, or score. The PHQ-9 has been validated with a wide variety of populations, including pregnant women, women in the postpartum period, as well as adults in the general population.

ECECD Periodicity:

- All models will administer the PHQ-9 within 60 days of enrollment and annually thereafter.
- During pregnancy, it will be completed once per pregnancy, within two months postpartum, and annually thereafter.
- The ECECD Home Visitor uses their judgment and critical thinking to determine if the questionnaire should be administered at an additional time.

Guidance:

- The client should complete the questionnaire themselves with support from the home visitor during the home visit.
- The client is asked, "Over the last 2 weeks, how often have you been bothered by any of the following problems?
- They then respond: Not at all (0), Several days (1), More than half the days (2), or Nearly every day (3)
- The PHQ-9 is calculated by assigning scores of 0, 1, 2, and 3 to the response categories of 'not at all', 'several days', 'more than half the days', and 'nearly every day' respectively.
- PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent cut-off points for mild, moderate, moderately severe, and severe depression, respectively (p. 5).
- The last question asks clients "to report 'how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?' This single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the client's global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life (p. 2).
- All nine items must be completed.
- Good clinical care also involves asking if the caregiver has fears about hurting the baby or fears of the baby coming to harm.

Instruction manual: Instructions for patient health questionnaire (PHQ-9) measures. Retrieved from https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf

Interpretation of Total Score and Recommended Action

Total Score	Depression Severity	Action
0-4	Minimal depression	
5-9	Mild depression	• Provide the *Mothers and Babies* curriculum as an intervention, as appropriate. • Monitor symptoms over time. • Rescreen according to ECECD periodicity requirements or sooner if symptoms worsen or concerns arise. • If symptoms increase, persist, or interfere with daily functioning, discuss referral options for further evaluation by a mental health professional.
10-14	Moderate depression	• Referral to mental health professional and/or Primary Care Provider for assessment.* • Provide the *Mothers and Babies* curriculum as an intervention, as appropriate. • Monitor symptoms over time.
15-19	Moderately severe depression	• Referral to mental health professional and/or Primary Care Provider for diagnostic assessment and treatment *
20-27	Severe depression	

A score of 10 and above requires a referral to a mental health professional and/or Primary Care Provider for assessment.

***An emergency referral is required for any client who has intention or plan that they would be better off dead or of hurting themselves or others in some way.**

Note: Home Visitors should follow their agency policies and procedures regarding referral and coordination of care for clients who screen above 10 or those who are in need of an emergency referral.