The Reliability and Validity of a Brief Self-Report Questionnaire to Screen for Mental Health Problems: The Health Dynamics Inventory

Stephen M. Saunders^{1,3} and James V. Wojcik²

Mental health problems are underrecognized in medical settings, leading to inadequate treatment. The present paper describes the development of the Health Dynamics Inventory (HDI), a brief, self-report questionnaire developed to evaluate mental health functioning. The HDI was written to evaluate the three aspects of mental disorders as described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*: (1) the experience of emotional or behavioral symptoms; (2) emotional distress; and (3) psychosocial impairment. This study evaluated the psychometric properties and construct validity of its items, scales, and subscales. Results indicated that the items distinguish patients from nonpatients, that the instrument's scales and subscales are reliable, and that the scales and subscales discriminates between persons with mental health concerns or diagnosable problems and those without such concerns or problems. The utility of the instrument for screening mental health problems in primary care settings is discussed.

KEY WORDS: mental health; screening questionnaire; self-report questionnaire.

The "service gap" between the need for and actual treatment of mental health problems is well-documented. Research indicates that approximately one in six adults will meet criteria for a mental illness in any given year (Narrow, Rae, Robins, & Regier, 2002). Although there are numerous effective interventions (cf. Lipsey & Wilson, 1993), mental health problems are seriously undertreated (Kessler et al., 1994; Narrow, Regier, Rae, Manderscheid, & Locke, 1993). One study found that only 40% of persons with a serious mental illness had received any treatment in the previous year, and that less than 40% of those had received "minimally adequate" treatment (Wang, Demler, & Kessler, 2002).

The underrecognition and undertreatment of mental health problems is a substantial public health

concern (Kessler et al., 2003), allowing unnecessary distress, suffering, and emotional hardship that affects both the ill individual and families. The impairment or disability associated with mental illness is greater than that associated with all but the most severe medical illnesses (e.g., Murray & Lopez, 1996; Wells et al., 1989). A conservative estimate of the financial cost of mental illness is \$80 billion per year (Rice & Miller, 1996).

The reasons for undertreatment of mental health problems are myriad and complex, and include problems of access, the stigma attached to mental illness, and misinformation about treatment options (Corrigan & Penn, 1999; Hirschfeld et al., 1997). Undertreatment is also related to poor recognition of mental illness in medical settings (Miranda, Mohmann, & Attkisson, 1994; Simon & VonKorff, 1995). Most mentally ill individuals who seek mental health care do so from the general medical sector (Regier et al., 1993), but primary care clinics often fail to evaluate, recognize, or treat mental illness appropriately (Leaf, 1994; Mechanic, 1990; Rogers, Wells, Meredith, Sturm, & Burnam, 1993;

¹Department of Psychology, Marquette University, Milwaukee, Wisconsin.

²Human Services, Inc., Oakdale, Minnesota.

³Correspondence should be addressed to Stephen M. Saunders, Department of Psychology, Marquette University, P.O. Box 1881, Milwaukee, Wisconsin 53233; e-mail: stephen.saunders@mu.edu.

Vazquez-Barquero et al., 1997; Wang, Berglund, & Kessler, 2000). For example, one study found that over 80% of adults with a likely depressive or anxiety disorder saw a health care provider, usually a primary care physician. Only 30% received any appropriate treatment, and the likelihood of treatment was substantially less when care was sought from a physician (less than 20%) than from a mental health specialist (90%; Young, Klap, Sherbourne, & Wells, 2001).

Improving the detection of mental illness in medical care settings might help close the gap between need and care (cf. Hirschfeld et al., 1997). Other reasons to improve mental illness detection include generating evidence of such problems so that patients might be persuaded of the need for mental health care or a referral, and the documentation of mental illness to convince health care payers that specialized treatment is necessary. Furthermore, the detection of a case in need of treatment only begins the assessment process, as research has identified premature termination of treatment as a major health risk. Indeed, treatment guidelines recommend the ongoing evaluation of treatment effects (Agency for Health Care Policy Research, 1993).

There have been several efforts to improve the detection of mental illness in primary care settings (e.g., Carlat, 1998) with varying levels of success (Kroenke, Taylor-Vaisey, Dietrich, & Oxman, 2000). Some have advocated for complex evaluation procedures, involving special personnel or training of current providers. For example, the PRIME-MD has been shown to have excellent accuracy in diagnosing major psychiatric disorders (Spitzer et al., 1994), but it has not been widely adopted because it is time intensive and takes special training to administer (Maurer, 1996). Others have demonstrated that relatively brief and easy-to-learn interview skills can greatly enhance the likelihood of a physician detecting a patient's emotional distress (Roter et al., 1995).

Attempts to improve the recognition of mental illness in such settings must occur within the constraints of primary care practice, such as the central task of medical evaluation and time limitations (Eisenberg, 1992; Lemelin, Hotz, Swensen, & Elmslie, 1994) and the limited training of medical personnel in mental health concerns (Broadhead, 1994; Eisenberg, 1992). For these reasons, others have advocated for screening approaches wherein primary care patients complete self-report questionnaires (cf. Mulrow et al., 1995). The present study evaluates a measure that might be used for that purpose.

The present paper describes the development of the Health Dynamics Inventory (HDI), a relatively brief, easy-to-use, self-report questionnaire developed to evaluate mental health functioning. The HDI was written to evaluate the three aspects of mental disorders as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*: "clinically significant behavioral or psychological syndrome or pattern . . . associated with present distress . . . or disability" (American Psychiatric Association [APA], 1994, p. xxi). Accordingly, the HDI assesses (1) the experience of emotional or behavioral symptoms that define mental illness, such as dysphoria, worry, angry outbursts, low self-esteem, or excessive drinking, (2) the level of emotional distress related to these symptoms, and (3) the impairment or problems fulfilling the major roles of one's life being exhibited. The present study evaluated the psychometric properties and construct validity of the HDI.

METHOD

Development of the HDI

The HDI asks respondents to consider their experiences during the previous 2 weeks, as this time frame maximizes the likelihood that the person will accurately recall and report problems relatively accurately (cf. Schwarz, 1999). The HDI comprises three major scales: morale (the opposite of distress), symptoms, and impairment. The symptoms and impairment scales comprise seven and three subscales, respectively.

Morale Scale

Distress was operationalized on the HDI as low levels of subjective well-being or "morale" (cf. Ware, Gandek, & IQOLA Project Group, 1994). A review of measures of well-being suggested that they tend to evaluate contentment, satisfaction with life, hopefulness, recurrent positive affect, and a sense of well-being and happiness (Andrews & Robinson, 1991). The Morale Scale of the HDI comprises four items that ask respondents to rate the level of their mental health, distress, contentment, and happiness over the past 2 weeks.

Symptoms Scale and Subscales

The symptoms exhibited or experienced determines whether a person meets criteria for a particular

mental disorder. It would be impossible for a practicable screening instrument to assess all of the symptoms of all *DSM* disorders. Therefore, the HDI was developed to assess the most frequently occurring ones, according to epidemiological research. Surveys consistently find that anxiety, depression, and the substance use disorders are the most commonly occurring in the general population (Kessler et al., 1994; Regier et al., 1993). The most common problems presented to mental health clinics include depression, anxiety, difficulty concentrating, eating disorders, anger management problems, and adjustment problems (Burststein, Loucks, Rasco, & Green, 1993).

Accordingly, the Global Symptom Scale of the HDI includes 32 symptoms categorized into seven subscales. The Depression Subscale contains nine items that evaluate affective (sad mood, anhedonia, mood swings), cognitive (self-esteem problems, difficulty expressing oneself, thoughts about death or suicide) and somatic (appetite and sleep problems, fatigue) problems associated with major depressive disorder and dysthymia. The Anxiety Subscale includes six items that evaluate commonly experienced anxiety symptoms: general anxiety, panic, worry, somatic symptoms, nightmares, and intrusive impulses. The Attention Problems Subscale comprises only two items evaluating problems paying attention and racing thoughts or excess energy.

The four items of the Substance Use Concerns Subscale ask about common affective (cravings, feeling guilty) and behavioral (using excessively, lying) aspects of alcohol and drug use problems. The four items of the Unusual Thoughts/Experiences Subscale include two that assess delusions (odd beliefs, feelings of being controlled), one that asks about auditory or visual hallucinations, and one that evaluates racing thoughts or excessive energy (also included in the Attention Problems subscale). The Eating/Weight Concerns Subscale includes four items assessing the behavioral (purging, binge eating) and cognitive (fear of weight gain, being troubled by one's body) symptoms associated with the eating disorders. The Behavior Problems Subscale comprises four items. Three assess problems with anger management (angry outbursts, using force, and feeling out of control), and the other assesses problems with sexual interest, impulses, or behavior.

The response options for all symptoms ask about the frequency of the problems at a certain level of severity. The header reads "How often have you been bothered by the following in the past two weeks?" The response options are "Not at all," "Rarely (once

per week or less)," "Occasionally (2–4 days a week)," "Almost every day," and "Several times per day or more."

Impairment Scale and Subscales

The HDI evaluates functioning in three primary roles: occupational, social relationships, and self-care. Problems fulfilling these roles are typical of concerns commonly presented to outpatient clinics (cf. Burststein et al., 1993). The Global Impairment Scale of the HDI contains 12 impairment items that constitute three subscales.

The four items of the Occupational/Task Impairment Subscale evaluate difficulty initiating and concentrating on tasks, as well as problems meeting the demands of and being interested in one's occupation (either as worker or student). The Relationship Impairment Subscale contains four items that evaluate difficulty having relationships with important others, meeting obligations to family, and functioning sexually. The four items of the Self-Care Impairment Subscale evaluate ability to maintain good diet or health habits, to enjoy leisure activities, to use friends for support, and to do things to promote positive self-regard.

The header of the impairment scale emphasizes that difficulty is caused by emotional problems: "Rate how much difficulty emotional or behavioral problems cause in your ability to do the following." The response options are the same for all of the impairment items: "No difficulty at all," "A little bit of difficulty," "Quite a bit of difficulty," and "A great deal of difficulty." The respondent is instructed "check NA [not applicable] if the item does not apply to you."

Creating Scale and Subscale Scores

Scale and subscale scores are created by assigning numerical values to each of the possible responses and summing the items constituting the scale or subscale. For the Morale Scale, responses indicating greater or more frequent distress were assigned a value of 1, whereas responses indicating less distress were assigned a value of 5. Calculated as the sum of the four items, relatively high scores on the Morale Scale indicate greater morale, whereas low scores indicate less morale or greater distress.

Symptom item responses were assigned numerical values so that higher scores indicated more frequent or intense experience of the symptom (range 1–5). To calculate the Global Symptoms Scale score,

all 32 symptom items are summed. Subscale scores are created by summing the items of the subscale.

Responses to the impairment items were also assigned numerical values so that higher scores indicated more impairment (range 1–4). For the Global Impairment Scale, the 12 items are summed. Subscale scores are created by summing the items of that subscale. If the response is “NA” to an item, the average of the other subscale items is substituted. Accordingly, higher scores indicate greater impairment.

Readability, Ease of Use, and Administration Time

The HDI was written to be easily understood by persons with varying degrees of education, disability, and disturbance. Items were written using nontechnical language while still covering relevant symptoms and problems. According to Flesch-Kincaid Grade Level readability analyses (Flesch, 1974), the HDI can be understood by persons with a sixth-grade reading capacity. The HDI's format emphasizes ease of use by clustering similar items together, which minimizes required mental shifts as respondents complete it. For example, items assessing depression are grouped together. Likewise, respondents respond to all of the HDI items using the same response categories (frequency of occurrence). In a small sample ($n = 100$ college students) of the general population, 73% of the respondents completed the HDI within 10 minutes, and all completed it within 15 minutes.

Clinician-Reported Information

For this study, clinicians were asked to record information about their patients who completed the HDI, including diagnostic information, the number of sessions administered to date, and treatment information. Several clinicians reported that it took them less than 5 minutes to complete this page.

Clinicians also rated the levels of distress and impairment of the client. To rate the level of distress, clinicians answered the question “How distressed or disturbed is this patient?” on a 5-point scale (*Not at all* = 1; *Somewhat* = 2; *Moderately* = 3; *Very* = 4; *Extremely* = 5). To rate the level of impairment, clinicians made three ratings regarding “the impairment being exhibited by this patient with regard to occupational and task impairment (i.e., meeting obligations at work, school, or home; initiating and completing assignments or tasks; absenteeism, tardiness),” “with regard to relationship impairment (i.e., meeting obli-

gations; having good relationships at home and work; involvement in social activities),” and “with regard to self-care impairment (i.e., leisure activities, tasks of daily living, obtaining appropriate health care, doing things to enhance self-esteem).” Impairment was rated on a 5-point scale (*None* = 1; *Some* = 2; *Moderate* = 3; *Much* = 4; *Extreme* = 5) with the option of reporting “Don't know” (which was not given a numerical value).

Data Collection

HDI's are collected as part of the standard intake procedure at a large outpatient behavioral health clinic in Minnesota. First developed in 1995, the HDI was extensively revised in 1998 to make it shorter and to incorporate needed changes in items and scales. Since its revision, the HDI has been taken by over 4,500 patients (mental health outpatients and inpatients).

As part of the normative data collection, the HDI was also administered to over 1,500 nonpatient volunteers at various sites around the country. This required rewording one of the Morale items: “How distressed have you been in the past two weeks because of the problem for which you are seeking treatment?” became “How distressed have you been in the past two weeks?”

Matched subsamples were drawn from each of these larger samples. First, a sample of 500 patients was randomly selected. Next, an equal number of nonpatients was drawn from the nonpatient sample based on matching characteristics of gender, age, and marital status (the characteristics available from both patients and nonpatients). Exploratory data examination was conducted. Cases with over 10% incomplete information and their matched case were dropped. This resulted in the elimination of 23 pairs of cases.

The demographic characteristics of the 954 participants used in these analyses are shown in Table I. Diagnostic information on the patient subsample was available from clinicians. All but 57 of the patients were given diagnoses.

RESULTS

Reliability Analyses

The results of the reliability analyses are shown in Table II. The internal consistencies of the scales and subscales of the HDI were computed using Cronbach's alpha coefficient for the whole sample, for the

Table I. Participant Demographics

	All participants (<i>N</i> = 954)	Patients (<i>N</i> = 477)	Nonpatients (<i>N</i> = 477)
Gender			
Female	487 (51.0%)	243 (50.9%)	244 (51.2%)
Male	467 (49.0%)	234 (49.1%)	233 (48.8%)
Age group			
18–29	240 (25.1%)	120 (25.1%)	120 (25.1%)
30–49	449 (47.0%)	225 (47.2%)	224 (46.9%)
50–69	227 (23.8%)	114 (23.9%)	113 (23.7%)
70–84	38 (4.0%)	18 (3.8%)	20 (4.2%)
Mean age (<i>SD</i>)	40.7 (14.6)	40.7 (14.6)	40.7 (14.6)
Marital status			
Single	277 (29.0%)	136 (28.5%)	141 (29.6%)
Married or remarried	439 (46.0%)	213 (44.7%)	226 (47.4%)
Live with romantic partner	54 (5.7%)	30 (6.3%)	24 (5.0%)
Sep/Div/Widowed	184 (19.3%)	98 (20.5%)	86 (18.0%)
Ever received outpatient counseling for an emotional or psychiatric problem?			
Yes	385 (40.9%)	262 (56.5%)	123 (25.8%)
Ever been hospitalized for an emotional or psychiatric problem?			
Yes	69 (7.3%)	50 (10.7%)	18 (3.8%)
Yes, more than once	39 (4.1%)	39 (8.4%)	0 (0.0%)

patient subsample, and for the nonpatient subsample. The split-half (Guttman) statistic was calculated for the whole sample of patients and nonpatients. The reliabilities of the scales and subscales were high enough to be acceptable.

The reliability for the Attention Problems subscale was not calculated, as it contains only two items. The correlation between these two items for the whole group of participants was .46, for the patient sample was .45, and for the nonpatient sample was .37 (all $ps < .001$).

Validity Analyses

To evaluate the validity of the HDI, responses given by the sample of persons seeking outpatient

mental health services were compared to those given by the sample of community residents. Analyses were conducted to evaluate the validity of the HDI items, scales, and subscales.

Item Analyses

The average score obtained by patients and nonpatients on the individual items of the HDI were compared using independent samples *t* tests calculated using unequal variances. (The average item scores obtained by the two groups are available from the first author upon request.) Results indicated that average scores obtained were significantly different for the patient and nonpatient samples for all but 3 of the 48 HDI items. Two of the items that did not differentiate patients and nonpatients were endorsed infrequently by both (an item from the Eating/Weight Concerns subscale “Purging behaviors” and “Lying about or hiding drinking or drug use”). In contrast, the item “Fear of gaining weight or becoming fat” was endorsed fairly frequently by both nonpatients and patients.

Scale and Subscale Scores: Patients Versus Nonpatients

Results of *t* test (using nonequal variances) contrasting the scores obtained by patients and nonpatients on the three major scales (Morale, Global Symptoms, and Global Impairment) and the symptom and impairment subscales are shown in Table III.

Table II. Coefficient Alphas and Guttman Split-Half Reliabilities of HDI Scales/Subscales

Scales/subscales	Patients (Alpha)	Nonpatients (Alpha)	All participants	
			Alpha	Guttman
Morale	.88	.86	.90	.88
Global Symptoms	.95	.94	.95	.80
Depression	.92	.87	.92	.91
Anxiety	.88	.80	.88	.83
Unusual Thoughts/ Experiences	.74	.69	.75	.73
Eating/Weight Concerns	.78	.71	.75	.84
Substance Use Concerns	.70	.74	.72	.70
Behavior Problems	.75	.77	.79	.81
Global Impairment	.92	.89	.93	.89
Occupational/Task	.89	.84	.89	.86
Relationship	.75	.76	.81	.82
Self-Care	.83	.79	.84	.81

Table III. HDI Scale and Subscale Scores Obtained by Patients and Nonpatients

Scale/Subscale (range)	Patients	Nonpatients	<i>t</i> -value ^a
	Average (<i>SD</i>)	Average (<i>SD</i>)	
Morale ^b (4–20)	11.84 (3.80)	15.77 (2.29)	19.26
Global Symptoms (32–160)	68.28 (21.69)	48.30 (14.52)	15.78
Depression (9–45)	24.23 (8.50)	16.25 (5.44)	17.21
Anxiety (8–40)	14.05 (6.05)	9.29 (3.42)	14.86
Attention Problems (2–10)	4.62 (2.19)	3.22 (1.32)	11.95
Unusual Thoughts/Experiences (4–20)	7.25 (3.19)	5.31 (2.00)	11.21
Eating/Weight Concerns (4–20)	6.45 (3.14)	5.80 (2.40)	4.24
Substance Use Concerns (4–20)	6.03 (2.70)	5.31 (2.06)	4.65
Behavior Problems (4–20)	7.76 (3.28)	5.37 (2.09)	13.34
Global Impairment (12–48)	26.58 (9.11)	18.92 (5.73)	15.25
Occupational/Task (4–16)	8.47 (3.55)	6.41 (2.33)	10.20
Relationship (4–16)	9.14 (3.33)	6.04 (2.14)	15.47
Self-Care (4–16)	9.04 (3.44)	6.45 (2.29)	13.43

^aAll *ps* < .001.^bHigher scores indicate better morale.

Patients generally obtained more pathological scores than nonpatients.

Subscale Scores of Patient Groups and Nonpatients

The validity of certain subscales was evaluated by comparing patients according to diagnostic categorization. It was predicted that patients with specific diagnoses would score higher on certain subscales than other patients and nonpatients (e.g., patients diagnosed with depression were expected to score higher on the Depression Subscale).

To do this, the patient sample was divided into diagnostic groups, and the groups were compared both to each other and to nonpatients. The results of analyses of variance (ANOVAs) contrasting the three groups are shown in Table IV. As shown, patients with

a diagnosis of depression scored significantly higher on the Depression subscale than both patients without such a diagnosis and nonpatients. The same was true for patients with an anxiety disorder diagnosis on the Anxiety subscale, for patients with either a drug and/or alcohol abuse problem diagnosis on the Substance Use Concerns subscale, and for both patients with a diagnosis of schizophrenia on the Unusual Thoughts/Experiences subscale.

Clinician Ratings and Scale/Subscale Scores

Correlational analyses contrasted the clinicians' ratings of distress and impairment with the global scales and the subscales (self-reported) of the HDI. As shown in Table V, the Morale scale was negatively correlated with clinician ratings of both distress and

Table IV. Subscale Scores Obtained by Patients With Associated Diagnoses, Other Patients, and Nonpatients

Subscale	Average (<i>SD</i>)			<i>F</i> value
	Depressed Pts	Other Pts	Nonpatients	
(<i>n</i>) Depression	(194) 28.67 (7.36)	(194) 21.17 (7.76)	(477) 16.25 (5.44)	248.91*
(<i>n</i>) Anxiety	Anxious Pts (79) 19.25 (5.28)	(341) 13.02 (5.65)	(477) 9.29 (3.42)	187.54*
(<i>n</i>) Unusual Thoughts/Experiences	Schizophrenia Pts (8) 11.00 (4.40)	(412) 7.19 (3.09)	(477) 5.31 (1.96)	70.64*
(<i>n</i>) Substance Use Concerns	Alcohol/Drug Pts (71) 8.60 (3.88)	(349) 5.47 (1.84)	(477) 5.31 (2.05)	69.51*

Note. 57 patients did not have any diagnosis.

*All *ps* < .001.

Table V. HDI Scales/Subscales Versus Clinician Ratings

HDI Scales and subscales	Clinician ratings			
	Distress	Occupational/task impairment	Relationship impairment	Self-care impairment
Morale Scale ^a	-.48**	-.44**	-.37**	-.44**
Global Symptoms Scale	.39**	.44**	.24**	.43**
Depression	.44**	.45**	.29**	.47**
Anxiety	.37**	.43**	.21**	.40**
Attention Problems	.27**	.35**	.14*	.31**
Unusual Thoughts/Experiences	.23**	.30**	.10	.20**
Eating/Weight Concerns	.17**	.23**	.12	.24**
Substance Use Concerns	.02	.17**	-.03	.21**
Behavior Problems	.23**	.19**	.19**	.15**
Global Impairment Scale	.42**	.47**	.34**	.44**
Occupational/Task	.35**	.52**	.20**	.38**
Relationship	.36**	.31**	.38**	.36**
Self-Care	.37**	.36**	.30**	.39**

^aHigher scores indicate better morale.

* $p < .05$. ** $p < .001$.

impairment. Likewise, the symptom scale and subscales were generally positively correlated with clinician ratings of distress and impairment. The Substance Use Concerns subscale was not significantly correlated with clinicians' ratings of distress. (This may reflect the reality that patients with substance abuse problems often do not present with clinically elevated levels of distress.) Clinicians' ratings of the patients' relationship impairment were also uncorrelated to the Substance Use Concerns, Unusual Thoughts/Experiences, or Eating/Weight Concerns subscales.

DISCUSSION

Most persons who seek mental health care prefer their primary care provider (cf. Saunders, 1993). Moreover, such a route into the treatment system is increasingly being mandated by health care insurers that require that physicians act as gatekeepers to specialty care. Accordingly, it is reasonable for patients to expect that medical providers can accurately screen and evaluate mental health problems.

This study evaluated the potential utility of a self-report screening measure. The results suggest that the HDI is both reliable and valid. These results support the conclusion that the HDI has adequate psychometric properties and validity, which indicates that the items of the scales and subscales of the HDI are internally consistent. Reliabilities were generally acceptable, ranging between .69 to .95. The validity of the HDI is supported by the finding that patients scored more pathologically than nonpatients on all but a few items, on all three major scales, and on all of the sub-

scales. The validity of the subscales was supported by analyses contrasting subgroups of patients, categorized according to diagnoses, as patients with particular diagnoses scored more pathologically on associated subscales (e.g., depressed patients obtained higher scores on the Depression subscale than both nondepressed patients and nonpatients). Also supporting its validity, patients' reports and clinicians' ratings were, for the most part, significantly correlated. In addition, substantial clinical experience using the HDI shows that it may fit well within the constraints of a typical primary care clinic. It is simple to administer and score, and it could be easily incorporated into routine clinical practice. Understanding and completing the HDI does not require special instructions, such that clinic support staff can disburse and score it without difficulty. The HDI items are easy for both clinicians and patients to evaluate and interpret. The inventory asks questions that are clinically relevant and intuitively obvious (such as, "In the recent past, how often have you been a happy or cheerful person?").

This study does not fully establish the validity of the HDI as a screening tool, because of shortcomings in the study. These results suggest that the HDI distinguishes patients from nonpatients, but does not directly address the question of whether the HDI can help primary care clinics identify patients with mental health concerns. This needs to be evaluated directly, as do questions of its sensitivity and specificity. Other research, however, suggests that screening measures can be quite useful. For example, Löwe et al. (2003) demonstrated that screening procedures—especially procedures aimed at detecting depression and

anxiety symptoms—significantly increase the likelihood of detecting psychiatric problems in medical outpatients.

Another weakness of this study include reliance on clinician-determined diagnoses. More standardized and valid methods of determining psychiatric diagnosis need to be utilized to demonstrate the HDI's utility.

In conclusion, there is a great deal of accumulated and ongoing research supporting the importance of accurate evaluation of mental health problems within primary care settings. Screening suggests whether specialized treatment should be sought or provided. It can be used to convince patients of the need for medications or a referral to a mental health provider. Finally, patients may be more likely to comply with treatment recommendations if shown evidence of the problem and the intent of the treatment.

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