SUGGESTED MEASURES TO EVALUATE THE INTEGRATION OF PRIMARY CARE AND MENTAL HEALTH SYSTEMS

Developed by Barbara Demming Lurie
based on the work of many others in the field
barb@ibhp.org
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Increasingly, specialty mental health clinics and departments are forging collaborative relationships with primary care providers to ensure that services address the whole person, not just one aspect of his or her condition. Literature has shown that integrated care often produces better clinical outcomes and increased client satisfaction.

Policy-makers, health administrators, payers and providers all have an interest in gauging the efficacy of these initiatives. In response to this need, we've put together an array of possible process and outcome measures to consider when assessing the level and effectiveness of integrative efforts.

While created expressly for Los Angeles County Department of Mental Health, this compendium of potential measures may be useful to others undertaking a similar course of action. The listing is intended only as a menu of possible avenues of evaluation; it is left to the evaluator to decide which, if any, are the most practicable, meaningful and suitable for the type of integrated care being assessed. Inclusion in the list does not necessarily imply endorsement by IBHP.

I. MENU OF PROCESS MEASURES

PHYSICAL HEALTH SCREENING MEASURES
• Percent of total enrollees screened for BMI • Percentage of clients screening positive for BMI (less than 18.5 or more than 24.9)
• Percent of total enrollees screened for smoking • Percentage of clients screening positive for smoking
• Percent of total enrollees screened for nonprescription substance abuse • Percentage of clients screening positive for nonprescription substance abuse
• Percent of total enrollees screened for co-occurring prescription substance abuse not including alcohol • Percentage of clients screening positive for co-occurring prescription substance abuse not including alcohol
• Percent of total enrollees screened for co-occurring alcohol dependence • Percent of clients screening positive for co-occurring alcohol dependence
• Percent of total enrollees screened for waist girth • Percentage of clients screening positive for waist girth (greater than 39.5 inches for men and 35.5 inches for women)
• Percent of total enrollees screened for psychotropic medications • Percentage of clients currently on psychotropic medications

• Percent of clients on psychotropic medications screened for A1C levels • Percent of clients on psychotropic medications with positive A1C levels (greater than 6.5)
• Percent of total enrollees screened for blood pressure • Percentage of clients screening positive for blood pressure (140 and above systolic and/or greater than 90 diastolic)
• Percent of clients screened for cardiovascular disease via lipids profile (HDL, LDL, triglycerides) • Percent of clients screening positive for HDL, LDL and/or triglyceride levels
• Percent of clients who completed a verbal or written medical history intake, including personal and family history • Percent of clients whose personal or family medical history indicated physical risk factors for diabetes, COPD or heart disease
• OTHER PROCESS MEASURES
• Percent of persons meeting project criteria approached for the pilot who agree to enrollment
• Percent of clients approached for pilot participation who have received primary care services in the past year
• Percent of pilot enrollees who have received primary care services in the past year
• Percent of enrollees whose screening indicated need for further health intervention who were referred to primary health clinic

• Length of time between primary care referral and behavioral health appointment within primary care clinic for enrollees
• Length of time between primary care referral from mental health clinic and first appointment for enrollees
• Reason why clients screening positive were not seen by primary care clinic (client's choice; referral not made; clinic not able to accommodate client; other)
• Percent of referrals resulting in appropriate behavioral feedback to referral source
• Percent of primary care clients who were referred for mental health services within the primary clinic
• Percent of primary care clients who were referred for mental health services outside the primary clinic
• Percent of clients completing the recommended course of treatment
• Frequency of clients referred to primary care from mental health keeping first appointment
• Frequency of clients referred from mental health clinic to primary care keeping first appointment
• Rate of kept/missed primary care appointments, not counting first visit
• Rate of kept/missed mental health appointments in mental health clinics, not counting first visit

• Rate of kept/missed mental health appointments in primary care clinics, not counting first visit
• Type and frequency of physical wellness-oriented programs/training conducted
• Number of enrollees seen per quarter
• Average number of clinic visits by enrollees per quarter
• Percent of enrollees with established integrated treatment plan
• Percent of enrollee smokers participating in smoking cessation activities
• Percent of enrollees with positive BMI and/or waist girth scores participating in nutrition/exercise programs and/or education
• Percent of enrollees evidencing physical problems receiving follow-up measurements at least once every eight weeks to assess progress
• Percent of enrollees who drop out of program (fail to appear for scheduled visits over a three month period)
• Percent of clients newly prescribed psychotropic medication
• Type and duration of treatment (mental health, substance abuse and primary care) by diagnosis
• Average length of treatment session by diagnosis
• Individualized cost of mental health services in mental health clinics

• Individualized cost of mental health services in primary care
• Individualized cost of substance abuse services in mental health and primary care setting
• Individualized cost of medical services
• Percent of clients enrolled in physical health program (wellness groups; smoking cessation programs; diet and exercise programs)
• Availability of written material to meet the linguistic needs of the population being served.
• Frequency of cross-discipline training of mental and physical health service providers; number and level of staff attending
• Availability of service personnel who speak the same language as the population being served.
• Number and qualifications of mental health professionals affiliated with primary care program
• Level of fidelity to collaborative agreements
• Percent of enrollees whose physical health risk factors are assessed at___(specify time intervals)
• Percent of enrollees whose mental health status is assessed at ____(specify time intervals)
• Percent of enrollees who receive active care management

• Percent of enrollees whose health medication is assessed at ___(specify time intervals)
• Percent of enrollees whose psychiatric medication is assessed at___(specify time intervals)
• Physical proximity of mental health services to participating primary care clinic
• Average amount of total staff time devoted to meeting enrolled clients' mental health needs
• Average amount of staff time devoted to meeting enrolled clients' physical health needs
• Accuracy of outcome data collected and reported by facility (as ascertained by an independent review)
• Timeliness of data submission by clinic
• Enrolled client to primary care provider ratio
• Percent of clients completing prescribed course of treatment
• Frequency of case conferencing between mental health and primary care professional staff
• Quality of services as assessed by random chart review
• Level of stigma and/or hesitancy (or alternatively, level of comfort) clients experience in accessing mental health care as measured by their self-report

- Client adherence to mental health treatment plans and medication

- Client adherence to medical treatment plans and medication compliance

- Establishment of agreements, memorandum of understandings, etc between the primary care and mental health systems

- Establishment of agreed-upon referral guidelines, policies and procedures

DEMOGRAPHIC DATA NEEDED FOR ENROLLEES

a. Client age, gender, race/ethnicity
b. Client personal/family health history, including diabetes, hypertension and cardiovascular disease
c. Personal/family history of and current substance abuse
d. Personal/family history of and current tobacco use
e. Client social supports
f. Presenting behavioral health problems and diagnosis
g. Presenting physical health problems and diagnosis
h. Presenting co-occurring substance abuse disorders
i. History of previous psychiatric treatment/hospitalization
j. Medications prescribed
k. Current housing situation (including whether clients have or are lacking a fixed, regular, and adequate nighttime residence)

LEVEL OF INTEGRATION INDICATORS

Dimensions:

- Level of communication between behavioral and primary care services

- Physical proximity of primary care and behavioral services
- Ease and timeliness of accessing services between behavioral and primary care services
- Availability of expertise between behavioral and primary care services
- Amount of cross-training between mental health and primary care services
- Availability of client information/records between services
- Level of care referrals between systems
- Level of understanding of each other's roles and responsibilities between services

POSSIBLE QUESTIONNAIRE TO DETERMINE LEVEL OF INTEGRATION

1. Behavioral health and primary care located:

   a) in different sites
   b) in same site, but separate floor or wing
   c) in same general space

2. Behavioral and medical care documentation is:

   a) kept separately
   b) kept in the medical chart, but some behavioral records are maintained separately
   c) contained in the same chart or electronic record accessible by both behavioral and medical staff

3. If a referral is made from the primary care provider to behavioral health, the client is:

   a) generally scheduled for an appointment at a later date and does not see the counselor that day
   b) generally introduced to the behavioral counselor, but treatment is scheduled for another time
   c) generally seen that day for treatment only in emergent situations
   d) generally seen that day for treatment regardless of condition

4. Behavioral health and primary care providers:

   a) seldom communicate about individual clients

b) communicate periodically about clients via email, phone or personal conferences
c) communicate frequently about clients

5. Behavioral treatment plans and clinical approaches are:

a) reached with both the input of the primary care physician and behavioral counselor
b) reached by the behavioral health counselor but okayed by the primary care physician
c) primarily reached by the behavioral health counselor

6. The clinic currently holds group and/or training sessions on:
a) pain management
b) depression, PTSD and/or other mental health issues
c) smoking cessation
d) nutrition
e) exercise
f) self-empowerment

7. (For primary care clinics) The clinic has:
a) psychiatrist(s) on staff
b) access to psychiatrist for limited psychiatric consultation/services (not part of staff)
c) no current access to psychiatrist

8. (*For mental health clinics)* The clinic has:
a) a primary care physician or nurse practitioner on staff
b) access to a primary care physician or nurse practitioner for limited consultation/services (not part of staff)
c) no current access to a primary care physician or nurse practitioner

9. The clinic offers:
a) care management coordinating behavioral health and medical services only within the clinic itself
b) care management coordinating behavioral health and medical services both within the clinic and resources in the community
c) no specific care management services currently

10. The clinic provides:
    a) a distinct substance abuse program run by a certified counselor
    b) substance abuse counseling as part of its regular behavioral health treatment, not a distinct program
    c) little or no substance abuse treatment

11. The clinic:
    a) uses a registry or electronic tracking system to track client behavioral health outcomes
    b) collects behavioral health outcome data without registry or tracking system
    c) does not systematically collect behavioral health outcomes

12. The clinic:
    a) uses a registry or electronic tracking system to track client physical health outcomes
    b) collects physical health outcome data without registry or tracking system
    c) does not systematically collect physical health outcomes

13. The clinic has policies and procedures on referrals between primary and behavioral care.
    ___yes ___no

14. The clinic has regularly scheduled case-conferencing between primary care and behavioral health.
    ___yes ___no

15. The clinic makes cross-training available at least once per quarter to its professional staff (i.e., primary care staff trained in behavioral health and vise versa)
    ___yes ___no

16. The clinic uses an established form for primary care/behavioral health referrals.
    ___yes ___no

17. When clients are referred between the behavioral health and primary care system, there is an established procedure for providing feedback to the referrer.
    ___yes ___no

II MENU OF OUTCOME MEASURES

The establishment of demographically-matched control groups, receiving treatment as usual, is strongly recommended for comparison purposes for most outcome measures. Without control groups, there is no clear way to attribute outcomes to the model itself, as opposed to other variables at play.

Dimensions that can be assessed to determine program effectiveness include:

• Level of client satisfaction with accessibility and effectiveness of mental health services
• Level of client satisfaction with accessibility and effectiveness of physical health services
• Competency level of mental health staff in recognizing physical disorders (as measured pre and post pilot
• Competency level of primary care staff in recognizing mental health disorders
• Provider satisfaction with mental health / primary care systems interaction and functioning
• Client self-assessment of functioning and of quality of life
• Mental health functioning as self-assessed by client

• Mental health functioning as assessed by provider
• Physical health status as assessed by client
• Physical health status as assessed by provider
• Cost-effectiveness of services, including cost of services and cost off-sets/savings
• Frequency of psychiatric hospital admissions by enrollees prior to, during and immediately after pilot
• Frequency of ER visits by enrollees prior to, during and immediately after pilot program
• Knowledge level of primary care medical staff in mental health areas, including identification of and approaches to psychiatric problems (as measured pre and post project)
• Knowledge level of mental health staff of physical conditions associated with mental health problems (as measured pre and post project)
• Level of familiarity of staff with national and local resources for persons with mental and/or physical disorders (as measured pre and post pilot)
• Primary care provider comfort level in dealing with persons with mental disorders (as measured pre and post pilot)

• Primary care rate of prescribing psychotropic medications (as measured pre and post project)
• Physical health indicators:
○ body mass index
○ waist girth
○ weight
○ blood pressure
○ glucose levels
○ lipid levels
○ smoking rate (where applicable)
○ exercise habits
○ nutritional habits
○ substance abuse frequency (where applicable)
○ alcohol use (where applicable)
○ degree of pain experienced

NOTE: Give the relatively short time-span of a pilot, it may be premature to collect the following information given that improvements may not be apparent in this limited period, but I'm including the measures anyway for your reference:

For clients with co-occurring mental disorders and chronic obstructive pulmonary disease:
- Oxygenation
- Pulmonary function
- Exercise capacity

For clients with co-occurring mental disorders and heart disease:
- incidence of death
- incidence of heart attacks
- incidence of strokes
- blood pressure
- heart-sensitive C-reactive protein level
- HDL/LDL levels
For clients with co-occurring mental health disorders and diabetes (in addition to weight/BMI and waist girth):
- Hemoglobin A1C levels
- Progression of microvascular disease of the eyes
- Abnormalities of the kidney
- foot exam

CLIENT SATISFACTION WITH SERVICES

The satisfaction survey should not only be an indicator of the consumer's level of contentment with services rendered; it should also be a measure of other integration dimensions, like accessibility and effectiveness. Some dimensions that the client satisfaction survey can assess (some of the items below were taken from the *Commission on Accreditation for Rehabilitation Facilities*):

- Convenience of location for consumers
- Ease of access to services
- Promptness of services – getting appointments
- Promptness of service – time spent in waiting room for scheduled appointment
- Sufficient time spent addressing consumer's needs

- Consumer involvement in the planning and delivery of services
- Accommodation to consumer preferences
- Degree of active consumer participation in decisions concerning their treatment
- Degree to which consumers receive information to make informed choices
- Degree to which consumers felt respected by staff
- Degree to which consumers felt informed about available resources in the community
- Degree of accommodation and sensitivity to the consumer's ethnicity and culture
- Level of consumer understanding regarding their self-management responsibilities
- Degree to which consumers felt their physical health needs were appropriately addressed
- Degree to which consumers felt their mental health needs were appropriately addressed
- Degree to which consumers felt their substance use needs were appropriately addressed
- Degree of accommodation to consumer's linguistic needs

I have attached a few client satisfaction surveys to review and possibly select from. I recommend a five point rating scale, which can either indicate level of agreement with a statement or can indicate response to a question posed. Below are some statements suggested for inclusion in the satisfaction survey (which can be made into questions if you opt for that construct). Note that this questionnaire is probably longer than practicable. I've erred on the side on inclusion, leaving the pruning to you. I separated some of the questions into "mental health" and "medical", but all of them can be bifurcated this way. You may also want to add "**substance abuse services**" to the questionnaires.

SAMPLE CLIENT SATISFACTION SURVEY:

	Strongly Agree	Some] what Agree	Neither Agree or Disagree	Some what Disagree	Strongly Disagree	This Doesn't Apply
The location of the **medical services** was convenient for me to get to.						
It was easy to get **mental health** services I needed.						
It was easy to get the **medical services** I needed.						
I didn't have to wait long to get an appointment for **mental health** services.						
I didn't have to wait long to get an appointment for **medical** services.						
Once at the **mental health** clinic, I didn't have to wait long to be seen.						
Once at the **medical clinic**, I didn't have to wait long to be seen.						
The staff gave me a satisfactory amount of time during my **mental health** visits						
The staff gave me a satisfactory amount of time during my **medical** visits.						
The **mental health** staff took my preferences into account in deciding what my treatment would be.						
The **medica**l staff took my preferences into						

account in deciding what my treatment would be.						
When I left, I clearly understood the purpose and risks of each medication I was prescribed						
I was given a good explanation of the things I needed to do to manage my **mental health**.						
I was given a good explanation of the things I needed to do to manage my **physical** health.						
I was satisfied with how my mental health needs were addressed						
I was satisfied with how my physical health needs were addressed						
The staff was sensitive and accommodating to my cultural/ethnic background						
Treatment information was given in a way that I could easily understand.						
I felt respected an well-treated by staff at the **mental health** clinic						
I felt respected and well-treated by staff at the **medical** clinic.						
I'm satisfied with how My substance use issues were addressed.						
I'm comfortable going to the **mental health** clinic for services						
I'm comfortable going to the **medical clinic**						

for services.						
The clinic helped me get the services I needed in the community.						
My **mental health** clinician kept me informed about my treatment and progress						
My medical clinician kept me informed about my treatment and progress.						
My clinicians kept each other informed about my treatment and progress**.**						
My clinicians worked well together to coordinate my care						
I knew which clinician to turn to when I had a problem.						

USING CLIENT SATISFACTION QUESTIONS AS FUNCTIONING OUTCOME MEASURES

If client functioning is not assessed in a separate questionnaire, they can be embedded in the satisfaction surveys. Below are a few simple questions that can be added, taken from *Integrated Behavioral Health* by William O'Donohue:

• *In the past 30 day, I have been able to meet my daily responsibilities very well.*
• *I am satisfied with the quality of relationships I have with family and friends.*
• *I am happy with life in general.*

Some other questions, taken from the MHSIP Consumer Survey (Version 1.1) and NOMS (using the same strongly agree >>>strongly disagree continuum), can be added to the satisfaction survey for a more in-depth assessment of functioning:

As a direct result of the services I received:
• *I do better in social situations.*
• *My housing situation has improved.*
• *My physical symptoms aren't bothering me as much.*
• *My mental symptoms aren't bothering me as much.*
• *I deal more effectively with my daily problems*
• *I am better able to control my life.*
• *I am better able to manage my condition*
• *I am better able to deal with crisis.*
• *I am getting along better with my family.*
• *I am happy with the friendships I have.*
• *I have people with whom I can do enjoyable things.*
• *I feel I belong in my community.*
• *In a crisis, I would have the support I need from family or friends*

PROVIDER SATISFACTION/ASSESSMENT

Questions posed to providers could include:

- How satisfied are you with the ease of referral to mental health services/primary care/substance use services?
- How much, if at all, did ease of referral to mental health/primary care/substance use services increase as a result of this project?
- How satisfied are you with the feedback you received about your clients' status and care after you referred clients to mental health/primary care/substance use services?

- How much time did it take, on average for your referred client to get an appointment with mental health/primary care/substance abuse services?

- How knowledgeable did you find the mental health/substance abuse/primary care providers in your own area?

- How knowledgeable did you find the mental health/substance abuse/primary care providers in their own area?

- How satisfied are you with the level of communication between your services and mental health/substance abuse/primary care services?

- How much, if at all, did the level of communication between your services and mental health/substance abuse/primary care services increase as a result of this project?

- How effective did you find the primary care/mental health/substance abuse services were in addressing the needs of your clients?

- How much, if at all, did access to consultation from primary care/mental health/substance abuse increase as a result of this pilot?

- In the last month, approximately how many times did you have contact with a mental health/primary care/substance abuse provider outside your own clinic regarding a client in the pilot project?

- How easy was it for you to access client treatment information, laboratory results, or medical records for the clients you were treating?

- What, if anything, is working well in the collaboration between primary care, mental health and substance abuse services?

- How much, if at all, did your comfort level in treating persons with mental disorders increase as a result of this project?

- How much, if at all, did your knowledge base increase regarding treating persons with mental disorders as a result of this project *(for primary care personnel)?*
- How much, if at all, did your knowledge base increase regarding cardiovascular diseases and diabetes (*for mental health personnel)*
- How would you rate communication between primary care and mental health in this project?
- What, if anything, is not working well in the collaboration between primary care, mental health and substance abuse services?
- What suggestions can you make to improve the collaboration between mental health, primary care and substance abuse services?

CLINICAL / FUNCTIONING MEASURES

I recommend that the **same** screening instrument also double as an outcome measure, indicating a baseline prior to services, then the progress achieved during and at the conclusion of services.

Among the several measures available:

SOME GLOBAL FUNCTIONING MEASURES

RAND HEALTH SURVEY

A self-administered physical health quality-of-life measure, the 36-item survey developed by the Rand Corporation is available for use contingent on meeting Rand's stipulations.

To access on the web:

http://rand.org/health/surveys_tools/mos/mos_core_36item_survey.html

OUTCOME RATING SCALE

Devised and copyrighted by Scott D. Miller and Barry L. Duncan, this brief scale asks clients' for subjective ratings of their well-being, family and social relationships and mood. It's very brief and simple; the downside may be that clients indicate responses along an unmarked scale, so quantifying data may be difficult.

To access on the web:

http://bloomingtonobgyn.net/Documents/QUESTIONARE.doc

DUKE HEALTH PROFILE

Popular among health and mental health researchers, this 17 item self-report instrument, measures both health and mental health status, though it may not capture needed information for more seriously impaired mental health clients. Indices include mental health, social health, perceived physical health, objective health and self esteem. Among the scales measuring dysfunctional health are depression, anxiety, pain and disability. This measure was used by some of our grantee clinics, but garnered criticism because of its bulk. On the positive side, established reference group scores are available for comparison purposes.

To access on the web:

http://healthmeasures.mc.duke.edu/images/DukeForm.pdf

CALIFORNIA QUALITY OF LIFE SURVEY (CA-QOL)

This 18-item questionnaire, adapted from Dr. Anthony **Lehman's Quality of Life Interview** by the State Department of Mental Health, asks respondents to rate their health, physical condition, living situation and emotional well-being.

CMHS NOMS: Adult Consumer Outcome Measures for Discretionary Services Programs

This SAMHSA-generated instrument contains a Client Perception of Care (which doubles as a Client Satisfaction Survey), an eight-question self-assessment of functioning and social connectedness, along with questions about arrests, education and employment, as well as process questions for the treatment staff.

See Using the Client Satisfaction Survey Questions as Functioning Outcome Measures above for some questions.

GLOBAL ASSESSMENT OF FUNCTIONING

Completed by the treating professionals, this subjective mental health rating scale may be subject to biases, especially considering that funding for services is involved in this pilot.

QUALITY OF LIFE QUESTIONNAIRE

Developed by Dr. Philip Long, this questionnaire might be too complex and involved to be practical, but perhaps questions can be extracted from it.

To access on web, go to:

http://www.mentalhealth.com/qol/IMHQOLScale.pdf

SF-36 and SF-12

These Survey scales with mental and physical health components are used by including the National Commission on Quality Assurance (NCQA) among other organizations.

SOME OTHER GLOBAL MEASURES:

- *Quality of Life Inventory*
- *Health and Daily Living Form*

- *15D Measure of Health-Related Quality of Life*
- *COOP/WONKA Charts*
- *Current Perceived Health*
- *McMaster Health Index Questionnaire*
- *WHOQOL-100*
- *MOS 36-Item Short Form Health Survey*
- *Patient Generated Index*
- *Spitzer Quality of Life Index*
- *Quality of Life Questionnaire*
- *Scale for the Evaluation of Individual Quality of Life*
- *UK Sickness Impact Profile*

SOME MENTAL-HEALTH RELATED MEASURES

MINI-MENTAL PATIENT HEALTH SURVEY

Developed and used by one our grantee clinics, Sierra Family Health in Nevada, this self-administered questionnaire is constructed so that an affirmative answer to a few basic questions triggers follow-up questions. Thus, if the initial responses are negative, the form can be completed with just a few checks. I'll attach it.

To access on the web:

http://www.ibhp.org/uploads/file/MINI%20health%20survey%20used%20by%20Sierra.doc

or go to pages 156-158 of the *Primary Care / Mental Health Collaboration Tool Kit* I developed.

BUNCOMBE COUNTY QUESTIONNAIRE

Buncombe County in North Carolina developed a simple five-question tool which touches on drug and alcohol abuse, depression, anger, and anxiety. The responder checks "never", "rarely", "sometimes" and "often":

1. In the last two weeks have you been feeling sad or angry?
2. In the last two weeks have you lost interest in or stopped enjoying the things that usually give you pleasure?
3. In the last _____ (time period), have you ever used more alcohol or drugs than you meant to?
4. In the _____ (time period) have you felt you wanted or needed to cut down on your drinking or drug use?
5. In the last four weeks, have you had an anxiety attack (suddenly feeling fear or panic)?

PH-Q 9 and **PHQ-2**

Based on the DSM-IV diagnostic criteria for major depression, this 9-item self-assessment for depression has been extensively field-tested and is available in multiple languages. Some clinicians prefer to use only the first two items (asking how often in the past two weeks the respondent has had “little interest or pleasure in doing things” and has been “feeling down, depressed or hopeless”), then following up with the remaining seven items if an affirmative response is given. [The abbreviated version is known as the PHQ-2.]

ADDICTION SEVERITY INDEX

This interview-based instrument is designed to assess the impact of alcohol and substance dependence on seven areas of functioning: employment, medical, legal, alcohol, drugs, family/social and mental health.
To access on the web, go to:
http://www.tresearch.org/resources/compscores/CompositeManual.pdf

THE GENERALIZED ANXIETY DISORDER (GAD)-7 SCALE

This brief form asked consumers “over the last two weeks, how often have you been bothered by the following problems?” The respondent checks off “not at all”, “several days’ “more than half the days”, or “nearly every day”. There is an abbreviated version of only two questions (GAD-2). The questions are as follows:

Feeling nervous, anxious or on edge
Not being able to stop or control worrying
Worrying too much about different things
Have trouble relaxing
Being so restless that it is hard to sit still
Feeling afraid as if something awful might happen.

A few other of the many mental health functioning assessment instruments available:

- Brief Psychiatric Rating Scale
- DASS-21 (depression and anxiety scale)
- BHI 2 (Battery for Health Improvement)
- MBHI (Millon Behavioral Health Inventory)
- PAI Personality Assessment Inventory