Clinical Toolkit

Clinical Tips: Modified PHQ-9 for use with Aboriginal and Torres Strait Islander Young People

Over the last 2 weeks, how often have you been bothered by any of the following problems? Never/A little/A lot/All the time

1. **Not enjoying things like you used to.**

   (Qualifier: The administrator may ask "What do you normally like doing?" "How often did you enjoy doing that in the last 2 weeks?")
2. **Feeling down, depressed or hopeless.**

   (Qualifier: The word "depressed" may be replaced by "sad" if the young person doesn't understand it).
3. **Trouble falling or staying asleep, or sleeping too much.**
4. **Feeling tired or having little energy.**
5. **Eating more or less than you used to.**
6. **Feeling bad about yourself. Felling shamed or that you have yourself or others down.**
7. **Trouble paying attention to what is going on around you**.

   (Qualifier: If the person doesn't understand this you can ask them: "What do you normally do?" "How often have you been able to pay attention when doing this in the last 2 weeks?").
8. **Moving or speaking so slowly that other people could have noticed?**

   Or the opposite – Being so nervous or restless that you have been moving round a lot more than usual.
9. **Thoughts that you would be better off dead or of hurting yourself or others in some way.**
10. **Have you felt angry?**

Esler et al. (2008). "The Validity of a depression screening tool modified for use with Aboriginal and Torres Strait Islander people". **Aust NZ J public Health** 32(4):317-21

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