# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

The PHQ-9 is a widely used, self-administered diagnostic instrument for screening, diagnosing, monitoring, and measuring the severity of depression. This nine-item questionnaire is based on the DSM-IV criteria for depressive disorders and has been validated in numerous clinical settings.

Healthcare professionals rely on the PHQ-9 to efficiently assess depression symptoms, determine treatment plans, and track patient progress over time. With its brief format and strong psychometric properties, the PHQ-9 serves as both an initial screening tool and an ongoing measurement of treatment response.

## GUIDANCE FOR LAW ENFORCEMENT PERSONNEL

Police officers are encouraged to regularly self-monitor using the PHQ-9 as part of their mental health maintenance. The high-stress nature of law enforcement can increase vulnerability to depression and related conditions. Officers should:

### 1 Complete the PHQ-9 quarterly

Regular assessment helps identify symptoms early, even during periods of high operational demand.

### 2 Track scores over time

Maintain a personal log of scores to identify patterns or gradual changes that might otherwise go unnoticed.

### 3 Seek support at threshold scores

Scores of 10 or higher indicate moderate depression and should prompt a confidential consultation with department mental health services.

Department wellness coordinators should normalize PHQ-9 use during routine check-ins and ensure officers understand that seeking help represents strength, not weakness. Early intervention supports officer wellbeing and maintains operational readiness.

# PHQ-9 Questionnaire Format

| ID #:<br>NAME: | DATE: | | | |
|---|---|---|---|---|
| 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.<br>Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2.<br>Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3.<br>Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4.<br>Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating<br>5. | 0 | 1 | 2 | 3 |
| 6.<br>Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7.<br>Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |

# PHQ-9 Questionnaire (Continued)

| | | | | |
|---|---|---|---|---|
| 8.<br>Moving or speaking so slowly that other people could<br>have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9.<br>Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| | add columns | | + | + |
| (Healthcare professional: For interpretation of TOTAL,<br>please refer to accompanying scoring card). | TOTAL: | | | |
| 10.<br>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? | | Very difficult | Not difficult at all<br>Somewhat difficult | |
| | | Extremely difficult | | |

# Monitoring Depression Severity

1

## Step 1

Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2

## Step 2

Add up 3s by column. For every 3: Several days = 1 More than half the days = 2 Nearly every day = 3

3

## Step 3

Add together column scores to get a TOTAL score.

4

## Step 4

Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.

5

## Step 5

Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

# PHQ-9 Scoring Instructions

Scoring: add up all checked boxes on PHQ-9

For every 3 Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

# Interpretation of Total Score

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

# Recommended steps based on score range

The following are evidence-based recommendations for clinical decision-making based on PHQ-9 score results. These guidelines should be used alongside clinical judgment and patient preferences.

| Score Range | Severity | Recommended Actions |
|---|---|---|
| 1-4 | Minimal depression | • Education about depression<br>• Supportive counseling<br>• Consider lifestyle modifications (exercise, sleep hygiene)<br>• Reassess at follow-up visits |
| 5-9 | Mild depression | • Watchful waiting with follow-up within 1 month<br>• Self-management resources<br>• Consider brief counseling<br>• Regular monitoring of symptoms |
| 10-14 | Moderate depression | • Develop a treatment plan (medication and/or psychotherapy)<br>• Follow-up visits every 2-4 weeks initially<br>• Consider referral to mental health specialist<br>• Monitor side effects if medication prescribed |
| 15-19 | Moderately severe depression | • Active treatment with medication and/or psychotherapy<br>• Consider referral to mental health specialist if not responding<br>• Weekly follow-up initially<br>• Assess for comorbid conditions |
| 20-27 | Severe depression | • Immediate initiation of medication and psychotherapy<br>• Urgent referral to mental health services<br>• Consider psychiatric consultation<br>• Assess for hospitalization if safety concerns present<br>• Monitor closely with frequent follow-up |

Important considerations for all severity levels:

- Always assess suicide risk regardless of PHQ-9 score (particular attention to item 9)
- Document treatment plan and response to interventions
- Adjust treatment if inadequate improvement after 4-6 weeks
- Consider cultural factors that may influence symptom presentation and treatment preferences
- Involve family members when appropriate and with patient consent

# Sources and References

The PHQ-9 and its clinical guidelines have been developed and validated through extensive research. The following sources provide the foundation for the recommendations in this document:

## Primary References


- Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.
- Spitzer RL, Kroenke K, Williams JB. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. JAMA. 1999;282(18):1737-1744.
- Löwe B, Unützer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care. 2004;42(12):1194-1201.


## Clinical Guidelines


- American Psychiatric Association. Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition. 2010.
- National Institute for Health and Care Excellence (NICE). Depression in adults: recognition and management. Clinical Guideline [CG90]. Published 2009, updated 2018.
- MacArthur Foundation Initiative on Depression and Primary Care. Depression Management Tool Kit. 2009.


## Additional Resources


- SAMHSA-HRSA Center for Integrated Health Solutions. Screening Tools: PHQ-9 Depression Scale.
- Centers for Medicare & Medicaid Services. Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan.
- World Health Organization. mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings. Version 2.0. 2016.


Note: The recommendations presented in the previous sections should be interpreted in accordance with local treatment protocols and updated clinical evidence.