# *Scoring Instructions and Interpretation*

**HANDS Screening Tool**

## HANDS® Screen for Depression

1. Record the numerical value of each answer in the "Staff Use Only" box at the end of each line. An answer of:

| | |
|---|---|
| "None or little of the time" | = 0 |
| "Some of the time" | = 1 |
| "Most of the time" | = 2 |
| "All of the time" | = 3 |

2. Add all the numbers in the "Staff Use Only" column and record the total in the box marked Total Score.

3. Use the following HANDS cutoff scores to determine the likelihood of a diagnosis of clinical depression:

| 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 that 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.

**MDQ Screening Tool**

## Mood Disorder Questionnaire© for Bipolar Disorder

Record the number of "Yes" statements for question number 1 in the box marked Total Score. The answers to questions number 2 and 3 will not be included in this Total Score.

**The individual is considered positive for Bipolar Disorder if they answered:**

1. "Yes" to 7 of the 13 items in question number 1

**AND**

2. "Yes" to question number 2

**AND**

3. "Moderate" or "Serious" to question number 3

All three of the criteria above should be met. A positive screen indicates that the person should be evaluated for Bipolar Spectrum Disorder.

**GAD Screening Tool**

## Carroll-Davidson Generalized Anxiety Disorder© Screen

Record the total number of YES responses to the 12 statements in the Total Score box. Use the following GAD cutoff scores to determine the likelihood of a GAD diagnosis:

| Total Score | Interpretation | Referral Guidelines |
|---|---|---|
| 0-5 | Symptoms not suggestive of GAD. | A complete evaluation is **not recommended.** |
| 6 or above | Symptoms suggestive of GAD. | A complete evaluation is **recommended.** |

Note:

- In studies, patients with scores of 6 or above who did not have a final GAD diagnosis had other important psychiatric problems, most often major depression or another anxiety diagnosis.
- A score of 0-2 during treatment of a patient with GAD is consistent with remission of the disorder.

**SPRINT-4 Screening Tool**

## SPRINT-4© Screen for PTSD

Record the total number of YES responses to the 4 statements in the Total Score box. Use the following SPRINT-4 cutoff scores to determine the likelihood of a PTSD diagnosis:

| Total Score | Interpretation | Referral Guidelines |
|---|---|---|
| 0-1 | Symptoms not consistent with PTSD. | A complete evaluation is **not recommended.** |
| 2-3 | Symptoms may be consistent with PTSD. | Further evaluation is **recommended.** |
| 4 | Symptoms correspond to PTSD. | A complete evaluation is **strongly recommended.** |

# NATIONAL DEPRESSION SCREENING DAY® – ADULT SCREENING FORM

Participant No. ______

1) Age: __________

2) Sex: __________ (M/F)

3) Current Marital Status:
- ☐ Divorced / Separated
- ☐ Living with Partner
- ☐ Married
- ☐ Never Married
- ☐ Widowed

4) Ethnic / Racial Group:
- ☐ African American
- ☐ American Indian
- ☐ Asian American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Other

5) Have you ever been treated for:
(Check all that apply)

| | Yes | No |
|---|---|---|
| Depression | ☐ | ☐ |
| Bipolar Disorder | ☐ | ☐ |
| Generalized Anxiety Disorder | ☐ | ☐ |
| Post-Traumatic Stress Disorder | ☐ | ☐ |
| If yes: Did treatment include medication | ☐ | ☐ |

6) Have you ever been treated for:
(Check all that apply)
- ☐ Alcohol Abuse
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Heart Disease/Stroke
- ☐ HIV
- ☐ Seizure Disorder
- ☐ Thyroid Problem
- ☐ None of the above

7) Have you ever attempted suicide: Yes ☐ No ☐

## THE HANDS® DEPRESSION SCREENING TOOL (The Harvard Department of Psychiatry / National Depression Screening Day® Scale)

| ■ 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 | Staff Use Only |
|---|---|---|---|---|---|
| 1. been feeling low in energy, slowed down? | | | | | |
| 2. been blaming yourself for things? | | | | | |
| 3. had poor appetite? | | | | | |
| 4. had difficulty falling asleep, staying asleep? | | | | | |
| 5. been feeling hopeless about the future? | | | | | |
| 6. been feeling blue? | | | | | |
| 7. been feeling no interest in things? | | | | | |
| 8. had feelings of worthlessness? | | | | | |
| 9. thought about or wanted to commit suicide? | | | | | |
| 10. had difficulty concentrating or making decisions? | | | | | |
| | | | | Total Score: | |

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## THE MOOD DISORDER QUESTIONNAIRE

| ■ Please answer each question as best you can. | YES | NO | Staff Use Only |
|---|---|---|---|
| 1. Has there ever been a period of time when you were not your usual self and... | | | |
| ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | ☐ | ☐ | |
| ...you were so irritable that you shouted at people or started fights or arguments? | ☐ | ☐ | |
| ...felt much more self-confident than usual? | ☐ | ☐ | |
| ...you got much less sleep than usual and found you didn't really miss it? | ☐ | ☐ | |
| ...you were much more talkative or spoke much faster than usual? | ☐ | ☐ | |
| ...thoughts raced through your head or you couldn't slow your mind down? | ☐ | ☐ | |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? | ☐ | ☐ | |
| ...you had much more energy than usual? | ☐ | ☐ | |
| ...you were much more active or did many more things than usual? | ☐ | ☐ | |
| ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | ☐ | ☐ | |
| ...you were much more interested in sex than usual? | ☐ | ☐ | |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky? | ☐ | ☐ | |
| ...spending money got you or your family into trouble? | ☐ | ☐ | |
| | | Total Score: | |
| 2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? | ☐ | ☐ | |

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?
Please check (✓) **one response only.** ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

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This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

**See reverse for additional screening tools**

**CLINICIAN: FILL OUT SCREENING RECOMMENDATION SECTION (See gray box on reverse side)**

## CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN©

| ■ **These questions are to ask about things you may have felt most days in the past six months.** | YES | NO | Staff Use Only |
|---|---|---|---|
| 1. Most days I feel very nervous. | ☐ | ☐ | |
| 2. Most days I worry about lots of things. | ☐ | ☐ | |
| 3. Most days I cannot stop worrying. | ☐ | ☐ | |
| 4. Most days my worry is hard to control. | ☐ | ☐ | |
| 5. I feel restless, keyed up or on edge. | ☐ | ☐ | |
| 6. I get tired easily. | ☐ | ☐ | |
| 7. I have trouble concentrating. | ☐ | ☐ | |
| 8. I am easily annoyed or irritated. | ☐ | ☐ | |
| 9. My muscles are tense and tight. | ☐ | ☐ | |
| 10. I have trouble sleeping. | ☐ | ☐ | |
| 11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress? | ☐ | ☐ | |
| 12. Were the things you noted above bad enough that you thought about getting help for them? | ☐ | ☐ | |
| | | **Total Score:** | |

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## MODIFIED SPRINT (SPRINT-4©) PTSD SCREEN

*If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either:*

| ■ **Please respond to these questions about how you have felt most days in the past week.** | YES | NO | Staff Use Only |
|---|---|---|---|
| 1. Have you been bothered by unwanted memories, nightmares, or reminders of this event? | ☐ | ☐ | |
| 2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened? | ☐ | ☐ | |
| 3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings? | ☐ | ☐ | |
| 4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you? | ☐ | ☐ | |
| | | **Total Score:** | |

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## THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

### PLEASE RETURN THIS FORM TO STAFF FOR SCORING.

## SCREENING RECOMMENDATION (TO BE FILLED OUT BY CLINICIAN ONLY)

■ **I spoke with the participant and recommended: (Check all that apply)**

Follow-up for: ☐ Depression ☐ Bipolar Disorder ☐ No follow-up needed
☐ Generalized Anxiety Disorder ☐ Post-Traumatic Stress Disorder

■ **If a Community-Based Site:**
- ☐ Outpatient Referral
- ☐ Inpatient Referral
  - ☐ Voluntary
  - ☐ Emergency

■ **If a Primary Care Facility:**
- ☐ Treated in office
- ☐ Referred Elsewhere
- ☐ Emergency