SECTION D

# 2 to 9-Item Patient Health Questionnaire (PHQ-2 to 9©) Reference Tool

Reliant® REHABILITATION

The **PHQ-2 to 9©** is a validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

If the resident is rarely/never understood or cannot respond, verbally, in writing, or using another method, the PHQ-9© Observational Version (PHQ-9-OV©) may be utilized. See Reliant's PHQ-9-OV© Resource for guidance.

**D0150. Resident Mood Interview (PHQ-2 to 9©)**

**Say to resident: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"**

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask resident: "*About **how often** have you been bothered by this?*"

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

| **1. Symptom Presence** | **2. Symptom Frequency** | 1. Symptom Presence ▼ | 2. Symptom Frequency ▼ |
|---|---|---|---|
| 0. No (enter 0 in column 2) | 0. Never or 1 day | | |
| 1. Yes (enter 0-3 in column 2) | 1. 2-6 days (several days) | | |
| 9. No response (leave column 2 blank) | 2. 7-11 days (half or more of the days) | | |
| | 3. 12-14 days (nearly every day) | Enter Scores in Boxes | |
| *A. Little interest or pleasure in doing things* | | ☐ | ☐ |
| *B. Feeling down, depressed or hopeless* | | ☐ | ☐ |
| **If both A1 AND B1 are coded 9 OR both A2 AND B2 are coded 0 or 1, end the PHQ interview. Otherwise, continue.** | | | |
| *C. Trouble falling or staying asleep, or sleeping too much* | | ☐ | ☐ |
| *D. Feeling tired or having little energy* | | ☐ | ☐ |
| *E. Poor appetite or overeating* | | ☐ | ☐ |
| *F. Feeling bad about yourself—or that you are a failure or have let yourself or your family down* | | ☐ | ☐ |
| *G. Trouble concentrating on things, such as reading the newspaper or watching television* | | ☐ | ☐ |
| *H. Moving or speaking so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual* | | ☐ | ☐ |
| *I. Thoughts that you would be better off dead, or of hurting yourself in some way* | | ☐ | ☐ |
| | **TOTAL SEVERITY SCORE** | **SUM** | |

The **Total Severity Score** is a summary of the frequency scores (column 2) on the PHQ-9© that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessment by providers or mental health specialists. See Reliant's PHQ-2 to 9© Flow Chart for details on calculating the Total Severity Score.

## TIPS

- Sit in a quiet, private setting ensuring the resident can hear you and see your face.
- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some residents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
- If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions.
- Noncommittal responses such as "not really" should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered him or her, even if it was only some of the time.
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies.
- If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part.

| **Total Severity Score** can be interpreted as follows: | 1-4 minimal depression | 5-9 mild depression | 10-14 moderate depression | 15-19 moderately severe depression | 20-30 severe depression |
|---|---|---|---|---|---|

**Questionnaire Instructions**

- Read the item as it is written.
- Do not provide definitions because the meaning must be based on the resident's interpretation.
- Each question must be asked in sequence to assess symptom presence (column 1) and symptom frequency (column 2) before proceeding to the next question.
- Enter code 9 in column 1 and leave column 2 blank if the resident was unable or chose not to complete the assessment or responded nonsensically.
- For a yes response, ask the resident to tell you how often he or she was bothered by the symptom over the last 2 weeks. Use the response choices in Column 2, Symptom Frequency.