Screening for Mental Health

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Depression and Generalized Anxiety Disorder:

A Guide for Health Care Clinicians

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Douglas G. Jacobs, MD
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Dear Clinicians,

The prevalence of depression and generalized anxiety disorder (GAD) in health care settings (15–20% and 8% respectively) increasingly puts the responsibility for diagnosing these disorders into the hands of health care providers. Today, almost 50 percent of patients receive mental health care through their primary health care provider. As a result, health care clinicians need to be well informed about the signs and symptoms of depression and generalized anxiety disorder and how to go about treating these conditions.

For the individual clinician in an office setting, screening is an easy and effective way to identify those patients with undiagnosed depression and GAD, as well as those who may be at serious risk for suicide. In order to help health care clinicians conduct depression and GAD screenings, Screening for Mental Health has developed this Clinician Guide and corresponding pocket cards as well as a screening form (which includes screening tools for depression, bipolar disorder, generalized anxiety disorder and post-traumatic stress disorder) as part of the screening kit provided through National Depression Screening Day®. NDSD provides clinicians with an easy-to-use model and screening kit for use throughout the year. These materials are designed to help you screen, diagnose and initiate treatment for mood and anxiety disorders among your patients. Screening for Mental Health has successfully developed and coordinated in-person and online mood and anxiety disorder screenings on a national basis for over a decade. The screenings are conducted on the local level by military installations, hospitals and other health care facilities, community organizations, primary care offices, colleges, high schools, corporations and health maintenance organizations as a way to promote awareness and early intervention as well as to reduce stigma around mood and anxiety disorders.

Whether you decide to screen all your patients or only the ones you believe may be at risk, I hope that these materials will prove helpful in identifying those patients at risk, deciding on a treatment plan and clarifying when to refer for more specialized care.

Please contact us with any questions or for references, or visit our website listed above.

Sincerely,

Douglas Jacobs

Douglas G. Jacobs, MD
Associate Clinical Professor of Psychiatry, Harvard Medical School
President and CEO
Screening for Mental Health, Inc.

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I. Why Screen for Depression and GAD (Generalized Anxiety Disorder)?

Prevalence

- One in five patients in health care settings show symptoms of some form of clinical depression, while the ratio in the general population is only one in ten.
- Among primary care patients, GAD has an 8% prevalence rate, making GAD the most prevalent anxiety disorder in the primary care setting. Lifetime prevalence rates among the general population are estimated at 5%.

Primary Care Clinicians as Gatekeepers

- Primary care or health care settings represent the first point of entry for many patients with mental health problems.
- The US Preventive Services Task Force has found good evidence that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults identified in primary care settings decreases clinical morbidity.
- Patients with GAD are more likely to seek treatment from a primary care physician than from a psychiatrist and to undergo extensive diagnostic testing in general medical than in psychiatric settings.

II. How to Screen

Depression

- Using the HANDS® questionnaire, a brief self-rating survey that is easy to administer in the office setting, will help you screen your patients (See pages 11–12 for HANDS® scale, instructions and scoring).

GAD

If a patient answers "yes" to either of the following two questions, you should further explore the possibility of GAD:

1. In the past 6 months, have you been bothered by feeling worried, tense or anxious much of the time, and more than is usual for you?
2. Do you frequently have trouble sleeping or experience fatigue, irritability, headaches, muscle aches, trembling, dizziness or stomach discomfort?

- You may decide to screen only those patients you believe to be at risk for depression, suicide or GAD (see risk factors below in Section III). Or, you may decide to screen all of your patients.

In either case, this guide will help you:

- Approach the topic of depression and GAD with patients
- Recognize symptoms of depression and GAD
- Determine who is at risk and how to screen
- Decide when to refer patients to a mental health professional
- Increase your knowledge about recommended medication dosage
- You will be able to treat many patients yourself, but more severe or complicated cases may need to be referred to a psychiatrist or other mental health specialist.

III. Who is at Risk?

Certain patient populations seem to be predisposed to depression and/or GAD. Women, for example, are twice as likely as men to have depression or GAD. The following is a list of risk factors associated with depression and GAD. Patients with more than one of these risk factors have an even higher likelihood of developing these disorders.

- ❑ Female
- ❑ Experienced a recent loss or are experiencing severe stress
- ❑ Personal or family history of mental illness, including depression, suicide or bipolar disorder
- ❑ Chronic or major medical illness:
  - Medical conditions associated with depression include stroke, coronary artery disease, AIDS, cancer, diabetes or chronic pain
  - Medical conditions associated with GAD include chronic fatigue syndrome, irritable bowel syndrome, self-reported peptic ulcer disease, stroke, migraine headache, hypertension, coronary artery disease, chronic pulmonary disease, chronic pain, diabetes
- ❑ Unexplained somatic symptoms and heavy utilization of medical services

- ❑ History of self-medicating behavior, including alcohol or drug use, and
  - In the case of depression, abuse of stimulants (or diet pills), and nicotine
  - In the case of GAD, abuse of sedatives, including marijuana

Additional risk factors specific to depression include:

- ❑ Have any symptoms of depression or suicidal ideation or demonstrate any self-destructive behavior
- ❑ Are in the post-partum period (note that women with a prior history of depression are at greater risk of post-partum depression, psychosis and mania)

IV. Making a Diagnosis

Depression

If your patient has scored positive on the screening indicating that he or she is at risk for depression, the next step is to make a diagnosis concerning the type of depression he or she may have.

There are several forms of depression, including major depression, bipolar disorder/manic depression, and dysthymia, as defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV.* Below are symptoms of the most prevalent forms of depression.

1) Major Depression

Depressed mood for at least 2 weeks accompanied by at least 4 of the following symptoms:

- Loss of pleasure or interest in ordinary activities
- Feelings of guilt, worthlessness, or hopelessness
- Decreased energy, fatigue, unexplained aches/pains
- Difficulty concentrating or making decisions
- Restlessness or irritability, or feeling "slowed down" (psychomotor changes)
- Inability to sleep or oversleeping
- Changes in appetite or weight
- Thoughts of death or suicide

2) Dysthymia

Fewer symptoms than Major Depression but the symptoms present are chronic.

- Depressed mood, more days than not, for at least 2 years
- At least 2 of the symptoms of Major Depression

3) Bipolar Depression

Bipolar Depression is the depressive phase of Bipolar Disorder (also called Manic-Depression). Bipolar Disorder is characterized by mood swings from overly "high" or irritable (mania) to overly sad and hopeless (depression) that may be mild to severe.

- If a patient shows symptoms of depression, it is important to ask about a history of elevated mood or even mildly elevated mood, as this is an important distinguishing feature between Major Depression and Bipolar Disorder, and the treatment for these disorders is different.
- Symptoms of elevated mood (hypomania or mania) include:
  - Extreme irritability, grandiosity, racing thoughts and speech
  - Increased energy, activity and restlessness
  - Reckless behavior or inappropriate judgment, such as spending sprees
- Historical features:
  - Strong genetic link; family history of mood disorders
  - Early age of onset; less than 20 years old
- Treatment requires special care because antidepressant medication without a mood stabilizer can induce agitation, mania or mood instability in some patients

If you suspect the presence of bipolar disorder, the patient should be referred to a psychiatrist

Generalized Anxiety Disorder

If your patient has answered "yes" to either of the two screening questions (see Section II) and has one or more of the risk factors for GAD (see Section III), the next step is to determine whether the patient qualifies for a diagnosis of GAD.

The fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV;1994) requires the following four criteria for a diagnosis of GAD:

1. Excessive anxiety and worry occurring more days than not for at least 6 months

2. The worry is about everyday matters and is not restricted to any particular situation or environment
3. The worry is difficult to control
4. The patient has 3 out of the following symptoms:
    - Restlessness, keyed-up, on edge
    - Fatigue, easy tiring
    - Difficulty concentrating
    - Irritable mood
    - Muscle tension
    - Sleep disturbance (slow onset, awakening, restless and unsatisfying sleep)

Other symptoms include: nausea; gastrointestinal discomfort; difficulty swallowing; diarrhea; cold clammy hands; excessive sweating; jumpiness; jitteriness; anxiety interfering with daily activities and effectiveness; depressive symptoms often mixed in.

However, patients can also present with subthreshold GAD (i.e., they have some symptoms from the above list, but do not meet the full criteria for a DSM IV diagnosis, especially the six month duration criterion). ***Any sub-threshold or full GAD that causes impairment in personal, social, and occupational functioning should be treated.***

V. Clarifying the Diagnosis

Certain medications, psychiatric, medical and psychological conditions can mimic symptoms of depression and GAD. Before confirming your diagnosis, you should rule out any correctable causes for depression and GAD-like symptoms.

Depression

Depressed Mood versus Clinical Depression

Many patients who describe themselves as depressed may not be clinically depressed, and not all patients who have depressive symptoms suffer from clinical depression. Medical conditions or illnesses, medications, marital or financial problems, or bereavement are some factors associated with certain symptoms seen in clinical depression. These persons may instead be suffering from depressed mood or "the blues" – which is *not* clinical depression and which occurs in 25% of patients. Persons suffering from depressed mood may present symptoms of clinical depression, but the presence of these symptoms alone is not sufficient to warrant a diagnosis of clinical depression. Patients with depressed mood often benefit from counseling. A more thorough assessment by a mental health professional may identify the need for a specific type of psychotherapy and/or antidepressant treatment.

Medications that can mimic depression

Individuals taking the following medications may experience some depressive symptoms, but generally do not present sufficient symptoms to be diagnosed with depression. Below are medications to monitor:

- Beta blockers and other antihypertensives
- Steroids
- Cimetidine
- Oral contraceptive pills
- Sedatives, sleeping pills, anti-anxiety drugs

Medical illness that can be associated with depression

It is important to monitor patients with the following illnesses. They may experience psychiatric problems such as depressed mood or unexplained physical abnormalities:

- Acute Intermittent Porphyria
- Addison's Disease
- Alcohol or drug abuse or withdrawal
- Cancer
- Cushing's Disease
- Diabetes
- Electrolyte disorders
- Heavy metal poisoning
- HIV/AIDS
- Hypothyroidism
- Parkinson's Disease
- Stroke
- Temporal Lobe Epilepsy
- Vitamin deficiencies, particularly Folate and/or B12
- Wilson's Disease

GAD

Medications that can mimic or provoke GAD

Individuals who are taking the following medications may experience GAD-like symptoms. These medications should be monitored, especially during the initiation or titration of treatment:

- Antidepressants (including selective serotonin reuptake inhibitors, bupropion, tricyclics,

monoamine oxidase inhibitors; especially early in treatment of depressed patients with prominent anxiety or somatic symptoms)

- β-adrenergics and other sympathomimetics
- Digoxin
- Steroids
- Theophylline
- Thyroxine
- Certain stimulating OTC medications (e.g., ephedrine)

Substance abuse or medication withdrawal

Individuals using or withdrawing from the following substances or medications could also experience GAD-like symptoms:

- Alcohol
- Cocaine or amphetamines
- Caffeine
- Nicotine
- Benzodiazepines
- Some antidepressants, especially short-acting serotonin reuptake inhibitors (notably including paroxetine and venlafaxine) soon after rapid discontinuation

Medical conditions to consider

Patients with the following medical conditions may also experience anxiety. These medical diagnoses should be considered or ruled out before giving a diagnosis of GAD:

- Cushing's disease
- Hyperthyroidism, hyper- or hypoparathyroidism
- Less commonly, carcinoid syndrome, pheochromocytoma, and electrolyte disorders
- Mitral valve prolapse syndrome

Psychiatric conditions to be differentiated from GAD

Patients who have certain psychiatric conditions may also have GAD or may be confused with patients who have GAD. Ninety percent of individuals with GAD will also have another psychiatric disorder at some point in their lives and two-thirds of them will have major depression. Therefore, before settling on a diagnosis of GAD, the following psychiatric conditions must be considered:

- Depression and bipolar disorder
- Social or performance anxiety disorder
- Post-traumatic stress disorder (PTSD)
- Somatization (Briquet's) disorder or hypochondriasis
- Alcoholism or other substance use disorders
- Psychotic disorders
- Personality disorders

In contrast to patients with GAD, whose worries are not restricted to any particular situation or environment, the fear or avoidance in patients with social anxiety disorder is limited to social or performance situations. Unlike patients with GAD, patients with PTSD have a history of trauma and some PTSD-specific symptoms (e.g., re-experiencing or flashbacks, avoidance/numbing, hyper-arousal and startle, sleep disturbances).

VI. Is the Patient Potentially Suicidal?

If you have diagnosed your patient with a form of clinical depression or GAD, you should also determine whether he or she is at risk for suicide.

All forms of clinical depression are risk factors for suicide. GAD can also be a risk factor for suicide. Therefore, it is very important for clinicians to assess their patients for depression and GAD and conduct a thorough suicide risk assessment, inquiring about the items listed below.

Components of Suicidality

- Ideation (thoughts of death, or preoccupation with one's own death or suicide)
- Intent (expectation or belief that self-destructive behavior will lead to death as opposed to altering environment)
- Plan (a specific method of killing oneself and a time and place to do it)
- Means (access to firearms, hoarded drugs, etc.)
- Prior suicidal behavior

Most individuals who are thinking about committing suicide will actually communicate their intent, though the clues can be hard to read.

- ❑ **Listen for clues** in what they say, including phrases like, "*I can't go on*," or "W*hat's the use*"
- ❑ Above all, if you are concerned, **ASK** the patient.

There is a common belief that asking someone about suicide may encourage it. This is not true. On the contrary, most people who are contemplating suicide welcome an invitation to talk about their suicidal feelings and ideas.

***PLEASE NOTE:* We strongly recommend that non-psychiatric clinicians refer suicidal patients to a psychiatrist (see referral section below). However, if a primary care clinician chooses to treat a patient with suicidal tendencies; follow-up should be frequent and regular.**

VII. Approaching the Topic of Depression and/or GAD

As with any diagnosis, you should discuss the diagnosis of depression and/or GAD with your patient. This discussion is often difficult to introduce, especially since many of these patients have come to you, a primary care physician, with only vague somatic symptoms. The following are some ideas found to be helpful in talking about depression and anxiety with patients.

- **Some patients will initiate the conversation themselves; others won't.**

Some patients may mention depressive symptoms, ("I'm not feeling like myself" or "I've been feeling down") or anxiety symptoms, ("I'm a worrier" or "I'm unable to relax"). In other cases, you may initiate the discussion by asking open-ended questions like, "How are things at home?" or "How are things going at work?" If a patient mentions a specific loss or stressor during the visit, you can seize the opportunity and follow up by asking, "How have you been coping?" or "How are you handling it?"

- **Some patients may complain about somatic symptoms (aches, pains, or "nerves") for which a work-up may find no medical basis.**

Patients presenting with vague somatic symptoms require careful attention, as they may be resistant to the idea of having a psychiatric illness due to its stigma. Approach the subject carefully but directly, explaining that physical symptoms are sometimes caused by "stress" and may require a different kind of treatment than the patient is used to receiving. When stress appears to be related to GAD or depression symptoms, we have found it useful to explain that these illnesses are not simply a normal reaction to stress. They are well-recognized disorders, for which treatment is indicated and available.

- **Patients react differently when informed that they are being diagnosed with depression or GAD.**

Approach each patient according to how you sense he or she will best handle what you are about to tell them. Many patients will welcome the diagnosis and find it a relief to learn that their problems are not their fault. Other patients may be resistant to and disturbed by the diagnosis, perhaps viewing it as a sign of personal weakness or a fault in personality.

The following statements or approaches may help to ease the discussion:

- **Depression and GAD are very common conditions.** About 16% of the U.S. population (approximately one in five patients in health care settings) has suffered from depression at some point during their lifetime. About 4–7% of the U.S. population has suffered from GAD at some point during their lifetime.
- **Depression and GAD are medical or biological conditions** involving the brain and nervous system, analogous to the chemical imbalances that may cause other diseases like diabetes or high blood pressure.
- **Depression and GAD are very treatable** and there are several effective ways to approach treatment. These therapeutic approaches include medication, psychotherapy, or their combined use.

VIII. Guidelines for Making a Referral

You may or may not choose to treat the patient with depression and/or GAD yourself. Below are guidelines for making a referral to a mental health specialist.

Consider making a referral to a mental health professional if any of the following are present:

- ❑ If there is a risk of suicide or there is a question about patient safety, or need for hospitalization
- ❑ If you are uncertain about the correct diagnosis
- ❑ If the patient has a complicated psychiatric history with a comorbid diagnosis such as substance abuse, personality disorder, severe depression or a bipolar disorder, suicidality or psychotic symptoms
- ❑ If the patient does not tolerate or respond to an appropriate pharmacologic treatment or requires multiple medications or unusually high doses of antidepressant or antianxiety medicines
- ❑ If you do not feel comfortable treating this patient or choose not to treat this patient

IX. Medications

If you choose to treat the patient with depression or GAD yourself, here are some things you should know about pharmacological treatment:

Classes of Antianxiety Medication

- The standard medication treatment for GAD includes antidepressants, benzodiazepines, buspirone, and hydroxyzine.
- Antidepressants, especially the serotonin reuptake inhibitors (most SSRIs) and the serotonin–norepinephrine reuptake inhibitors (SNRIs, including venlafaxine and duloxetine), are generally a first-line of treatment for GAD and are relatively safe in acute overdoses. FDA-approved options for the treatment of GAD include venlafaxine (SNRI) and paroxetine and escitalopram (SSRIs).
- Benzodiazepines are best limited to short-term treatment and slowly tapered once patients are stabilized on antidepressant therapy for at least 4 weeks. For some patients, short-term treatment may not be feasible; they will require monitoring and a slow tapering schedule.

Selection and Dosage of Antidepressant and Antianxiety Medications

For a list of commonly used antidepressants and antianxiety medications, and dosage recommendations, see Table 1.

Monitoring Medication

- ***Most patients experience a response to antidepressants within 4–6 weeks, but some patients require up to 12 weeks for a response. Note that it will take longer to achieve remission or to be symptom-free.***

  Emphasize this to all patients to prevent disappointment and premature discontinuation. This delayed response is not likely to be well-accepted by patients, and in the case of GAD patients may well require early use of rapidly acting alternatives, including benzodiazepines. For all medications, you may wish to start out with a low dose and work up to a full therapeutic dose in the first weeks, depending on a patient's age, the side effects, and the presence of comorbid conditions.

- **Patients should be carefully monitored**

  You will want to monitor to gauge side effects, promote treatment adherence, avoid demoralization before the onset of beneficial effects, and monitor for suicidality. The frequency of visits should depend upon the severity of the illness, presence of comorbid medical problems, availability of social supports, and the patient's cooperation during the initial phase of treatment.

- **About 70–80% of depression patients and 50–70% of GAD patients will respond to pharmacotherapy.**

  For those who do not respond to pharmacological treatment, referral and/or consultation with a mental health specialist may be helpful. Once a full response is achieved, you should continue to monitor the patient. In order to avoid relapses, it is often necessary to continue the patient on the same dose of medication for at least 6 months after a full response is achieved.

Duration of Treatment

Depression

Since more than half of all patients with a major depressive episode will experience at least a second one, many patients will continue to require antidepressant treatment.

GAD

GAD is a chronic illness with high relapse rate. Most GAD patients require long-term therapy of at least 6–12 months duration. Long-term studies of treatments and outcomes in GAD remain rare. The chronicity implies that short-term interventions are often inadequate.

Discontinuation

When the decision is made to discontinue treatment, a gradual tapering of any anti-anxiety or antidepressant medication is essential, perhaps with a combination of psychotherapy. This practice minimizes risk of withdrawal-associated symptoms in those taking antianxiety medications. A slow tapering of benzodiazepines and SSRIs over several weeks may be necessary to avoid withdrawal symptoms. Tapering also allows for timely detection of emerging depression or anxiety symptoms and recurrences and, if necessary, a patient can be returned to full therapeutic levels.

Side Effects

- Side effects are the most common cause of **medication noncompliance**.
- **The side effect profile should be considered** when choosing a medication because side effects vary even among medications from the same class.

Physicians should review a reference, such as the Physician's Desk Reference (PDR), before prescribing unfamiliar medications.

- **Discuss the side effects** as well as the benefits of medications in advance, so patients can participate in the decision-making process and will be mentally prepared for any side effects that may arise.
- **Counteracting side effects**: Many side effects clear up after a few days of treatment, as the body becomes accustomed to the medication, especially if early dosing is done slowly and carefully. In other cases, however, side effects may prove unmanageable, and may warrant a decrease in dose or a switch to another medication.

Special Populations

- **Elderly patients**: The motto with elderly patients is "start low and go slow." Use medications that have more benign side effect profiles. For example, avoid medications associated with orthostatic hypotension to reduce the risk of falls. With elderly patients, you may also want to choose medications that have less cognitive impairing or anticholinergic effects. Benzodiazepines should be used very cautiously, if at all, with elderly patients; even quetiapine may be a better option.
- **Pregnant and nursing women**: SSRIs and tricyclic antidepressants are generally considered safe for use in pregnant and nursing women, although newborns who have been exposed to SSRIs and SNRIs during the late third trimester should be monitored for possible withdrawal or toxicity symptoms. There is also some evidence of an association of mid-line facial defects (cleft lip or palate) of fetuses exposed to benzodiazepine. However, maternal anxiety disorder may pose more danger to a fetus or a baby than medication.

  If a woman discovers that she is pregnant while she is already taking a medication, the fetus has most likely already been exposed to that drug for several weeks. If that drug has been effective, changing to a different medication, especially abruptly, may not be prudent. An individual assessment of the risks and benefits of continuing or changing therapy is necessary. Factors to consider would include effectiveness of the medication, alternative therapies, known risks to the fetus, and the number of weeks of gestation completed.
- **Patients with liver disease**: Care must be taken with patients who have liver disease since antidepressants are mainly metabolized in the liver. Liver function needs to be monitored in such patients.
- **Seizure threshold**: Antidepressants have the potential to decrease the seizure threshold.

Awareness of Drug-Drug Interactions

Antidepressants may have interactions with other medications via the Cytochrome P450 system. This system comprises a family of liver enzymes, which are involved in the metabolism of many medications. Some medications interfere with the metabolism of other medications, either by P450 induction (increased activity) or by inhibition (decreased activity). Altered metabolism by the P450 system can result in increased or decreased plasma levels of the different drugs the patient is taking.

X. Psychotherapy

The literature demonstrates that a combination of pharmacotherapy and psychotherapy is the most effective treatment for depression and GAD. Patients can be offered the opportunity for psychotherapy and referred to a mental health specialist. A mental health specialist should be consulted regarding which type of psychotherapy is most appropriate for the patient.

XI. Resources

Further information can be obtained from the following Web sites:

American Psychiatric Association
www.psych.org

National Institute of Mental Health
www.nimh.nih.gov/healthinformation/anxietymenu.cfm

Anxiety Disorders Association of America
www.adaa.org

National Anxiety Foundation
www.lexington-on-line.com/naf.html

American Board of Professional Psychology
www.abpp.org

Academy of Cognitive Therapy
www.academyofct.org

XII. Table 1: List of Commonly Used Antidepressant and Antianxiety Medications

Revised as of July 2006

Generic Name	*Starting Dose (mg/day)*[a]	*Usual Dose (mg/day)*
Tertiary amine tricyclics		
Amitriptyline	25–50	100–300
Clomipramine	25	100–250
Doxepin	25–50	100–300
Imipramine	25–50	100–300
Trimipramine	25–50	100–300
Secondary amine tricyclics		
Amoxapine	50	100–400
Desipramine	25–50	100–300
Maprotiline	50	100–225
Nortriptyline	25	50–200
Protriptyline	10	15–60
Selective serotonin reuptake inhibitors		
Citalopram	20	20–60
Escitalopram	10	10–20
Fluoxetine	20	20–60
Fluvoxamine	50	50–300
Paroxetine	20	20–50
Paroxetine CR	12.5	12.5–37.5
Sertraline	50	50–200
Serotonin-norepinephrine reuptake inhibitors		
Duloxetine	20	40–60
Venlafaxine	37.5	75–225
Venlafaxine, XR	37.5	75–225
Dopamine-norepinephrine reuptake inhibitors		
Bupropion[b]	150	300
Bupropion, sustained release	150	300
Serotonin modulators		
Nefazodone	50	150–300
Trazodone	50	75–300
Norepinephrine-serotonin modulator		
Mirtazapine	15	15–45
Monoamine oxidase inhibitors (MAOIs)		
Irreversible		
Phenelzine	15	15–90
Selegiline patch	6	9–12
Tranylcypromine	10	30–60

Continued on next page

Generic Name	*Starting Dose (mg/day)*[a]	*Usual Dose (mg/day)*
Reversible MAOI-A		
Moclobemide	150	300–600
Benzodiazepines		
Alprazolam	0.25–0.5	0.25–4
Chlordiazepoxide	10	100
Clonazepam	0.25–0.5	0.5–6
Clorazepate	7.5–15	15–60
Diazepam	2–5	5–30
Estazolam	1	1–2
Flurazepam	15	15–30
Lorazepam	1–2	2–6
Quazepam	7.5	7.5–15
Other sedatives		
Hydoxyzine	25	25–100
Buspirone	15	15–60

Physicians: consult the PDR before prescribing.

[a] Lower starting doses are recommended for elderly patients and for patients with hepatic impairment, general comorbidity, or a high level of anxiety about taking medication.

[b] These medications are likely to be optimal medications in terms of the patient's acceptance of side effects, safety, and quantity and quality of clinical trial data.

American Psychiatric Association (2000). In American Psychiatric Association *Practice Guidelines for the Treatment of Psychiatric Disorders,* (pp. 413–495). Washington, DC: American Psychiatric Association.

XIII. HANDS® Screening Form
Sample Scored Form and Instructions

1. The value for each answer is indicated below. Add the total across and enter that value in the box at the end of each line. *Please note that column one for each section will always score zero points, column two will score 1 point, etc.*
2. For each section, add all the numbers down in the far right-hand column and record the total in the box marked "Total Score."
3. The total for questions 1–10 is the HANDS® score.

THE HANDS® SCREENING TOOL

■ **Over the past TWO WEEKS, how often have you:**	None or little of the time	Some of the time	Most of the time	All of the time	For Staff Use Only
1. been feeling low in energy, slowed down?	0	1	2 ✔	3	2
2. been blaming yourself for things?	0	1 ✔	2	3	1
3. had poor appetite?	0 ✔	1	2	3	0
4. had difficulty falling asleep, staying asleep?	0	1	2 ✔	3	2
5. been feeling hopeless about the future?	0	1 ✔	2	3	1
6. been feeling blue?	0	1	2	3 ✔	3
7. been feeling no interest in things?	0	1	2 ✔	3	2
8. had feelings of worthlessness?	0	1	2 ✔	3	2
9. thought about or wanted to commit suicide?	0 ✔	1	2	3	0
10. had difficulty concentrating or making decisions?	0	1	2	3 ✔	3
				Total Score:	16

Scoring Interpretation

CLINICIAN — For questions #1-10, use the following HANDS® cutoff scores to determine the likelihood of a diagnosis of clinical depression. As the number and intensity of depressive symptoms increase from mild to severe levels, so does the HANDS® total score.

Total Score	Interpretation	Referral Guidelines
0–8	Symptoms are not consistent with a *major depressive episode*. Presence of a major depressive disorder is **unlikely**.	A complete evaluation is not **recommended**, except in the case of a positive response to the ***suicide question*** (item 9) or other clinical indications elicited during the screening interview.
9–16	Symptoms are consistent with a *major depressive episode*. Presence of a major depressive disorder is **likely**. In a self-selected population, such as seen on National Depression Screening Day, it is also possible the person instead suffers from a DSM-IV *anxiety disorder*.	A complete evaluation is **recommended**. In a self-selected population, the clinician should consider the possibility of the presence of an *anxiety disorder* instead of, or as well as, *a major depressive episode*. Severity level is typically mild or moderate, depending upon the degree of impairment.
17–30	Symptoms are strongly consistent with criteria for a *major depressive episode*. Presence of major depressive disorder is **very likely**.	A complete evaluation is **strongly recommended.** In this higher range, the severity level may be more severe and require immediate attention.
Note	Further evaluation is suggested for any individual who scores 1 point or more on the **suicide question** (Item 9), regardless of the total score on the HANDS®.	

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Douglas G. Jacobs, M.D., President and CEO

Screening for Mental Health, Inc. (SMH), a non-profit organization based in Greater Boston, pioneered and currently provides national programs of mental health education and screening for military installations, general and psychiatric hospitals, mental health clinics, social service and governmental agencies, primary care clinicians, employers, healthcare organizations, colleges and high schools. The screening programs are available in two formats: one-day, in-person screening events and year-round, online screening. All programs provide comprehensive materials and screening tools that promote early detection and intervention of common, under-diagnosed and treatable mental health disorders including depression, bipolar disorder, suicide intervention, generalized anxiety disorder, post traumatic stress disorder, alcohol problems, and eating disorders.

SMH's programs support clinicians to screen patients for mood and anxiety disorders during routine office visits on or around October's National Depression Screening Day, and for alcohol problems on or around April's National Alcohol Screening Day. The goal is to help establish mental health screening as an integral part of preventive and routine medical care.

Douglas G. Jacobs, M.D., the organization's President and CEO, is a Harvard affiliated, clinical psychiatrist and nationally recognized expert on depression and suicide. In 1991, Dr. Jacobs spearheaded the country's first large-scale mental health screening initiative, National Depression Screening Day®.

Over the years, SMH's programs and events have motivated hundreds of thousands of people to get needed treatment and to overcome the stigma surrounding mental illness.

Screening for Mental Health, Inc. is a non-profit 501(c)(3) organization supported by federal, foundation and corporate grants, as well as registration fees from participating organizations.