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CABIN CREEK HEALTH SYSTEMS – DAWES CLINIC

Learning Objectives

1. Development of the PHQ - 9
2. Utility of the PHQ- 9
3. Two methods of scoring the PHQ - 9
4. What about item # 9? What to do when scored 1 or above
5. Experiential learning exercise

Development of the PHQ - 9

- Developed in 1999 by Spitzer, RL and colleagues to be used in primary care settings
- Is one version of the Primary Care Evaluation of Mental Disorders (PRIME-MD)
  - PRIME-MD was designed for criteria based diagnosis of several mental disorders commonly found in Primary Care (e.g., anxiety, depression, alcohol, eating, and somatoform)
- It was based on the DSM-IV and ICD-10 diagnostic criteria for major depressive disorder (MDD)
- It has was initially validated in a large study that include 8 primary care clinics and 7 obstetrical clinics with a total of 9000 participants (Spitzer, RL and colleagues (1999)
- Since then, the PHQ-9 has been translated into many languages, is used worldwide, and it's validity and reliability has been replicated by numerous studies

Utility of the PHQ - 9

- To use with adults
- To be self-administered
- Quick and cost affective
- A quick diagnostic *screening* used for assessing and monitoring depression severity
- Caution about it's diagnostic properties
  - Without a proper assessment, other mood disorders may be missed (e.g., bipolar, hypomanic, dysthymic disorder), bereavement, a physical disorder, and/or medication/drug induced)
  - It is not recommended as a stand alone instrument to give a diagnosis of major depressive disorder (either a clinical interview and/or other instruments such as the Structured Clinical Interview for DSM-5 (SCID-5), should be conducted by a trained provider)

Two methods of scoring the PHQ - 9

- Algorithm method:
  - To diagnose with major depressive disorder:
    - A score of 2 (more than half the days) or higher on item 1 (anhedonia) or on item 2 (depressed mood), plus a score of 2 or higher on five additional items (item #9 counts even if only a score of 1)
    - Other conditions have to be ruled out by a physician, psychiatrist, and/or mental health provider

- Summary score method:
  - Scores range from 0- 27
  - Add up the scores to get a Total Score
  - Scores severity
    - 1-4 = minimal
    - 5-9 – mild
    - 10-14 = moderate
    - 15- 19 = moderately severe
    - 20 – 27 = Severe
- Scoring instructions:
  - If the total score ranges from 0-4, no action is necessary
  - If the total score ranges between 5-9, administer the PHQ-9 again in one month
  - If the total score is 10 or greater, refer for psychological or psychiatric assessment to assess for possible depressive disorder
- Recommended cut off score = 10 or higher

Item #9 “Thoughts that you would be better of dead or of hurting yourself in some way”

- Problems with using Item 9 to screen for suicide risk?
  - Item is unclear
  - It assesses both passive thoughts and the desire for self-harm in a single item
  - Might give false-positives
  - Would not assume that patient is actively suicidal
  - Would also not probe, if you haven’t been trained to assess suicidal risk
  - Useful as an initial screening measure, assessment should be followed with a clinical interview and/or a more structured suicide risk scale (e.g., C-SSRS)
  - Refer to a mental health provider or specialist who has been trained to conduct a suicidal risk assessment

Examples of scored PHQ-9s

Pt. 1

Visit 1: 4/1/18

Total score = 23

Visit 2: 5/1/18

Total score = 20

Pt.2

Visit 1: 2/20/18

Total score = 16

Visit 2: 3/20/18

Total score = 13

Visit 3: 4/26/18

Total score = 6

Pt. 4

Visit 1: 1/2/18

Total score = 6

Visit 2: 2/6/18

Total score = 8

References

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QUESTIONS!