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| **Patient Health Questionnaire-9 (PHQ-9)**  (Please note: The PHQ-9 is 1 page) |

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| **Purpose:**  The most common mental health challenges experienced by NFP clients are depression and anxiety, which can interfere with a mother’s ability to achieve what she wants for herself and her child. A mother also may exhibit other mental health problems that interfere with her ability to care for herself and her child. The Edinburgh was originally designed for use with postpartum women. The PHQ-9 has been validated with a wide variety of populations, including pregnant women, women in the post-partum period, as well as adults in the general population. It has become the standard tool in primary care for assessment of depression, so the Nurse Home Visitor (NHV) can communicate the score to other medical professionals with greater confidence that the scores will be used to collaboratively guide treatment interventions. The questionnaire relies on patient client-report. T  **General Guidelines:**   * This form is completed 5 times: Pregnancy Intake, Pregnancy 36 Weeks, Infant 1-8 weeks (the NHV uses her clinical judgement to determine the best time to complete this), Infant 12 months, and Toddler 18 months. * The NHV uses her clinical nursing judgment and critical thinking to determine if the questionnaire should be administered at a different/additional time.   **Definitions/Directions for Completing Form**   * The client should complete the questionnaire herself, unless she has limited English or has difficulty with reading. * The client is asked “Over the last 2 weeks, how often have you been bothered by any of the following problems? * She then responds: 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 patient’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 mother has fears about hurting the baby or fears of the baby coming to harm.   Instruction manual: Instructions for patient health questionnaire (PHQ-9) and GAD-7 measures. Retrieved from  <http://www.phqscreeners.com/instructions/instructions.pdf>.  Interpretation of Total Score and Recommended Action on next page…………………………..  **Interpretation of Total Score and Recommended Action**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Total Score** | **Depression Severity** | **Corresponding**  **STAR Coding** | | **Action** | | 0-4 | Minimal depression | 0 | Low Risk |  | | 5-9 | Mild depression | 1 | Moderate Risk | * Referral to Primary Care Provider for assessment * NHV assesses with the client any needs for additional support and offers additional information/education * Consider administering PHQ-9 earlier than next scheduled date * Assessment with each NHV contact | | 10-14 | Moderate depression | | 15-19 | Moderately severe depression | 2 | High Risk | * Referral to Primary Care Provider/Mental Health Services for diagnostic assessment and treatment \* * NHV works with the client and community health professionals to develop a collaborative plan of care * Assessment with each NHV contact | | 20-27 | Severe depression |   **\*An emergency referral is required for any client who intentions or plan to harm herself, baby, or someone else.**  **Note: NHVs should follow their agency policies and procedures regarding referral and coordination of care for clients who screen positive or those who are in need of mental health evaluation/assessment based on the nurse’s clinical judgment.** |

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| **Client Name:** |

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| --- | --- | --- | --- | --- |
| **Client ID:** |  | **Nurse ID:** |  | **Date:** |

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| **Check one:** | * Pregnancy Intake | * Pregnancy 36 Weeks | * Infancy 1-8 weeks |
| * Infancy 12 months | * Toddler 18 months | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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 |
| 1. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 1. 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 |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| **Nurse Home Visitor to Total** | 0 + | + | + |  |
|  | **= Total Score:** | |  |

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| --- | --- | --- | --- |
| 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  🞎 |

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