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WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

REPORT OF THE CONSULTATION ON THE WHO COLLABORATIVE PROJECT ON HEALTH & SOCIAL SERVICES UTILIZATION BY THE MENTALLY ILL

GENEVA, 6-9 SEPTEMBER 1987

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1. Introduction

A meeting on the WHO Collaborative Project on Health and Social Services Utilized by the Mentally Ill was held at the WHO in Geneva, Switzerland on September 6-9, 1987. The meeting was chaired by Dr. J. Arroyo Sucre. Invited participants and their addresses are listed in Appendix I. Dr. C. Siegel and Dr. H. Katschnig acted as rapporteurs. Appendix II contains the agenda of the meeting.

2. Objectives of Meeting:

Prior to the meeting a draft protocol of a multi-national project to develop and implement a methodology to assess the utilization of mental health, health and social services by the mentally ill within a defined area had been circulated to the invited participants. The meeting was convened to discuss the feasibility of carrying out the project and to incorporate into the protocol suggestions of the potential participants. Specifically, the goals of the meeting were to:

- review the draft protocol

- delimit the project in terms of specific populations to be covered, services to be included, data to be collected, instructional modules for planning and clinical modules to be developed;

- discuss adaptation of protocol in different cultural setting

- develop a work plan leading to implementation.

3. Description of the study

The study was described and its objectives and methodolgy were discussed. The project involves carrying out a one or two week census survey of patients with psychiatric disorders receiving mental health, health or social services in a defined geographical area. Characteristics of the area, patients and providers would be collected using structured instruments. A screening instrument would be used to identify psychiatric patients in the general health and social services sector. The development of modules to demonstrate the utilization of the information collected for planning, education, and clinical management are viewed as part of the project as well.

The global objectives of the study were reformulated by the group as:

- to develop a practical and replicable survey methodology for assessing health and social services utilization by persons with mental problems;

- to demonstrate the usefulness of the information collected for planning, monitoring and evaluation of health, mental health and social service and programmes; and

- to increase the awareness of non-psychiatric health and social services personnel to mental health problems and to strengthen their ability to identify and manage such problems.

The components of the methodology are:

- a set of structured survey instruments to collect information on:
  - the socio-demographic and basic health statistics of an area;
  - the characteristics of the providers;
  - the characteristics of the patients and of the services received in the one or two week period.

- A psychiatric screening instrument to identify patients who are psychiatrically ill among those receiving health or social services.

- A statistical approach for estimating the annual number of psychiatric patients receiving services based on the number served during the census survey period.

- A set of instructional modules for planning that illustrate how to use the data collected to:
  - characterize the population in treatment;
  - characterize the service network;
  - assess unmet need by relating service utilization to area characteristics.

- Clinical management modules for patients with psychiatric problems seen in non-mental health settings.

- Educational modules for primary health care givers to increase their awareness of psychiatric patients and their needs related to these disorders.

- An evaluation plan to assess the methodology in different countries in terms of costs, benefits and administrative feasiblility so as to be able to provide recommendations for its use elsewhere.

4. Country Reports

Reports about their countries were presented by participants from Austria, Brazil, Czechoslovakia, Ghana, Nigeria, Panama and the United States of America. Geographic, socio-demographic, health, and service provider characteristics were presented and potential study areas were described. These were based on preliminary material which had been filled out on a questionnaire by the participants. Table 1 presents highlights of these reports for the countries. Potential study areas were also discussed. It turned out that those would represent a wide range of health infrastructures, socioeconomic conditions and technological sophistication. They had been proposed by the national participants to represent areas in which planning amongst health sectors would be feasible. Thus,

the suggested sites would provide a good basis for an evaluation of the methodology in terms of its cost-effectiveness and administrative feasibility among diverse areas.

5. Utility of the Project

The usefulness of the project was summarized from two perspectives, the public health consequences and specific planning uses of the information to be collected by the survey.

5 .1 Public Health Consequences

The implementation of the project in an area will have the positive effect of demonstrating that mental health is important. It would provide a general, replicable, administratively feasible methodology for service planning and patient management that comprehensively covers health, mental health, and social services and could act to enhance the integration, coordination, and development of special programmes for the mentally ill in an area that would improve both the mental health and the general health of patients and their families. Through this project it would be possible to identify the dimensions of the burden of the mentally ill on the health and social service sector because of their psychiatric problems. As a consequence it will be possible to formulate and develop special programmes within the non-psychiatric services that are responsive to psychiatric problems that are prevalent within an area. It is expected that the identification and appropriate treatment of psychiatric morbidity will reduce the work load of the non-psychiatric services and hence lead to a more effective use of scarce resources. Further, the project may help stimulate research into the design of intervention programmes for dealing with psychosocial problems that present at the general health care level.

The methodology of the project would allow for the development of an estimate of the annual number of psychiatrically ill patients receiving services and hence also for the development of the corresponding prevalence rates. These estimates can be used to set policy and to justify budget requests and allocation of funds for services to the mentally ill. The screening instrument that is developed to identify the mentally ill in the general health and social service sectors can be used as an educational tool to train primary health care and social workers to recognize and be aware of the needs of these patients thus making health and social services more effective. The diffusion of psychiatric knowlege into non-psychiatric health and social services could be promoted through management modules which would provide mangement strategies for specific psychiatric problems acceptable to local non-psychiatric professions and through teaching modules geared to train non-psychiatric care-givers in diagnosing and managing mental disorders.

5.2 Specific Planning Uses of the Information to be Collected by the Survey

The data on mental health services will give an indication of the absolute and the relative amounts of service being delivered by the various providers to various patient types. Imbalances, such as gross under or over service utilization by one or another patient group or by one or another provider may suggest that steps need to be taken either to understand the reason or to correct the problem. Reassignment of personnel, reallocation of resources or justified requests for a redistribution of budgets may result.

The data on general health and on social services will give an estimate of the absolute and the relative amounts of service provided to the mentally ill. Such information can spur a reallocation of resources or additional funding in recognition of the burden placed on non-psychiatric services by the mentally ill and of the probable benefits to providers and patients alike were more appropriate mental health services made available.

Target groups with high need can be identified and programmes developed according to a priority list based on the prevalence of identified problems.

The use of such concepts as "social area analysis" to impute the needs of local subareas defined geographically or by risk group clusters in conjunction with service utilization rates developed for these areas can provide indications of the extent to which the existing health system is responsive to local needs.

6. Issues Concerning Participating Study Areas

The group agreed that desireable features of the study areas are that the size of the chosen study area should relate to the density of services within the area. The higher the density of services, the smaller the study area should be. The area should be self contained in terms of the care seeking patterns of the population: that is, persons living in the participating study area should, for the most part, seek and receive services within the area.

The implementation of the project would be facilitated if there are local staff from the participating area who are available to assist in data collection and analysis.

The availability of small unit census data for a study area is desirable. These data would enhance the ability to create indicators of need for subareas which would be used to relate need to the utilization of services.

7. Issues Concerning Services/Providers

Screening for all of the mentally ill in all types of services in any participating study area might be impossible because of the large number of health care providers and social services. This is true in industrialized countries as well as in developing countries. For example, in Pakistan the bulk of the mentally ill are treated by traditional healers including homeopaths, hakims (herbalists) and faith-healers.

Some of these care-givers would not participate and others might be difficult to reach.

To insure that the survey results will be utilized for retraining, planning and/or reorganizing service delivery, the providers in the chosen area must either formally or informally be able or amenable, to carry out the changes indicated. The ability to motivate service providers to participate in the survey should be taken into account when choosing those to be covered.

If, in a general health service, there is a priori knowledge about the demand for care by the mentally ill, this information should be used in decisions concerning services to be included. Prior to final selection of the service providers to be covered, each participating study area should develop an inventory of the existing services and providers. Preliminary "guesstimates" should be made as to the demand for services by the mentally ill and should be used as a guide to the selection of providers.

The group agreed that the services to be screened should include at a minimum the general hospitals, psychiatric hospitals and a representation of the general practice within the area. In addition in many areas social services and other special services known to see psychiatric patients would be screened as well.

8. Issues Concerning Priority of Psychiatric Disorders to be Screened

The question arose as to whether the project should concern itself with an inclusive approach of screening for the entire spectrum of mental disorders or opt for a more selective approach of screening for a selection of mental disorders. Problems were raised concerning the possible effect of neglecting certain conditions, e.g., childhood disorders, on inferences which would be made on those with psychotic and neurotic conditions. Also a selective approach might lead to a situation in which a problem category that is prevalent in a setting is not examined, and hence estimates of service utilization by the psychiatrically ill would be underestimated. Whether an inclusive or selective approach to screening is taken will impact decisions concerning screening instruments, participating personnel and particular populations to be screened.

While the inclusive approach avoids, to some extent, an underestimation of the demand made by the mentally ill on current services, the selective approach may be more feasible given the current state of screening instruments in psychiatric research, the practical situation exisiting in many of the potential study areas and the priorities identified by those currently working in these areas. The group agreed that within the context of the project, screening for neuroses has high priority and psychoses a lesser priority. Preliminary discussions were held on the feasibility of identifying within areas specific target groups or problem populations that are of concern to the health and social services of the area, e.g. substance abusers or dementia patients.

9. Issues Concerning Methods for Case Identification

There was group recognition that the case identification procedure for identifying patients with mental problems among attenders of non-psychiatric health and social services will depend on the decision of the types of services to be included, the types of disorders selected and the type of personnel who would carry out the screening. The possibility of using either existing or newly designed instruments was discussed.

If existing instruments are adapted to the project, the benefits would include building on prior experience and that a smaller research effort would be required. If neurosis were to be chosen as a primary disorder for screening, the group suggested adapting the "Self Report Questionnaire (SRQ)". This instrument has simple rating procedures and is already translated into many of the languages of the potential participants. In addition it has been studied in terms of appropriate cut-off points for several cultures. It avoids some of the problems of the General Health Questionnaire, a widely used screening instrument, such as more complicated rating procedures and missing chronic cases. If this option is chosen, it was suggested that a small working group of experts (including some familiar with the use of the SRQ in the WHO Strategies Study) undertake methodological work to adpat the SRQ to the project. In addition, for other disorders, it was suggested that appropriate sections of the screening instrument already described by H. Katschnig be used as a starting point.

Newly designed instruments are another option. In this case the work effort would be considerably larger but the instruments would be tailored to the needs of the project.

Problems related to the carrying out of the screening procedure were also raised and would require clarification prior to the implementation of the project. The first concerns who carries out the project, the care provider or a research assistant. The benefits of having the care provider do the screening, include the advantage of having the provider's knowledge of the patient's mental problems and prior history of service use. In addition the use of the screening instrument by the clinician could have a salutory teaching effect. The drawback would be a burden on the clinician's time. The benefit of having a research assistant do the screening would include increased reliablity and a reduced burden on the clinician's time, but not necessarily on the service whose routine would be disrupted by the project.

Another problem that was raised concerned the verification of the caseness of the patients identified by a screening questionnaire. While a psychiatrists' verification of caseness would be ideal, this may be too costly. If this approach is not feasible, the screening instrument itself would determine caseness with occasional psychiatric verification during the project. If this option is chosen, the screening instrument would have to be validated to an acceptable standard as a case identification procedure.

10. Management and Teaching Modules

The group recognized that developing and implementing clinical management modules for patients with psychiatric problems seen in non-mental health settings and educational modules for primary health care givers to increase their awareness of psychiatric patients and their needs related to these disorders was important. Just motivating local health politicians and health care providers to identify psychiatric patients and not helping them to manage these patients will certainly create frustation and may even lead to a negative image of psychiatry. This would clearly be in contrast to the basic aims of the project. However, these features were not considered to be directly in the mainstream of the proposed project. The group raised for consideration the possibility that some settings carry out aspects of these features as special studies.

11. Logistic Issues

Several issues concerning the implementation of the project were discussed, such as the establishment of local project teams, training and related topics.

11.1 Coordinating Local Committee

The group agreed that a local committee of interested and committed persons should be organized to plan for and to ensure that the objectives of the project are realized. The team should consist of, at a minimum, if possible, psychiatric/clinical representation, an epidemiologist/statistician, representation from the various sectors participating in the project and administrative staff, and also possibly government and community leaders. The local committee would be responsible for initiating publicity to the government and to community leaders, developing local modifications to the implementation plans of the study, training survey staff, supervising implementation, ensuring early data analyses, reporting results to health administrators and to government and community leaders, and publishing results.

11.2 Training and Implementation Plan

It was recognized that each participating study area will need to determine a strategy for conducting the survey and designate a study team to carry it out. The selection of the members of the team will depend on the availability of personnel, availability of funds, scope of the survey and anticipated size of the relevant populations.

Three options for conducting the survey were considered: research team model in which a research team would have primary responsibility for filling out all forms and applying the psychiatric screens; health workers model in which local health workers (e.g., community nurses, social workers, psychiatric nurses) would be trained by research staff and have primary responsibility for filling out all forms and applying the psychiatric screens; direct care staff model in which facility staff and providers would be trained by research staff and have

primary responsibility for filling out all forms and applying the psychiatric screens.

In order to obtain annualized estimates of the number of psychiatrically ill persons receiving services and the volume of services delivered to this group, a typical week for the provider within a service needs to be chosen. While the week can vary by provider, it is desireable for a variety of reasons to have these weeks as close to each other as is possible. It was decided that each participating local area would have to decide on a typical week. The week should be chosen to take into account issues of obstacles such as holidays, weather conditions and other local factors that might produce abnormal staff levels or influence the number and types of patients who would be seen. To the extent possible, the plan for the conduct of the study should try to avoid procedures that would cause atypical patient or staff patterns, e.g., publicity about the survey that might cause either fewer or more patients to come for services during the survey week than would normally come.

12. Issues on the Study Methodology

12.1 Survey Instrument Design

Three survey instruments need to be designed in order to collect

- census, socioeconomic, health and vital statistics for the participating area and its geographical subunits,

- characteristics of the providers, and

- patient characteristics and patient service utilization data.

Appendix IIIa contains the list of items that had been suggested in the draft protocol.

It was suggested that a list of a subset of these items (Appendix IIIb) be recirculated to the meeting participants for their review and rating of these items as to usefulness, ease of collection and reliability. These ratings will be reviewed by the WHO Secretariat who will collate the responses, and develop a list of core survey items to be used by all participants.

The group agreed that the survey instruments should not take too long to fill out. Using experiences in local pilot studies, estimates of time required to gather information to fill out each item in the instrument will be obtained. Adjustments to the core set of items based on time limitations will be made locally based on the pilots.

The WHO Secretariat will develop English language wording for each data item, for the instructions for responding, and for dictionaries and will suggest a

format for the forms. The participating study areas will use these as the basis for local translations and rewording.

12.2 Sampling Issues

The group realized that total enumeration, while desirable, may not be feasible because of the number or dispersion of providers and the volume of patients seen in a week. Sampling may be necessary, and specific strategies would need to be developed on a local basis in consultation with WHO experts and consultants. The sampling goal is an accurate estimate of the number of patients served across the full scope of designated providers. Sampling strategies might be required to sample both providers and patients.

In a local study area, participating providers or services should attempt to estimate the volume of patients seen (in whatever unit of measurement is available) and to estimate the expected proportion of these patients with psychiatric disorders. Rough estimates are better than no estimates in terms of the development of a sampling strategy. These estimates together with budget and staff availability data will help to guide the choice of sampling strategies.

The methodology for sampling providers will depend on the assumptions that can be made about the expected distribution of psychatrically ill patients served by providers. Sampling rates would be developed for stratum of providers who are expected to see similar numbers of psychiatrically ill patients. Strata definitions would be locally determined.

Under the assumption that patients served by a provider randomly arrive for care, a provider specific sampling rate would be developed for administering the patient characteristic instrument and the screen for psychiatric disorders.

12 .3 Pilot Studies

An initial pilot study may need to be carried out in one or two settings to allow for first-stage modification of survey and screening instruments.

The group strongly endorsed the plan that within each participating area, a pilot study be carried out to identify necessary modifications of the core instruments. These local modifications may be required to take into account the local implementation strategy adopted, budget and time constraint issues, rewording requirements or local relevance of particular data items as a consequence of social and cultural factors. In particular, adjustment of the cutpoints of the screening instrument may be required on a local level.

In addition, it was felt that the experience of the local pilot study will guide the development of training and implementation tools for the full scale study.

13. Project Work Plan

A draft work plan was outlined by the group. A detailed and annotated version of the plan is to be prepared and circulated to the participants by the WHO Secretariat.

TABLE 1

SOCIO-DEMOGRAPHIC INDICATORS FOR SELECTED COUNTRIES

COUNTRY	CSSR	GHANA	NIGERIA	PAKISTAN	USA
Population in Millions	15.6	12.3	96.5	100.4	238
Population Density/sq.km.	122	52	103	125	25
Sex Ratio M:100F	95.2	97.2	98	107.8	95
Median Age	32.6	16.6	15.8	17.9	31.3
% Age 0-14	24.5	46.7	48.3	43.6	27*
% Male	51.1	50.6	45.9	52	51.1
% Age 65 +	11.0 **	2.8 **	2.3	2.8	11.7
% Male	38.9	49	45	52.3	39
% Urban	65.3	31.5	23	29.8	73.9
% in Cities of 100000 Pop	19	9	3	16	50.6
Illiteracy Rate %	1	49.8	56	73.8	-
GNP Per Capita/US$	-	380	800	380	13450
Life Expectancy at Birth	71	52	48.5	50	74.3
Infant Mortality per 1000 births	16	98	114	120	11
Suicide Rate/100000	18.5	-	-	-	11.6
Homicide Rate/100000	1.1	-	-	-	7.9
# Hosp Beds	195000	-	40000	58000	1.3 Mil
# Psych Beds	19700	850	2000	1200	247300
# Physicians	50000	1560	5000	46500	528000
# Psychiatrists	1200	12	50	106	27500
Leading Causes of Death	Heart Dis Neoplasms Respiratory	Cardiovascular Heart Dis Respiratory	Infectious Dis Cardiovascular Accidents	Infectious Dis Cardiovascular Neoplasms	Heart Dis Neoplasms
Cerebrovascular					

NOTES:
* 0-17
** 60 +
- Not Available

# Psychiatrists	-	-	8	6	1

APPENDIX I

List of Participants

Dr. C. Adomako, Ghana Medical School, University of Ghana; Accra, Ghana

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Dr. A. Clare, St. Bartholomew's Hospital Medical College, Department of Psychological Medicine; London EC1, UK

Dr. J. A. Costa e Silva, State University of Rio de Janeiro; R. Getulio das Neves, 22-Gavea; Cep 22.461; Rio de Janeiro, Brazil

Dr. G. Eichberger, Niederosterreisches Landeskrankenhaus fur Psychiatrie, Klosterneuburg, Austria

Dr. R. O. Jegede, University College Hospital; Ibadan, Nigeria

Dr. H. Katschnig, General Hospital of the City of Vienna, Psychiatric University Clinic, Vienna, Austria

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Dr. M. O. Olatawura, University College Hospital, Ibadan, Nigeria

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L. Roy, WHO, Division of Epidemiological Surveillance and Health Situation & Trend Assessment,

Dr. N. Sartorius, WHO, Division of Mental Health

APPENDIX II
AGENDA

Consultation on the WHO Collaborative Project on Health and Social Services Utilization by the Mentally Ill

GENEVA, 6-9 SEPTEMBER 1987

1. Opening

2. The objectives of the project

   2.1 Type and extent of mental problems in health and social services in relation to socio-demographic characteristics of a geographically defined area

   2.2 Case finding and management of mental disorders in health and social services, and implication for training of health and social workers

3. Country reports

   3.1 Austria
   3.2 Brazil
   3.3 Czechoslovakia
   3.4 Ghana
   3.5 Nigeria
   3.6 Pakistan
   3.7 Panama
   3.8 United States of America

4. Specific aspects of study design and project implementation

   4.1 Possible medium-term public health consequences to be considered in the study design

   4.2 Types of services to be included

   4.3 Types of disorders to be covered

4.4 Management of identified disorders and assessment of service utilization

   4.5 Case finding procedures (screening instruments, validation, logistics)

   4.6 Sampling design

5. Plan of work and time-table

6. Closing

APPENDIX IIIa

COMPREHENSIVE LIST OF SURVEY ITEMS EXCERPTED FROM DOCUMENT

"WHO CENSUS PROJECT", 1/86

6.5 SELECTION OF SURVEY ITEMS

The project secretariat has made a preliminary selection of variables to be included in the survey based on the "Monitoring of Mental Health Needs Project," the New York State Survey of Patient Characteristics, and the Israeli adaptation of the New York State Survey instrument. The items selected were categorized as "primary" meaning they are essential to the survey and "secondary" meaning suggested for collection.

6.5.1 CENSUS DATA

These data are to be collected on the local area census subunit level (e.g., census tract level). Items were selected on the basis of their relevance to mental health problems, their use in identifying high-risk populations, and their ability to describe the general social and economic structure of the area.

A. Primary:

1. Population Density

   Population of the country at last census

   Population of census subunit

   Area in sq. km.

2. Distribution of the Population by Sex and Age:

Age groupings have been chosen to correspond to different phases of the life cycle each of which may be linked to possible mental disorders. Based on these data, sex and age specific rates of the population in treatment will be developed for each subunit and for the entire local area.

-Number of males and number of females by age groupings:

under 15, 15-24, 25-44, 45-64, 65-74, 75 and over.

3. Ethnic distribution by sex and age

Ethnic categories will be locally determined and may be distinguished by nationality, race, language, religion, tribe, customs of dress or food, etc. To belong to a minority ethnic group, however defined, may result in an increased risk of mental illness, especially if the minority group differs considerably from the majority one.

Based on these data ethnic, sex, age, specific rates of the population in treatment will be developed for each area.

-Number by ethnic group by age groupings (as above).

4. Socioeconomic descriptors

These need to be collected for the nation as a whole, for the local area as a whole, and for the census subunits within the local area. They will be used in a social areas analysis to categorize areas from high to low (see Section 6.7.3) on the likelihood of containing populations at risk for mental illness.

-Median income

-Indicator of urbanicity

National and local area: % population living in rural, urban, suburban areas

Census unit level: classification of unit as rural, urban, suburban

-% Overcrowded housing if available; otherwise

-Housing

1. The average number of persons per household
2. The percentage of population in one-person households and in five or more person households
3. The percentage of dwellings with
   (a) one or two rooms
   (b) three or four rooms
   (c) five or six rooms
   (d) seven or more rooms.

The size of dwellings in relation to the size of households, will be used as an indication of overcrowding.

5. Annual Vital Statistics

(a) Live births, legitimate and illegitimate; number; rate per 1,000 population

(b) Infant mortality rate

(c) Total deaths and crude death rate per 10,000

(d) Marriages and divorces

Items (a) through (c) can provide some indications of the general health status of the area. Information about illegitimate births and the number of divorces (in relation to the number of marriages) may be indicators of the degree of stability of the population. In interpreting such data, however, it must be kept in mind that in certain countries communal marriages are commonplace and birth of children as a result of these "marriages," though reported as illegitimate, do not represent problems to society. Hence, data on illegitimate births must be considered in light of the customs of the country.

B. Secondary:

1. Population 15 and Over, Age, Sex and Marital Status

(15-24, 25-44, 45-64, 65-74, 75 years and over)

Marital status rates for different age groups will reflect different expected patterns
of service utilization and "risk." For example, single persons under 25 years of age are not a high- risk group; single persons 45-64 years are.

2. Five Leading Causes of Death by Age

(infants, under 1 year; young children aged 1 to 4; school children, aged 5-14; young adults, aged 15-29; middle-aged adults, aged 30-64; and older persons, 65 and over)

Cause of death may be indicative of the level of the general health services in the study area; if causes of death reflect a poor level of general health care, there will be little chance for more than the minimum provision of specialized mental health services, at least until more basic health services are available. In some developing countries, cause of death is not tabulated, or if tabulated, may be considerably underreported; hence, such

data may not be useful as an indicator of the general health of the area. Decisions regarding use of these data will be made in consultation with local authorities.

3. Migration

Migrants may come from another country, or they may move to/from other areas within their own countries. Persons who are likely to be at risk of developing mental disorders include foreign workers who are not allowed to bring their families with them and migrants from within the country, especially those moving from rural to urban situations and from nomadic to urban living.

4. Other Important Minority Groups, e.g., Refugees: Refugees may have an increased risk of mental disorder because of their experiences before leaving their countries, the loss of family, friends and often worldly goods, and the difficulties of adaptation to new environments.

5. Employment

The percentage of economically active persons provides a general idea of the socioeconomic status of an area. For example, a large proportion of employed children under 15 years of age may be consonant with poor educational levels and general underdevelopment. In some countries, a higher proportion of women working, especially during the childbearing ages, may relate to a risk of stress for them and their children.

6. Industry

These data indicate whether an area is predominantly agricultural or industrial.

7. Education

These data not only reflect the stage of development of the community, but also examined together with employment, can indicate some high risk situations. For example, if substantial proportions of those with high educational levels are

unemployed, this may indicate risk of frustration and other stresses for them which may result in behavioural disorders.

8. Health Resources

These data show the extent of general inpatient and outpatient health and specialized care available. The level of general health care available seems to be an indicator for the probable development and growth of the mental health services. If the general health care system is adequate, there is a better chance that a mental health system can be or has been developed.

9. Suicide Rate and Criminal Statistics

These are useful indicators of the stability of the society.

10. Other Social or Demographic Factors Important to Mental Health or Mental Health Services in the Study Area

The items would indicate unusual factors which might cause problems in a particular area. For example, migrants coming into an area without their families may bring special problems not affecting other area.

6.5.2 DESCRIPTION OF THE PROVIDERS

Characteristics of the providers who participate in the study will be obtained. Information will be collected on the type of organization, the types of services provided, revenue and staffing patterns.

A. Primary:

1. Type of Organization

This refers to the operational auspices or organization of the facility. These could be categorized as:

a. Public

Federal, national, regional, hospital administrative area

b. Nonpublic

For profit: individual, partnership, corporation

Not for profit: religious, university, others

2. Modality of Services Provided

At the primary level, the broad levels of service will be collected. Possible categories are:

a. Inpatient/Institution based:

Freestanding hospital for the mentally ill

Psychiatric ward in general hospital

Night hospital

Psychiatric nursing home

b. Residential/Community based:

Halfway house

Supervised living: therapeutic communities, work villages, hostels

Supportive living

Crisis residence

Family care home

c. Outpatient:

Clinic treatment programmes

d. Day Treatment:

Psychiatric treatments received for several hours

e. Day training:

Sheltered workshops, training centres,

patient cooperatives

3. Sources of Revenue:

a. Public

b. Union/worker funds

c. Private

patients fee

insurance

others

B. Secondary:

1. Groups served classified by broad age groupings (children, adolescents, adults and aged) including: mentally ill; mentally retarded; alcoholics; epileptics; offenders; referrals for diagnosis (outpatient programs only); former patients (for rehabilitation or industrial work included in data collection in day care programs only).

2. Specific details on modalities of service

For outpatient modalities, the range of services provided: general psychiatric treatment; child guidance; marriage guidance counseling; EEG, ECT; diagnostic services; group therapy; others (to be specified).

For day treatment and day training, the range of services provided: general psychiatric treatment; group therapy; occupational therapy; paid industrial work; rehabilitation; other psychiatric care; physical exercise; social activities; personal care; others (to be specified).

For inpatient facilities: number of wards; number of beds in each ward; available staffed beds.

3. Staffing Patterns

For each profession the full time equivalents of patient care staff; general administrative and supportive staff.

6.5.3 DESCRIPTION OF THE PATIENTS

Patients who receive service during the one week period of the study in a special mental health facility or who have been identified as ill on a screening instrument and

who were subsequently diagnosed as mentally ill by a mental health specialist of the area will be included in the survey. The following items are to be collected on each patient:

A. Primary

1. Place of residence (coded to the census subunit level)
2. Sex
3. Date of birth or approximate age
4. Marital Status

   This could be categorized as never married, presently married, separated/divorced, widowed, unknown.
5. Ethnicity

   These categories will be locally determined and should be in the same form as the categories used for ethnicity in the census data.
6. Date of Most Recent Admission to Unit

   This data should represent the date on which the patient began to receive service from the reporting unit.
7. Legal Status

   This item pertains to inpatients and could be categorized as voluntary or involuntary.
8. Number of Residential Days Since Latest Admission

   This is the length of stay for inpatients and days in residential care for those in other intramural settings.
9. Type of Programme/Service

   This should identify the modality of care and for nonresidential programmes the type of service being received. These service types should be the same as these used in the description of the providers.
10. Number of Visits During Survey Week

    If a patient receives multiple services, the number should be made specific to the type of service type.

11. Probable Source of Revenue

    Categories should be identical to those used in the description of the providers.

12. Prior Service

    This variable will aid in determining the chronicity of the patient and should not be limited to the type of service given by the reporting Unit. Possible categories are: no prior, prior inpatient/institutionalized, prior residential/community based, prior nonresidential mental health care.

13. Diagnosis

    This should represent the locally determined diagnosis associated with the reason for the service.

14. Comorbidity

    This should cover any significant disabilities the patient has besides mental illness. Possible categories are: physical disability (to be coded), mental retardation/developmental disability, alcoholism/alcohol abuse, drug/substance abuse.

15. Current Employment Status

    Current refers to a two week period prior to admission to the reporting unit. This is a good indicator of the patient's level of functioning. Possible categories are: employed full time, employed part time, unemployed, looking for work, unemployed, not looking for work, army, not in the labor force (homemaker, child, student, retired, inmate of institution).

16. Number of Weeks Since Last Service with any Provider in the Scope of the Survey

    This question is included to allow for the estimation of the annual size of the population from the one week sample. If the patient's last service was within the reporting unit, medical records can be checked. Otherwise contact with other providers may be required. Caution should be used if patient or family recall is the basis of the response. Cross-validation among "significant others" should be attempted.

    Instructions on the required response to this question will note that

inpatients or residential patients who have been in continuous treatment for more than one week should report "one week."

B. Secondary:

1. Housing/Living Arrangements

   Possible categories:
   Housing - in household, group quarters, in institution, homeless.
   Living - alone, with parent(s), with spouse, with children, with other relatives, with non-related persons.

2. Source of Referral (of admission)

   Possible categories:
   self/family/friend, criminal justice system, private health practitioner, mental health clinic, school, public welfare agency, general hospital, psychiatric hospital, community residence, nursing home.

3. Termination disposition (if discharged within week)

   Possible categories:
   No referral: no further treatment need, further treatment needed but rejected,patient moved/died,
   lost contact with patient, left treatment against medical advice, referral service needed not available.
   Referral: inpatient/institutional care, residential/ community based care, outpatient, day treatment/ training, local practitioner.

APPENDIX IIIb

DRAFT LIST OF SELECTED ITEMS FOR CORE STUDY

WHO Collaborative Project on Health and Social Services Utilization
by the Mentally Ill

Item Evaluation

In order to assist in the development of the survey instruments for the WHO Collaborative Project on Health and Social Services Utilization by the Mentally Ill, we would like you to rate each of the following items which are proposed for inclusion in the surveys on their usefulness, reliability and ease of collection. The rating scales are defined below. Note that in each case "1" denotes the "best" evaluation, and "5" the "worst." Rate each item on each dimension. Please note we are only asking you to rate the item type. Specific categories for items will be locally determined. Any categories shown are only for illustrative purposes.

Usefulness

Will the item in question be useful for planning purposes or provide a clinical understanding of patient populations? Use the following scale to rate each item:

1 = Extremely useful
2 = Very useful
3 = Somewhat useful
4 = Not too useful
5 = Not useful at all

Reliability and/or Accuracy

How well will the information reflect the real situation? Would two different respondents fill in the response in the same way? Use the following scale to rate each item:

1 = Extremely reliable
2 = Very reliable
3 = Somewhat reliable
4 = Unreliable
5 = Very unreliable

Ease of Collection

How accessible to most potential respondents is the information required to answer each item? Use the following scale to rate each item:

1 = Extremely easy to collect
2 = Very easy to collect
3 = Somewhat easy to collect
4 = Difficult to collect
5 = Very difficult to collect

Place in the columns the rating that indicates your evaluation of each item. In each case, "1" denotes the "best" and "5" the "worst" evaluation.

	USEFUL	RELIABLE	EASE OF COLLECTION
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
I. CENSUS DATA			
A. Population Density			
1. Population at last census:			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
2. Size of area:			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
3. Other, specify:_____			
B. Population Distribution by Sex, Age, Ethnicity, Marital Status			
1. # Males and # Females			
In age categories			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
In ethnic categories			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
In age/ethnic categories			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____

	USEFUL	RELIABLE	EASE OF COLLECTION
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2. Marital Status			
In sex categories			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
In sex/age categories			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
C. Socioeconomic Descriptors			
1. Median Income:			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit	_____	_____	_____
2. Urbanicity: defined by			
% people in rural areas,			
% in urban areas,			
% in suburban areas			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
3. Housing:			
average # persons in a household			
% people in households larger than average			
% people in 1 person households			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____
Average # rooms in a dwelling			
% dwellings larger than average			
% dwellings smaller than average			
National	_____	_____	_____
Local study area	_____	_____	_____
Census subunit within study area	_____	_____	_____

4. Other, specify:_____

	USEFUL	RELIABLE	EASE OF COLLECTION
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

D. Annual Vital Statistics

1. All live births, legitimate and illegitimate:
   Rate per 1,000 pop.
   National _____ _____ _____
   Local study area _____ _____ _____

2. Infant mortality rate:
   Rate per 1,000 births
   National _____ _____ _____
   Local study area _____ _____ _____

3. All deaths: Crude death
   Rate per 10,000 pop.
   National _____ _____ _____
   Local study area _____ _____ _____

4. Marriages: Number
   National _____ _____ _____
   Local study area _____ _____ _____

5. Divorces: Number
   National _____ _____ _____
   Local study area _____ _____ _____

6. Other, specify: _____

_____

_____

_____

COLLECTION	USEFUL	RELIABLE	EASE OF
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

II. DESCRIPTION OF SERVICES/PROVIDERS WHO PARTICIPATE IN THE STUDY

1. Sponsorship of service/provider: (e.g., government, charities, private) _____ _____ _____

2. Types of services provided: (e.g., psychiatric inpatient, general health outpatient, residential) _____ _____ _____

3. Sources of payment for services: (e.g., government, union/worker funds, private insurance) _____ _____ _____

4. Staffing: (e.g., number of full time equivalents by professional type) _____ _____ _____

5. Other, specify: _____

_____

_____

_____

	USEFUL	RELIABLE	EASE OF COLLECTION
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
III. DESCRIPTION OF PATIENTS SEEN IN THE SURVEY PERIOD			
1. Place of residence (e.g., address code)	_____	_____	_____
1a. Type of residence (e.g., own home, group home)	_____	_____	_____
2. Sex	_____	_____	_____
3. Date of Birth	_____	_____	_____
3a. Age	_____	_____	_____
4. Marital status	_____	_____	_____
5. Ethnicity	_____	_____	_____
6. Type of programme/service	_____	_____	_____
7. If inpatient, legal status (voluntary/ involuntary admission)	_____	_____	_____
8. If in residential service, number of residential days since latest admission	_____	_____	_____
9. If outpatient, number of visits during survey period	_____	_____	_____
10. Probable payment source for service	_____	_____	_____
11. Prior psychiatric service	_____	_____	_____
12. Psychiatric diagnosis			
-For patients in psychiatric services use clinical diagnosis			
Primary	_____	_____	_____
Other	_____	_____	_____
-For patients in non-psychiatric services diagnosis to be based on screen and clinical confirmation			
Primary	_____	_____	_____
Other	_____	_____	_____

	USEFUL	RELIABLE	EASE OF COLLECTION
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13. Comorbidity (e.g., physical illness, physical disability, mental retardation/ development disability, alcoholism/ alcohol abuse, other substance abuse)	_____	_____	_____
14. Current employment status (e.g., full time, part time employment; unemployed, looking for work; unemployed, not looking for work; not in labor force-homemaker, child, student, retired, inmate of institution)	_____	_____	_____
15. Number of weeks since last service with any provider in the scope of the survey	_____	_____	_____
16. Number of weeks since last service with this provider	_____	_____	_____

17. Other, specify: _____

_____

_____

_____

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