

0915

WORLD HEALTH ORGANIZATION



ORGANISATION MONDIALE DE LA SANTE

HLT

SOUTH-EAST ASIA REGION

INFORMATION
ORIGINAL IN REGISTRY FILE

M4/87/35 SE 197

SEA/Ment/92 ✓
16 February 1987
RESTRICTED

Psychology, Social

South-East Asia

6561-2



DEVELOPMENT OF EFFECTIVE PSYCHOSOCIAL INTERVENTIONS

Report on a Meeting of the Regional Coordinating Group for the Mental Health Programme. *Meeting*

SEARO, 22-27 September 1986

RECEIVED IN REGISTRY
13 MAR 1987
REP-WHO-GENEVA

Project: ICP RPD 002

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted or quoted without the agreement of the World Health Organization. Authors alone are responsible for views appearing under their names.

100

CONTENTS

	<u>Page</u>
1. INTRODUCTION	1
2. OBJECTIVES OF THE MEETING	1
3. STATUS REPORTS OF WORK ON INDICATORS	1
3.1 The Subjective Well-Being Inventory (SWBI)	2
3.2 Child Mental Health and Healthy Psychosocial Development	2
3.3 Psychosocial Aspects of Primary Health Care Services	3
3.4 Quality of Community Life	4
4. A HEURISTIC MODEL OF CLASSIFYING BEHAVIOUR AS A BASIS FOR INTERVENTION	
5. OUTLINE OF PLANS OF WORK ON THE FURTHER DEVELOPMENT OF INDICATORS AND OF PSYCHOSOCIAL INTERVENTIONS	5
5.1 Subjective Well-Being	5
5.1.1 Further development of the subjective well-being inventory (SWBI)	5
5.1.2 Interventions to improve subjective well-being	6
5.2 Psychosocial Health of the Child	8
5.3 Quality of Community Life	10
5.4 Psychosocial Interventions of Primary Health Care	10
5.4.1 Recording psychosocial problems by primary health care workers	11
5.4.2 Video Films of Primary Health Care Workers at Work	11
5.4.3 Role-playing	11
5.4.4 Communication facets	11
6. FUTURE WORK AND CONCLUSIONS	12

ANNEXES

1. List of Participants
2. Agenda
3. List of Background Documents

4. Address by Dr U Ko Ko, Regional Director,
WHO South-East Asia Region
5. Outline of a Protocol for the Further Development of the
Subjective Well-being Inventory (SWBI)
6. Proposed Project: Mental Health Education for School-age Children
7. Psychosocial Interventions in Patients with
Functional Complaints
8. Outline of a Protocol for Work on Adversity and the SWBI
9. Outline of a Protocol for Work on Healthy Child Development
10. Development of an Interview Instrument for Measuring the
Quality of Community Life
11. Study on the Impact of Recording Health Problems Tri-axially
on the Psychosocial Sensitivity of Health Personnel

1. INTRODUCTION

The meeting of the Regional Coordinating Group for the Mental Health Programme was held at the WHO Regional Office for South-East Asia, New Delhi, from 22 to 27 September 1986. It was attended by participants from six countries of the Region. The list of participants and secretariat are attached (Annex 1). The agenda for the meeting is given in Annex 2.

This meeting is in continuation of three previous meetings, held in 1982, 1983 and 1985, respectively, for the planning and coordination of components of the Regional Mental Health Programme.

A list of background documents is attached as Annex 3.

Dr U Ko Ko, WHO Regional Director, who inaugurated the meeting, welcomed the participants, and emphasized the importance of mental health to meet the target of 'Health for All' by the year 2000, to which all Member Countries are committed. He noted with satisfaction that mental health services had become more community-oriented during the past decade. Various countries had evolved mental health training programmes for workers of different levels and initiated decentralization of mental health services. The topic of this meeting contained broader aspects of mental health, and he expressed the hope that the technologies evolved following the work to be planned by the Group would help to improve the quality of health care and facilitate community participation, which is crucial for the success of all health programmes. (see Annex 4 for the full text of the address).

Dr Prawase Wasi was nominated as the Chairman and Dr Narender Kumar as Rapporteur for the meeting.

2. OBJECTIVES OF THE MEETING

The specific objectives of the meeting were defined as follows: To establish a regional plan of work for the development of psychosocial interventions in major public health concerns such as malnutrition, EPI and family planning non-compliance and sanitation, as these are reflected in the indicators of mental health, work on which is going on in the Region. These intervention trials will finally lead to training packages on behavioural and social skills for general health staff and other agents of development.

3. STATUS REPORTS OF WORK ON INDICATORS

During the last two meetings of the Regional Coordinating Group in 1983 and 1985, detailed plans for work on various groups of indicators of mental health have been prepared (ref. documents SEA/Ment/79 and 89). The following are summaries on the status of implementation of these plans of work.

3.1 The Subjective Well-Being Inventory (SWBI)

In an initial process of protracted brainstorming, eight broad areas had been identified which were perceived as being related to, or parts of, subjective well-being. A set of 130 questions covering these theoretical dimensions was prepared, pre-tested and administered to a sample of 520 persons from the general population in and around Delhi. These responses were subjected to factor analysis and 13 meaningful factors were obtained. All items loading .40 or above on any of these factors were retained. Thus, the number of items was reduced to 102. This work has been published*. The 102-item questionnaire was administered to two samples from Bangalore and Jodhpur, respectively, and factor analysis was again carried out. The results very clearly confirmed the factorial structure as established, based on the first sample. However, two factors were considered not sufficiently robust over the samples and were dropped. Furthermore, a sub-sample of the original sample was re-tested 18 months after the original interview. The responses showed a high degree of stability over time. As had been predicted, positive items showed a higher stability over time than did negative ones. The number of items had been further reduced to 58, based on factor loadings. A further sample showed a relative increase in correlations between items not belonging to the same factor in some areas, perhaps pointing to an increase of transfer effect between items following the reduction in their number. However, overall, the factorial structure still remained very clear. A further reduction in the number of items per factor can thus still be tried.

3.2 Child Mental Health and Healthy Psychosocial Development

The work on indicators of child mental health and healthy psychosocial development in Indonesia was initiated in 1983. In the first stage, a questionnaire was developed to cover three factors which were considered to be important, namely, (1) an emotionally stable and reassuring surrounding, (2) good social interaction with other children and adults, and affectionate attachment to key persons, and (3) sufficient social and intellectual stimulation. The inter-rater reliability was found to be quite unsatisfactory, however.

At the meeting in September 1985, it was agreed that the main objective was to develop indicators for the family and home environment, in order to identify markers of 'at-risk families'. It was decided that the study should focus on five factors, adding the capacity of the child to express happiness and the impact of preventive and promotive programmes to the three areas mentioned above.

The present study was carried out on 250 families selected using stratified random sampling from a population of one kecamatan. The 125 variables were reduced to 24 by deleting the inefficient variables using the criteria of strength of the theoretical base and absence of multicollinearity. These 24 variables were factor-analysed to yield nine factors.

A multiple regression analysis was done on: (a) the psychosocial condition of the family (family health), and (b) the child's health, to assess which of the 24 variables contributed significantly to these. Three

*Subjective Well-Being: SEARO Regional Health Papers No. 7, WHO/SEARO, 1985.

variables contributed to both family health and child's health: poverty rating, frequency of temper-tantrums and regular daily routine for the child's activities. Further, the item 'organization of the home' was a predictor of the child's mental health, and the item 'supervision during play' predicted the psychosocial health of the family.

It was recommended that the study should be carried out in relatively poor areas. This would help in the identification of more variables for intervention and also provide an opportunity to validate the instrument with another independent criterion, namely, malnutrition.

The 'home risk card' developed in Sri Lanka was now in use in the entire country. The use of 'home risk cards' had shown that 5 to 20% of families were 'at-risk' families.

A UNICEF-funded cross-sectional study on optimal and risk factors for child development had produced data adding to the validity of the 'home risk card'. The preliminary results show, for example, that children from homes rated as disorganized have on the average a delay of one year in copying a square at the age of 6 years as compared to children from homes rated as organized. There were also more refusals in children from disorganized homes and lower rates of health compliance.

3.3 Psychosocial Aspects of Primary Health Care Services

At the meeting in 1985, it had been agreed that the work should be carried out by covering four sources of information on psychosocial aspects of PHC using four different instruments: (1) patients' satisfaction with the clinic contacts, (2) integration and social acceptability of health workers as reported by the health workers themselves, (3) community leaders' opinion/experiences of PHC services, and (4) household heads' opinion/experiences.

A study on the first aspect, viz., patients' satisfaction with the clinic contact, had been carried out at Bali. Three proformae (used before, during and after the clinic contact) were administered to 400 cases attending the OPD. The patients' satisfaction, as elicited after the out-patient contact, was found to be quite high in most cases. The number of patients with low satisfaction was probably too small to provide adequate information on possible reasons for dissatisfaction with PHC services. This may be the result of a bias in the reporting of satisfaction, due to the fact that patients were asked to give their opinion by employees of the clinic itself and at the time when they had come to seek help from the clinic. Further, the rates of non-respondents was not clear. It was recommended that these points be clarified between Dr Salan and the investigators.

The regression analysis of the data showed that four items were good determinants of patients' satisfaction: the method by which the patient came to the health facility, the length of service of the physician in the health facility, the expectations expressed by the patient prior to the clinical contact, and the health worker's inclination to respect and understand the patient's feelings.

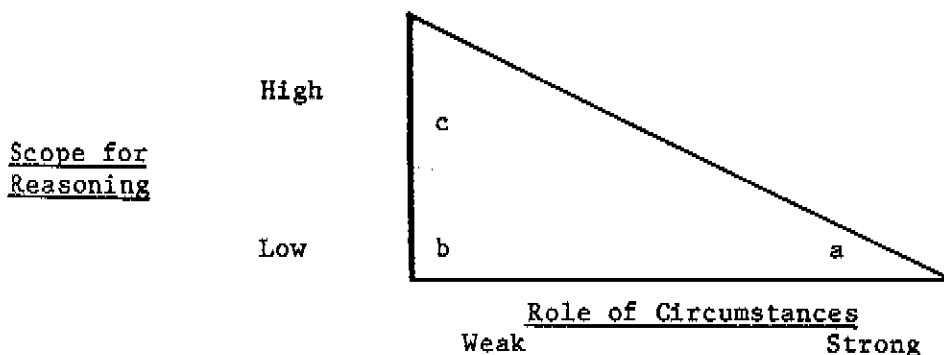
It was found that asking patients about their expectation before the clinic contact did not influence their satisfaction.

3.4 Quality of Community Life

No progress was reported in implementing the detailed plan of work prepared in 1985 in this area. Data from Thailand will, however, be available in six months.

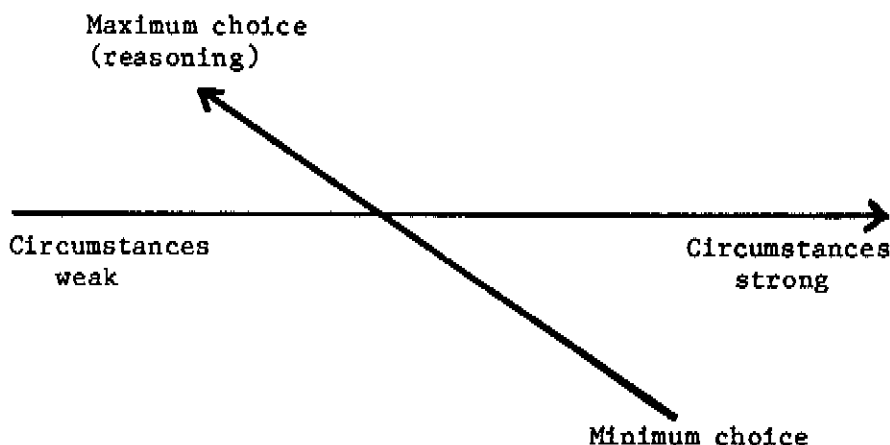
4. A HEURISTIC MODEL OF CLASSIFYING BEHAVIOUR AS A BASIS FOR INTERVENTION

A heuristic model of classifying reasons for certain behaviours was discussed. The model is shown below in diagram form:



Corner 'a' in the above diagram depicts strong influence of circumstances. The intervention in such a situation may attempt to develop coping skills which may bring about 'desensitization' to the external pressure or situation. Some forms of suicide, mob violence and initiation to illicit drugs are examples of such impetuous harmful behaviours. Corner 'b' depicts strong emotional and 'internalized' stimuli. Political or religious fanatics or drug addicts would be located near 'b'. Type 'b' behaviours will require social interventions through the environment of the person concerned. A behaviour in a situation of relative free choice would be located in the corner 'c'. Interventions to change such behaviours will be an increase in knowledge and measures of general unspecific motivation. It was agreed that there were, in fact, a large number of dimensions which influence behaviour and the latter cannot be completely depicted by a simple scheme as given above. However, the group agreed that a simple heuristic model of classifying or diagnosing behaviour may be useful for developing psychosocial interventions. It was also noted that the usefulness of the model is actually being field-tested in some projects in the Region, especially the feasibility of its use by basic health workers.

It was suggested that the behaviour model be depicted in a slightly different form to make it more dynamic, as shown below:



The two axes are conceived as oblique because the strength of circumstances must obviously be perceived as correlated with the possibility to choose (expressed in the triangle by the need to stay inside the triangle). The bi-axial model above would permit, for example, a 'wise abstainer amongst heroin users' in the right upper space.

While agreeing on the usefulness of these heuristic models as models to classify behaviours and develop interventions accordingly, the group did not express preference for either of the two presentations. However, it was pointed out that the triangle may be easier to grasp for basic health workers of low educational status. It was proposed that the acceptability of both presentations to such personnel be compared.

5. OUTLINE OF PLANS OF WORK ON THE FURTHER DEVELOPMENT OF INDICATORS AND OF PSYCHOSOCIAL INTERVENTIONS

The following summary outlines for work in the various areas for which indicators have been or are being developed were prepared by small groups during the meeting.

5.1 Subjective Well-Being

The Subjective Well-Being Inventory (SWBI) presently consists of 58 items which form 11 independent factors. These factors possess a high internal consistency and are extraordinarily robust and replicable even in relatively small samples from different parts of India.

The group agreed to the following plan of work:

5.1.1 Further development of the subjective well-being inventory (SWBI)

For work on the further development of the SWBI, the following components were identified:

(1) A further reduction in the number of items. In its first version the SWBI consisted of 130 items. This number has so far been reduced to 58 without weakening the factorial structure. From the original 13 factors, 11 have been shown to be sufficiently robust to retain their clear identity even in small samples from various parts of India and in five different languages (English, Hindi, Kannada, Malayalam and Tamil). In the 58-item version, each factor is represented by 5 items (with some additions for clinical reasons). It was agreed that the instrument may usefully be further shortened to retain only three items per factor. For reasons of special 'clinical' interest, all items of factor 8 ('inadequate mental mastery') will be retained since this factor seems to represent depression and equivalents. Equally, the six items of factor 9 ('perceived ill-health') will be retained for reasons of SEARO's special interest in patients with functional complaints and because such complaints have been shown to vary in their specific prevalence regionally, making a greater comprehensiveness advisable.

A 40-item instrument will, therefore, evolve. This will be used for further work if it can be shown that the factorial structure is retained, in spite of the further reduction in the number of items.

(2) Identification of items/factors which contribute to single-item or overall assessment of subjective well-being

A number of studies have shown that an overall or single-item rating of subjective well-being has a fair degree of validity and also of reliability and stability over time. Since such single-item measurements are extremely easy to obtain and, therefore, likely to be used in the future also, it will be important to establish data on the mechanism by which individuals arrive at a global rating of well-being in relation to the detailed evaluation of the various life concerns when using the SWBI. Several hypotheses can be tested: (a) Each individual has his personal strategy or value system to draw his/her global rating from any of the factors or an individual combination, i.e., the overall rating cannot be interpreted in terms of the SWBI, (b) the overall rating is drawn from a summary or averaging process of a special factor or a fixed set of factors, (c) there are several processes each followed by certain groups of individuals, e.g., some draw the overall evaluation from a sum of all positive factors and others from a sum of all negative factors, and the like.

(3) Applicability and usefulness of the SWBI for specific population groups

Amongst the four samples studied to-date (about 1200 persons), certain groups are under-represented, viz., women, adolescents and the elderly. Larger numbers of these groups need to be studied in order to permit separate factor analyses for each group to ensure comparability of the factorial structure of the SWBI for each. Equally, a factor analysis for the different socio-economic groups is needed to confirm universality of the identified factorial structure.

The group prepared an outline of a protocol for the work under (1)-(3) above, which is annexed (Annex 5).

5.1.2 Interventions to improve subjective well-being

Four priority areas were identified in which work should be done to develop interventions to improve well-being or reduce the risk of ill-being:

(1) Interventions in adolescents

It is hypothesized that by imparting social, problem-solving and coping skills in small group interactions to high school or college students between 12-25 years, the subjective well-being of adolescents and youths can possibly be increased. The precise techniques to be used will have to be developed but it was pointed out that a substantial body of expertise exists already on which to build, including experiences in India. Such intervention trials may clarify the relative importance of some specific factors of the SWBI, particularly Subjective Well-Being - Positive Affect, Expectation - Achievement Congruence, Confidence in Coping, Transcendence and Inadequate Mental Mastery. They may also reduce the risk of youths participating in anti-social or other harmful impetuous behaviour and, therefore, form a useful component of 'education for responsible living', for example, in the context of the career guidance programme in Indonesia.

A draft protocol outline prepared in WHO headquarters was presented to the group (Annex 6). The group expressed keen interest in this project which has clear linkages with projects in the SEA Region (mainly in India, Indonesia and Sri Lanka) to develop education material to prevent specific harmful impetuous behaviours in adolescents, such as initiation into illicit drug use, group violence, suicidal behaviour, teenage pregnancies and the like. The view was expressed that the age range for this protocol (Annex 6) may perhaps usefully be higher since the formative years for adult personality traits as well as the age of particular risk of impetuous harmful behaviour is likely to be from 14 years onwards.

Also, the time period for evaluation which is two months in the proposal may be too short because the impact of highest interest is, of course, in the long term. An evaluation after at least 6, but probably 12, months should, therefore, be added.

(2) With an increasing number of elderly in the population of developing countries, and in view of the far-reaching changes in the social rules following urbanization and industrialization, intervention programmes for the protection and improvement of the well-being of the elderly are particularly appropriate.

For purposes of the development of effective psychosocial interventions in the elderly, four groups were identified as particularly accessible in sufficient numbers:

- (a) the rural elderly
- (b) institutionalized elderly
- (c) pre-retirement employed persons
- (d) members of ex-service organizations.

Some specific risk situations could also be envisaged for intervention trials:

- (a) retirement
- (b) bereavement
- (c) physical illness
- (d) return from prolonged hospitalization (de-institutionalization).

It was proposed that interventions to be developed would also cover social and coping skills and this training should also be given in small group interactions.

As a measure to evaluate impact the SWBI should usefully be supplemented by a simple measure of self-esteem. Factors known to affect the well-being of the elderly will have to be controlled, such as group and other social activities, health and economic status, disabilities, especially those affecting communication (hearing, seeing problems), job and leisure opportunities, etc. The above training should also be supplemented by factual information about ageing, the dynamics of well-being and ill-being, the sequences of reactions to bereavement, and the like.

It would probably be possible to find sponsorship from voluntary or government agencies, or employers in case of pre-retirement training, for such interventions.

(3) Interventions in patients with functional complaints (FC)

It was agreed that the SWBI may be a useful tool to establish sub-groups in the large numbers of patients presenting themselves as FC in primary care settings. These patients cannot actually be classified in a satisfactory manner. The reason why no intervention or treatment strategies have consistently proven superior to non-intervention may well be the heterogeneity of this patient group.

Work in this area will, therefore, have two phases:

- (a) efforts to develop some sub-grouping, and
- (b) the development of specific interventions for eventual sub-groups of FC cases.

An outline of a protocol is annexed (Annex 7).

(4) Interventions in persons facing severe adversity

It is hypothesized that the classical three phases following bereavement, viz., denial, hopelessness or demoralization, and reorganization can be reflected in specific changes in scores of positive and negative factors.

The phase of denial would be characterized by an increase in negative scores with little or no changes in the positive scores (more negative outlook on life but unaffected positive outlook or, in HEADEY and WEARING's terms, maintained extroversion but reduced personal competence).

In the phase of demoralization, both sets of factors would be affected equally. During reorganization the positive factors would return to their earlier levels, irrespective of the behaviour of the negative scores.

Interventions would aim at shortening or avoiding the phase of demoralization, and especially prevent 'chronic demoralization'.

It was pointed out that adversities may usefully be classified as to their loss and their threat components. Furthermore, it may also be controlled whether predictors can be found for an increased probability of physical disorders (such as streptococcal infections) as a consequence of adversity. It was proposed that as many contextual factors be included in a study as possible. As measures in addition to the SWBI, neuroticism and a brief measure of self-esteem may also be useful.

An outline of a protocol for this work is annexed (Annex 8).

5.2 Psychosocial Health of the Child

Within all populations there are families in which at least some of the children are at risk of developing adverse health consequences and of being slow to develop. Work has already been carried out in Sri Lanka and Indonesia which has led to the development of a list of risk factors which can help to identify such families.

Considerable work has taken place in many countries on providing psychosocial interventions to improve the development of children. However,

such work rarely concentrated on children and their families most in need of such interventions. Both home-based and centre-based interventions have been evaluated. The advantage of home-based interventions is that they have a higher likelihood of being continued by the mother throughout the early years of the child and of generalizing to other siblings, whereas centre-based ones may rely too much on interventions from others outside the family and may, therefore, not be compatible with the routine the child is expected to follow at home. Such early stimulation programmes are only of recent origin in the SEA Region and experiences in their successful management are, therefore, rather limited. WHO has, therefore, sent a short-term consultant to two countries of the Region on the issue of early stimulation. These consultancies made it very clear that whereas considerable progress had been made in the Region to identify risk families, there was little expertise on intervention programmes. For this reason, a set of indicators of the quality of day care/early stimulation programmes has been developed in SEARO and is actually being field-tested in Sri Lanka.

Three areas were identified by the group wherein activities related to interventions for improved child development could be envisaged:

- (1) Health education. Education on family life and on children's needs, including early stimulation, could be imparted during marital counselling, during antenatal contacts or in schools. This could be done through intermediaries such as social workers, traditional birth attendants or community leaders. Such education could consequently be evaluated.
- (2) Intervention through a service infrastructure. Service interventions such as antenatal care and growth and development monitoring will have in their own right an impact on children's physical and psychosocial development. Monitoring of child development in the form of acquainting mothers with a developmental ladder will probably have considerable impact on children's development by improving maternal care. Similarly, day-care programmes, especially when specifically involving 'risk mothers', are likely to improve child development. However, it has been shown that without this specific involvement of risk mothers, children most in need are unlikely to benefit substantially from day care. At least for schools it has been shown that children from high adversity homes show a particularly high rate of emotional and behavioural problems when going to good schools.
- (3) Research. Priority areas for research in the field of child development were considered those where tools for service development or improvement are required. For the countries of the SEA Region, this would include development of easily and reliably quantifiable milestones appropriate for the various cultures and for the infrastructure which is meant to use them, including mothers; development of simple screening instruments for the early recognition of psychopathology in children; and instruments to identify risk families.

Out of the above areas of work, the group decided to choose the evaluation of a simple intervention aimed at improving healthy child development through the use of an aid for mothers to monitor child development, i.e., a developmental 'ladder' as proposed by one consultant for Indonesia. The outline of a protocol is attached (Annex 9).

5.3 Quality of Community Life

Little work has been done on the development of indicators for the quality of community life, as outlined in the previous reports of the Regional Coordinating Group (docs. SEA/Ment/79 and SEA/Ment/89). The group, therefore, found it difficult to conceptualize work on interventions in an area in which the main focus of work will have to remain on the development of measures to quantify the eventual impact of such interventions. At the same time, the group agreed that the development of indicators of the quality of community life should have a high priority. A vast number of development projects are going on in the Region, being carried out by governments and nongovernmental organizations as well as private, bilateral and multilateral agencies, and some of them are considered highly successful, but all lacking quantifiable measures for their impact in terms of their final aim, viz., an improvement of the quality of community life and individual well-being. There was agreement that measures for the quality of community life and for the subjective well-being of individual members of the community would probably share a substantial part of their variance. Therefore, studies on the quality of community life should usefully also include measures of subjective well-being.

In view of the considerable amount of work still needed to develop simple, reliable and valid measures of the quality of community life, the group felt that it would be somewhat premature to draft a plan for the development of specific interventions. Instead, the indicators could be developed and validated in areas where seemingly successful development projects are going on (examples of these were mentioned from Bihar, India, e.g., Usha Martin, a private enterprise; Nepal, Indonesia and Thailand). This would perhaps lead to the identification of features of such programmes critical for their success. Such features could then later form the basis of specific interventions for testing. The outline of a protocol for work on indicators of the quality of community life is attached (Annex 10).

5.4 Psychosocial Interventions on Primary Health Care

Primary care physicians have been shown in a SEARO-coordinated multi-centric study in the Region to exhibit very little communication skills during out-patient contacts, to recognize psychosocial problems very infrequently unless specifically trained to do so, and to give hardly any advice except on drug-taking and diet. The amount of 'informational care' is equally low (SEA/Ment/78). Furthermore, over-prescribing and indiscriminate prescriptions for patients with psychosocial problems are widespread, thereby incurring enormous wastage and possibly resulting in health hazards.

To develop techniques to increase the psychosocial sensitivity of health personnel was, therefore, agreed to be a high priority for the Region. Several possible interventions were discussed for evaluation.

5.4.1 Recording psychosocial problems by primary health care workers

Traditionally, only physical problems are recorded in primary care settings. It is possible that training of primary care workers to record psychological and social problems in addition to the physical ones, i.e., tri-axial recording, may lead to increased psychosocial sensitivity and related behavioural changes. An international standard triaxial-recording form has been developed by the Mental Health Division of WHO headquarters, Geneva, which could be used for this purpose. An outline of a study protocol is annexed (Annex 11).

5.4.2 Video films of primary health care workers at work

Video tapes showing primary health care workers at work with different degrees of psychosocial intervention could be shown to groups of such workers, who would then be asked to comment on the performance. This participatory exposure can be expected to effect behavioural change which can be assessed.

Ideally, video recordings should be made of health worker-patient interactions and analysed by a group or, as in the technique of Inter-personal Process Recall (IPR), by the health worker together with the patient and a trainer. The necessary equipment will, however, not be available in most instances.

5.4.3 Role-playing

Primary health care workers can be asked to role-play patients-health providers interactions under the observation of the trainers. Role-playing can be expected to cause behavioural change among the primary health care workers, which can be assessed. A number of positive experiences with this technique exist in the Region.

5.4.4 Communication facets

Another technique which may be effective in increasing the psychosocial sensitivity of health personnel may consist of brief workshops where the staff is requested to establish, in a group process, a list of desirable communication facets. In the group process to identify such facets, role-play and/or video tapes can usefully be included.

Such a list of facets exists from related work in industrialized countries. It includes: friendly expression (eye contact, smiles, gestures), polite greetings, expression of concern for the patient's troubles and inconveniences such as long waiting time, sympathetic listening with empathetic attitude, sufficient problem clarification (the patient and/or his/her relatives feel that they are able to express clearly all important points and that the staff makes an effort to get a clear picture), asking questions about social and psychological concerns, e.g., worries or special life circumstances, unobtrusiveness and warmth of physical touch (as culturally appropriate), and sufficiency of explanation by the staff. The list of facets prepared during a short workshop of the selected staff will be similar to the one above. The process of establishing such a list can best be based on videotapes and role-play as motivators to group decision-making. A Delphi-type of group process can be

used where each participant notes down a list, followed by discussions on discrepancies, animated by video tape shows and role play. Afterwards, each participant produces another list, etc., until group consensus is achieved.

The list will then be put on cards and kept at the desk where the health worker sees patients.

Again, it will have to be decided by a study whether the resulting changes in behaviour are retained over longer periods of time and whether they lead to a reduction in over-prescribing and to better job satisfaction in addition to the other indicators of the psychosocial aspects of primary care services.

6. FUTURE WORK AND CONCLUSIONS

Out of the participating centres or countries, the National Institute of Mental Health and Neuro Sciences, Bangalore, newly designated WHO Collaborating Centre for Research and Training in Mental Health, agreed to continuing involvement in the work on subjective well-being and the various intervention trials. This will certainly include continuous work on the subjective well-being inventory (SWBI) and work in relation to well-being and adversities. The latter work will be done in collaboration with the Cancer Unit of WHO headquarters, where a project on the quality of life of cancer patients is being launched.

Bangladesh may also take up work on subjective well-being.

Furthermore, WHO headquarters is considering initiating an inter-regional project on subjective well-being. Other components of this work may also be taken up by WHO/HQ if extra-budgetary resources can be found.

The Indonesian group will continue its work on indicators of child mental health and will extend this into the work on interventions into risk families. This will be linked with work on culture-appropriate milestones.

The Lucknow centre will also take up the work on child mental health.

The group in Thailand as well as the Ranchi centre reiterated their commitment to developing indicators of the quality of community life. The chief investigator in the work on indicators for psychosocial aspects of primary health care services is in the process of being transferred to another mental hospital in Indonesia. This may cause some delays in the finalization of this work and its extension into intervention trials.

The Thai and Bangladesh groups also expressed interest in this work and may be able to initiate studies.

The work will be reviewed by the Regional Coordinating Group during its next meeting, tentatively towards the end of 1987. On that occasion, ways of including the instruments and technologies developed into national mental health planning processes will also be explored.

Annex 1

LIST OF PARTICIPANTS

BANGLADESH

Dr Hedayetul Islam
Director-cum-Professor of Psychiatry
Organization of Training in Mental Health
Sir Salimullah Medical College, Dhaka
Mitford Hospital, Dhaka-1

Dr Enayetul Islam
Director
Mental Hospital, Pabna

INDIA

Dr S.D. Sharma
Director
Central Institute of Psychiatry
P.O. Kanke
Ranchi, Bihar

Dr S.M. Channabasavanna
Professor and Head of the Department of Psychiatry
National Institute of Mental Health and Neuro Sciences
P.O. Box 2900
Bangalore, Karnataka

Dr B.B. Sethi
Director
Sanjay Gandhi Post-graduate Institute of Medical Sciences
Rae Bareli Road,
Post Box 375
Lucknow, Uttar Pradesh

Dr Narender Kumar
Senior Research Officer
Indian Council of Medical Research
Ansari Nagar
New Delhi

INDONESIA

Dr Pranowo Sosrokoesoemo
Director of Mental Health
Directorate General of Medical Care
Ministry of Health
Jl. Percetakan Negara 23
Jakarta

Dr Rudy Salan
Head, Sub-Directorate of Epidemiology and Psychopharmacology
Directorate of Mental Health
Ministry of Health
Jl. Percetakan Negara 23
Jakarta

Dr Sri Ami
Chief
Health Centre
Jebers, Surakarta

NEPAL

Dr Bishnu Prasad Sharma
Chief
Mental Hospital
Lagankhel, Lalitpur

Mr Chiranjī Bahadur Thapa
Chief Health Education Officer
Health Education Section
Ministry of Health
Teku, Kathmandu

SRI LANKA

Dr U.A.M. Perera
Medical Officer
Health Education Bureau
No. 2, Kynsey Road
Colombo

Dr (Mrs) W.R. Perera
Psychiatrist
Mental Hospital, Angoda

THAILAND

Dr Thamrong Dasananjali
Director
Nitichitawej Hospital
23 Phutthamonthon Sai 4
Bangkok

Dr Prawase Wasi
Head of the Department of Medicine
Faculty of Medicine
Mahidol University
Siriraj Hospital, Bangkok

TEMPORARY ADVISER

Dr A.S. Henderson
Director, Social Psychiatry Research Unit
The Australian National University,
Canberra ACT 2601, Australia

SECRETARIAT

Dr Uton M. Rafei, Director, Health Protection and Promotion

Dr B.A. Jayaweera, Director, Research and Family Health

Dr J. Orley, Senior Medical Officer, Division of Mental Health,
WHO/HQ.

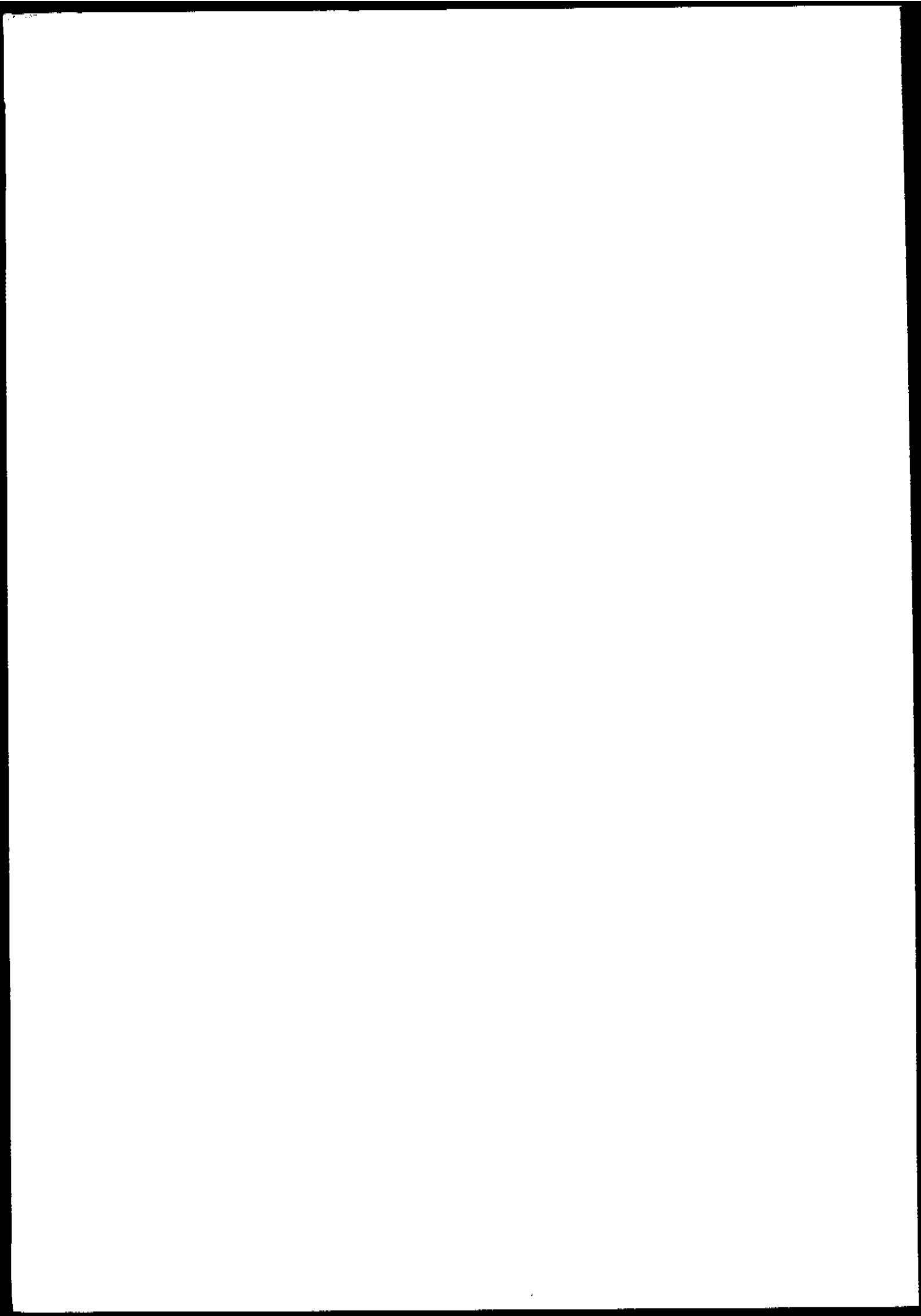
Dr Helmut L. Sell, Regional Adviser on Mental Health, WHO/SEARO

Dr S.H. Hassan, Regional Adviser on Health Education, WHO/SEARO

Dr Soon Young Yoon, Social Scientist, Research Promotion and
Development, WHO/SEARO

Dr Cipriano A. Canosa, Regional Adviser, Maternal and Child Health,
WHO/SEARO

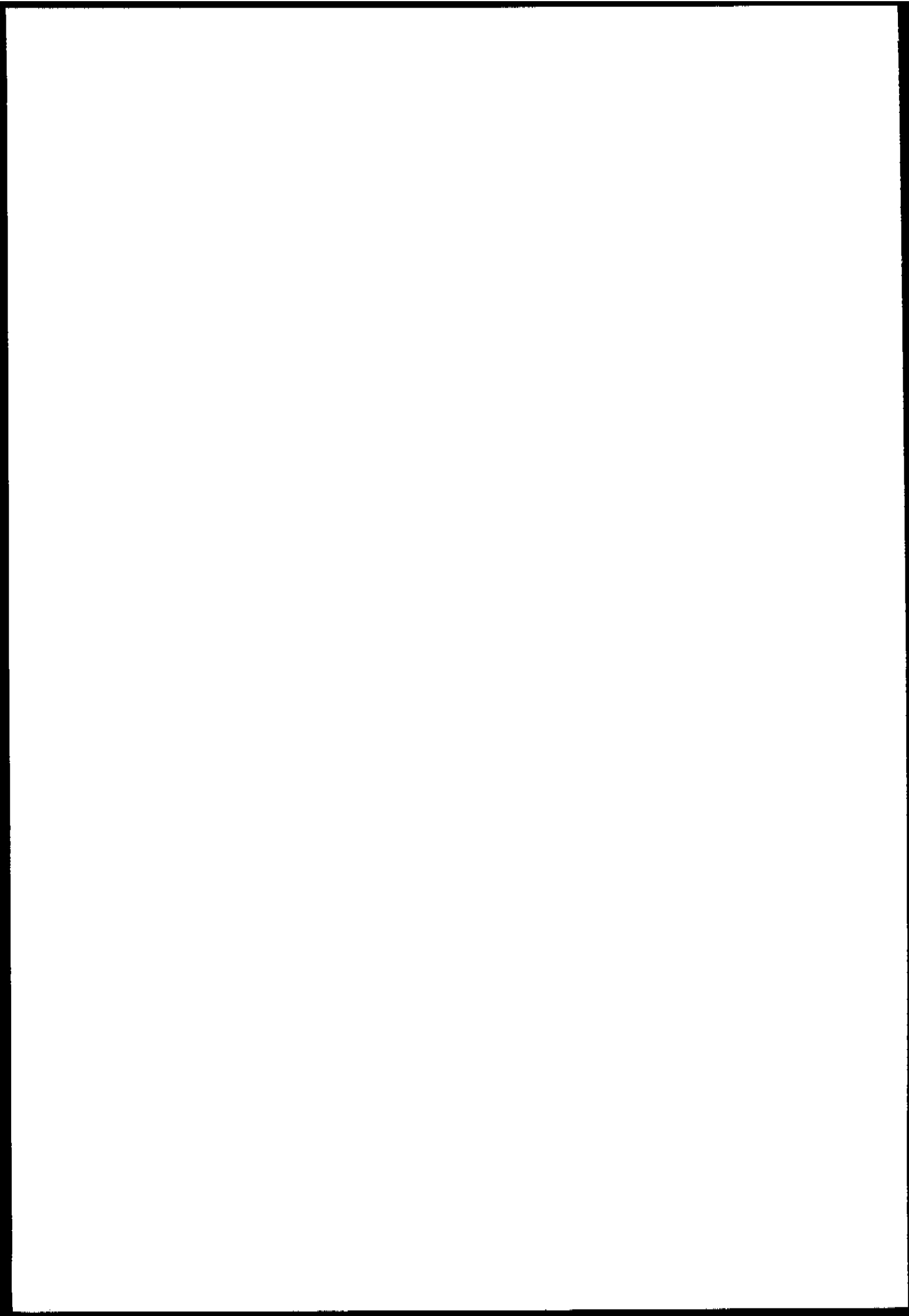
Dr Palitha Abeykoon, Medical Officer, Medical Education, WHO/SEARO.



Annex 2

AGENDA

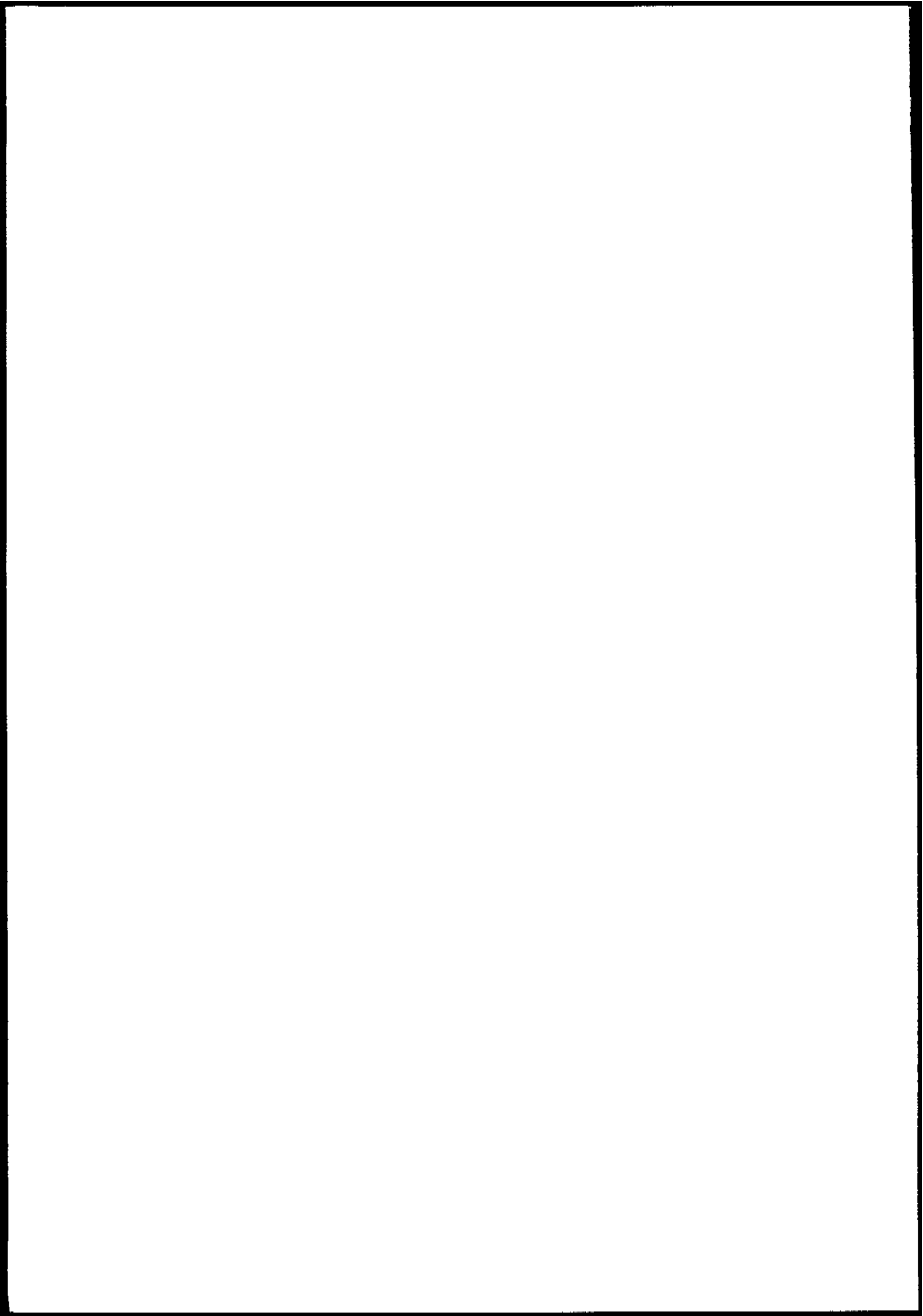
1. The Global mental health programme.
2. The Regional mental health programme.
3. Activities related to social science research.
4. Report on work on indicators of mental health and mental health needs since September 1985:
 - Subjective well-being and quality of family life;
 - Child mental health and healthy psychosocial development of children;
 - Quality of community life;
 - Psychosocial factors in primary health care.
5. Diagnosing behaviour as a basis for psychosocial interventions : A model for classifying behaviour.
6. Plan of work on further development of indicators and of psychosocial interventions in various areas of indicators.
7. Implementation of the respective components of the work plan.



Annex 3

LIST OF BACKGROUND DOCUMENTS

1. Advances in Mental Health (doc. SEA/Ment/73).
2. Health Behaviour Research: An Orientation. Soon Young Yoon.
3. Indicators of Mental Health (doc. SEA/Ment/79).
4. Epidemiology of Mental Health Needs (doc. SEA/Ment/89).
5. Brief on the Subjective Well-Being Inventory (SWBI). H. Sell and R. Nagpal.
6. The Subjective Well-Being Inventory.
7. Diagnosing Behaviour as a Basis for Psychosocial Interventions. H. Sell.



Annex 4

ADDRESS BY DR U KO KO, REGIONAL DIRECTOR,
WHO SOUTH-EAST ASIA REGION

It gives me great pleasure to welcome you all to this meeting of the Regional Coordinating Group for the Mental Health Programme.

You are all, no doubt, familiar with the social goal of Health for All by the Year 2000, to which the Member States of WHO have collectively committed themselves, and with the key approach to this goal, namely, primary health care.

It is obvious that this commitment has considerable implications for WHO's programmes and activities. We all have to scrutinize our programmes and plans constantly as to their compatibility with the policies and strategies emanating from this new orientation. I would like to urge you, with the important mandate of a Regional Coordinating Group for the Mental Health Programme, to keep the policy implications of health for all vividly in your minds during your deliberations.

I have observed with satisfaction that the mental health programmes in our Member Countries have, over the last decade or so, taken a definite turn away from the isolated, institution-based speciality of psychiatry towards integrated and community-oriented mental health programmes. Several operational steps have been involved in this change. First, a de-centralization and de-professionalization. This means psychiatric units in general hospitals rather than the exclusive accumulation of psychiatric beds in mental hospitals. It also means the apportionment of psychiatric tasks and the training of various levels of health personnel to enable them to perform them. It means further that mental hospitals become, in reality, what they should be, namely, tertiary levels of care which support, through leadership and training, two-way referral and care at the primary and secondary levels, and health service research and out-reach programmes. Second, and of special relevance for the topic of the present meeting, it means broadening the scope of concern of psychiatrists to become more than doctors specialized in the treatment of severe mental disorders. It should also be what one could call de-compartmentalization, that is, psychiatrists becoming mental health professionals in a broader sense, a weakening or crossing of professional borders, and a healthy softening and overlapping of professional concerns. We are all familiar with the anxieties and insecurities which follow when the distinction and specificity of professional roles gets reduced and merged with other professions or paraprofessionals. We all know the problems of so many professionals being engaged in team work, which, for example, involves the pooling of expertise - the expertise of all members of the team to be made available, to a certain extent, to the others, and the readiness of the team members to take on some of this shared expertise.

The topic of this workshop, namely, the development of effective psychosocial interventions, contains such broader mental health concerns. It is a logical step that the areas for which psychosocial interventions are to be developed are those for which indicators have been, or are being, developed. And I also appreciate that these areas are of clear relevance to primary health care, in the context of the HFA/2000 target, namely, subjective well-being or the reduction of suffering generally, not necessarily related to disease. I would hope that these indicators and the technology which may be developed will enable health and other developmental personnel to help people in distress and to improve their well-being - the overriding concern of every human being. Work on indicators of child mental health and healthy psychosocial development has already led to an instrument, now in country-wide use in one Member State, which enables health personnel to focus their activities on families most in need of preventive and promotive interventions. I hope that your deliberations will finally lead to interventions which will help improve the future of the children growing up in these families. Further, I hope that you will be able to develop interventions which will enable us to improve the quality of community life, because I do believe that good community organization is a necessary precondition for effective community participation, an essential element of primary health care.

The last topic, of course, is of the most direct relevance for PHC: psychosocial factors in health services, or the psychosocial sensitivity of health personnel. WHO attaches particular importance to this area of work because I hope that with the interventions that you will endeavour to develop we may hold a key in our hands to improve an aspect of our primary care services which may well be critical for their effective functioning. This will, I hope, enable our Member Countries to reduce the sometimes substantial waste and lack of impact of our health infrastructure.

May I once again welcome you all and wish your deliberations every success. I look forward to seeing their outcome in terms of physical, mental and social well-being, and in the context of our target of Health for All by the Year 2000.

Annex 5

OUTLINE OF A
PROTOCOL FOR THE FURTHER DEVELOPMENT OF THE
SUBJECTIVE WELL-BEING INVENTORY (SWBI)

Objectives:

- (1) Further shortening of the SWBI;
- (2) identification of items/factors which contribute to the global assessment of subjective well-being on one-item measures like Fordyce's or Andrew's Ladder;
- (3) establishment of the usefulness of the SWBI in adolescents; and
- (4) establishment of the usefulness of the SWBI in persons aged 60 years and above.

Methods:

(1) Selection of the sample: Four types of areas, namely, a rural area, a city slum, a middle-class locality (such as a colony of government quarters), and a posh area will be selected by purposive sampling. A sample of 100 families will be selected from each of the four types of areas by simple random sampling.

(2) Shortening of the SWBI: Three items which explain a maximum of the within-factor variance will be selected for each factor. Within each factor, items for which the sum of squares of correlations with the other items is maximum will sequentially be selected first. This exercise will be carried out on the data already available on the 58-item inventory. For clinical reasons the items of factors 8 (inadequate mental mastery) and 9 (perceived ill-health) will be retained. This will lead to a 40-item SWBI.

Administration of 40-item subjective well-being inventory and Andrew's ladder:

The 40-item SWBI, preceded by Fordyce's Ladder, will be administered first to all persons aged 13 years and above in 100 families selected from one of the areas. The returns will be subjected to factor analysis in order to establish whether the original factor structure is retained in spite of a further reduction in the number of items. If the original factor structure is retained, the 40-item subjective well-being inventory and Fordyce's Ladder will be administered to the other 300 families in the other three areas also.

However, if the factorial structure collapses for the 40-item version, the 58-item inventory (and Fordyce's Ladder) will be administered to all the 400 families selected from the four areas.

Statistical analysis:

(1) Multiple regression analysis will be carried out, taking the global rating on Andrew's Ladder as the criterion variate and the 40 items of SWBI (58 items if the 40-item inventory fails to retain the original factorial structure) as independent variables, in order to establish the items/factors which contribute significantly in making the global assessment.

(2) Factor analyses will be run separately for (a) males, (b) females, (c) adolescents, and (d) persons aged 60 years and above, and for the three socio-economic groups, in order to establish whether the respective factorial structures are comparable and whether the inventory can be used equally well for all these groups.

Annex 6

MENTAL HEALTH EDUCATION FOR SCHOOL-AGE CHILDREN

Proposed Project:

The WHO Division of Mental Health is developing a project in which mental health skills will be taught to school children between the approximate ages of eight and 14. It is planned that these skills will be introduced through the school system at test sites in a number of developing countries and that the results of the programme will be systematically evaluated.

Skills which might be taught include social skills, problem-solving skills and coping skills for dealing with emotional stress. These general skill areas were selected based on the current research literature, which emphasizes their potential importance in preventing mental health problems in children (Kent and Rolf, 1979; Rutter, 1985a).

Introduction:

As a result of better sanitation, improved nutrition and more effective curative medicine, the health of children throughout the world has shown consistent improvement over the past 100 years, and continues to show increased improvement in the most recent decades (Doll, 1983). As a result, the majority of chronic disorders affecting children consists largely of educational, psychological and psychiatric problems (Graham, 1985).

Survey studies indicate that the prevalence of persistent and socially handicapping mental health problems among children aged 3-15 in developed countries is between 5 and 15 per cent and there is reason to believe that similar rates exist in developing countries (WHO, 1977).

Despite the increased awareness of the severity of children's mental health problems as well as the resultant long-term personal, social and financial costs (Robins, 1978), there are limited resources for dealing with these problems. The mental health needs of children receive too little attention in health education programmes (WHO, 1977), and available methods employed in developed countries focus almost exclusively on the remedying or treatment of problems, despite the fact that these procedures have been consistently criticized as providing "too little too late" (Pellegrini and Urbain, 1985).

The majority of mental health problems in children are quite different from adult disorders. In childhood, such problems are characterized by quantitative rather than qualitative deviations from healthy or normal development, children often show severe difficulties in one situation but not in another (for example, at school but not at home) and many problems can be seen as responses to specific situations. These

characteristics indicate that children's mental health problems are linked to environmental factors in a more direct way than at any other age period (WHO, 1977), and may be best understood as deviations from normal psychosocial development resulting from disrupted or chaotic experiences in the family, at school or in peer relationships (Hartup, 1983; Rutter, 1985a).

As a result of these considerations, there has been an increased interest in the prevention of mental health problems by promoting normal psychosocial development in children.

Social Skills:

Programmes for teaching social skills to children have received increased interest from child development as well as mental health professionals during the past decade. A growing body of empirical literature documents the important contribution which satisfactory social relationships with both peers and adults have on psychosocial development (Schneider, Rubin, Ledingham, 1986). Many of these programmes have been developed for use in educational settings. They involve systematic instruction and training in specific behaviours which are considered to be importantly related to social competence in children.

These behaviours include very basic social skills such as maintaining eye contact, smiling, speaking clearly, asking questions, offering suggestions, taking turns and sharing as well as more complex skills including listening, assertiveness, effective communication, recognizing emotions in others, conflict resolution using negotiation and compromise, and resisting peer pressure. The basic skills have been emphasized in programmes with younger children aged 6 to 10 (Gasten *et al*, 1979; Ladd, 1981; Oden & Asher, 1977), while the more complex ones have been employed beginning with young adolescents (Hazel *et al*, 1981; Robin, 1985). There is a rapidly expanding store of resource materials, including pamphlets, films, games and group exercises which have been developed for use in social skills training programmes with children of all ages.

In training these skills, teachers make use of a variety of techniques including modelling, role playing, discussion, guided practice and rewards.

Problem solving:

The major objective of problem-solving training programmes has been to teach children how to think rather than what to think (Meichenbaum, 1977). The emphasis is on teaching children concrete skills which can be applied to a wide variety of problem situations. Although much of the early work in problem-solving training utilized academic, non-social content, more recent programmes with children have applied the training to social problems and interpersonal conflict.

Within the past 15 years, a number of systematic social problem-solving training programmes have been developed for pre-school and school-aged children (see Pellegrini & Urbain, 1985, for an excellent review of these programmes). In the majority of these programmes, the problem-solving process is broken down into specific component skills which are systematically taught to children using modelling, rehearsal and feedback.

The skills which have been taught include learning to identify and describe different types of problems ("problem definition"), systematically generating a variety of potential solutions to a particular problem ("alternative thinking"), identifying the strengths and weaknesses of each potential solution ("consequential thinking"), selecting and implementing what appears to be the most appropriate solution to the problem and, finally, evaluating the outcome of the solution and selecting another if the first is ineffective or incorrect.

Training has been carried out both individually and in groups and a variety of programme materials, games and exercises have been developed for use by teachers, parents and health care workers for children of different ages (Kendall & Braswell, 1985; Shure & Spivak, 1978; Weissberg *et al.*, 1981).

Trainers are encouraged to make liberal use of modelling, rehearsal and praise in teaching these skills. In most programmes, the importance of training the teachers or mental health workers in these procedures is also emphasized.

One advantage of teaching problem-solving skills in an educational setting is that the skills are as relevant to the solution of certain types of academic problems as they are to social reasoning. In fact, some programmes begin by teaching the component skills with academic, non-social material (e.g., form discrimination, mazes, mathematical problems) and gradually introduce social content in subsequent lessons (Kendall & Braswell, 1985).

Coping with stress:

Another set of skills which appears to be importantly related to mental health in children involves successfully coping with stress and emotional upset. Specific skills which have been taught include relaxation, recognizing signs of stress, learning the importance of rest, nutrition and physical exercise for controlling stress, assertiveness and learning how to say no to unwanted advances, developing an appreciation of one's personal strengths, learning how to recognize and respond to depression in oneself and others, and dealing with family conflict.

These skills have been introduced in a number of health courses for older primary and secondary school students, from approximately 10 to 16 years of age. Resource material, including films, discussion topics, home

work assignments and group exercises, is available predominantly in English (e.g., Mental Health Association in Delaware, 1983; Hazel et al, 1981; Mitchell, 1986).

The general topic of stress management seems to be particularly suitable for educational settings because of its close association with other health-related topics such as drug and alcohol education and reproductive health, which are increasingly being included in family and health education courses for secondary school students.

There are several reasons why schools are desirable settings for a mental health education project. Schools represent one of the few socialization systems with which nearly all children come in contact. Thus, programmes which are designed to promote the psychological health of children would be inexpensive and effective in reaching many children if integrated into the on-going routine of class-room education (Allen et al, 1976). During recent years, there has been increasing awareness of the influence which the educational system and school experiences have on the psychological and social development of children, as well as the potentially important role which schools can play in the prevention of mental health problems in children (Rutter, 1985b). Teachers who understand the basic principles of psychosocial development and who can effectively teach social, problem-solving and coping skills to their students represent a rich resource for mental health promotion in children. Finally, teachers in most cultures have good credibility and command respect from children and parents alike. Thus, they are likely to be able to introduce topics of social and emotional content in a professional way.

Procedures:

The development of the programme is likely to require several phases. Initially, a number of educators and children's mental health workers from a given test site would meet, possibly with outside consultant help, to discuss which social, problem-solving and coping skills would be the most important and relevant for the psychosocial development of children in that country. At the same time, measures of psychosocial development and mental health problems would be selected.

A second phase would entail the development and testing of workshops or courses for use in training teachers. These workshops would include an introduction to the "curriculum materials" to be used directly with the students, but also training in the use of various intervention techniques with children such as role play, modelling, the effective use of reward, and effective listening skills.

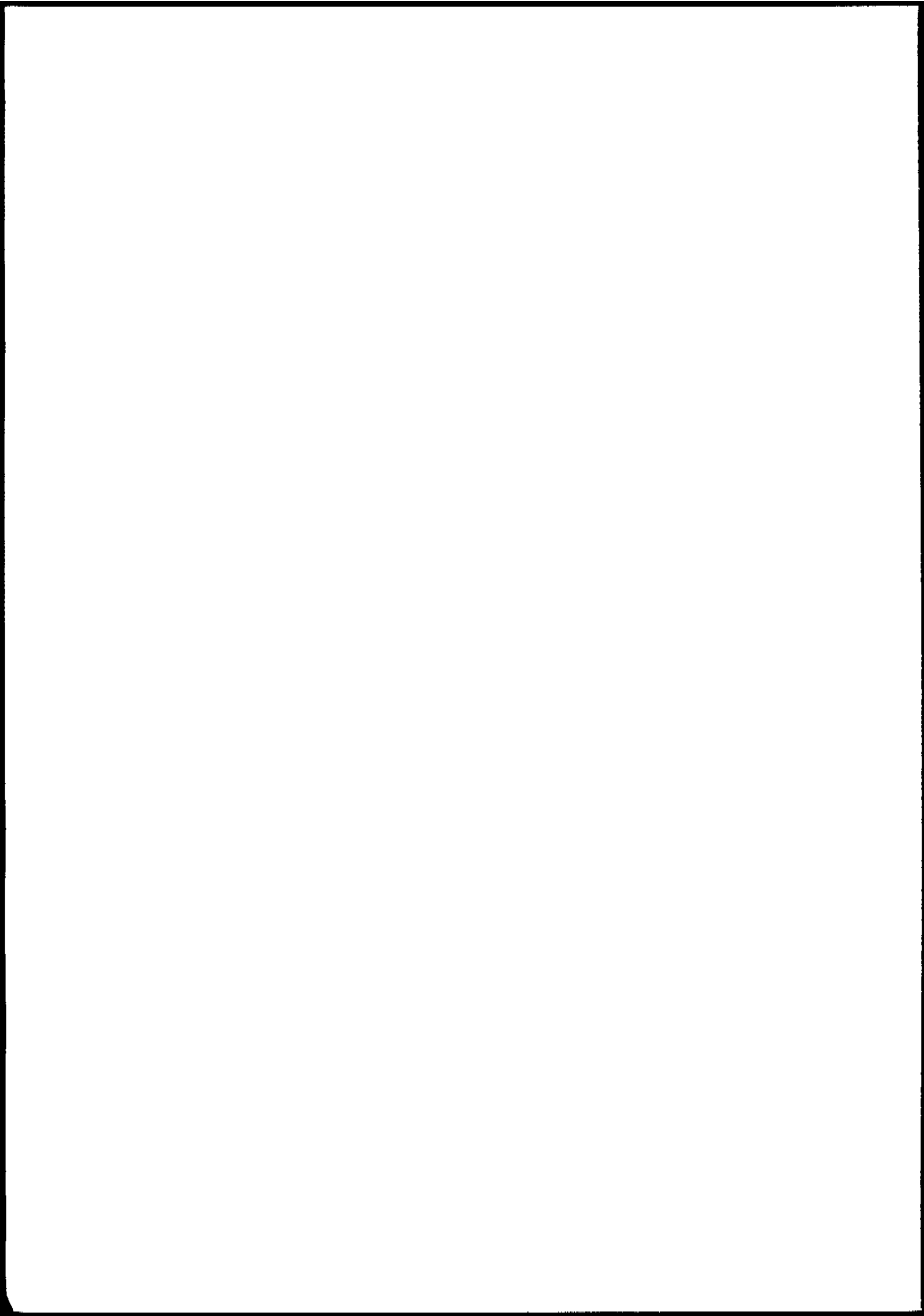
After the teacher training was completed, measures of mental health problems, psychosocial development and skill levels of the students would be collected followed by a period of time (e.g., two months) during which the teachers would implement the mental health training with the students.

The training would be followed by a second collection of the skill and problem measures to determine the effects of the training. Finally, an extensive de-briefing would take place with the teachers, mental health workers, other professionals involved and, possibly, several students, to determine what changes should be made to improve the programme.

REFERENCES

- Allen, G.J., J.M. Larcen, S.W. Lockman, J.E. & Selinger, H.V. (1976). Community psychology and the schools: a behaviourally oriented multi-level preventive approach. Hillsdale, New Jersey: Lawrence J. Erlbaum.
- Doll, R. (1983). Prospects for prevention. British Medical Journal, 286:445-453.
- Gesten, E.L., Flores de Apodaca, R.F., Rains, M., Weissberg, R.P. & Cowen, E.L. (1979). Promoting peer-related social competence in school. In: M.W. Kent & J.E. Rolf (Eds) The primary prevention of psychopathology, Vol. e, Social competence in children. Hanover, NH: University Press of New England.
- Graham, P. (1985). Psychology and the health of children. Journal of Child Psychology and Psychiatry, 26:333-347.
- Hartup, W. (1983). Peer relations. In: E.M. Hetherington (Ed), Socialization, personality and social development, Vol. 4, Mussen's handbook of child psychology (4th edition). New York, Wiley.
- Hazel, J. Schumaker, J., Sherman, J., & Sheldon-Wildgen, J. (1981). Asset: A social skills program for adolescents. Champaign, IL: Research Press.
- Kendall, P.C. & Braswell, L. (1985). Cognitive-behavioural self-control training. New York: Guilford.
- Kent, M.W. & Rolf, J.E. (Eds). (1979). Primary prevention of psychopathology, Vol. 3, Social competence in children. Hanover, NH: University Press of New England.
- Ladd, G. (1981). Effectiveness of a social learning method for enhancing children's social interaction and peer acceptance. Child Development, 52: 171-178.
- Mental Health Association in Delaware (1983). I can handle it: classroom activities for mental health. available from MHAD, 1813 N. Franklin Street, Wilmington, Delaware 19802, USA.
- Meichenbaum, D. (1977). Cognitive behaviour modification. New York: Plenum.
- Mitchell, A. (1986). When parents split up: divorce explained to young people (rev. ed). Edinburgh: W & R Chambers.
- Oden, S.L. & Asher, S.R. (1977). Coaching children in social skills for friendship making. Child development, 48:495-506.
- Pellegrini, D.S. & Urbain, E.S. (1985). An evaluation of interpersonal cognitive problem-solving training with children. Journal of Child Psychology and Psychiatry, 26:17-41.
- Robin, A. (1985). Parent-adolescent communication training. In: R.M. McMahon and R. DeV. Peters (Eds) Child disorders: behavioural-developmental approaches. New York: Brunner-Mazel.

- Robins, L. (1978). Sturdy childhood predictors of adult antisocial behaviour: replications from longitudinal studies. Psychological Medicine, 8:611-622.
- Rutter, M. (1985a). Family and school influences on behavioural development. Journal of Child Psychology and Psychiatry, 26:349-368.
- Rutter, M. (1985b). Education and mental health: The role of schools. World Health, August-September.
- Shure, M. & Spivack, G. (1978). Problem-solving techniques in child rearing. San Francisco: Jossey-Bass.
- Weissberg, R.P., Geston, E.L., Carnrike, C.L., Toro, P.A., Rapkin, B.D., Davidson, E. & Cowen, E.L. (1981). Social problem-solving skills training - a competence-building intervention with 2nd-4th grade children. American Journal of Community Psychology, 9:411-424.
- WHO Technical Report Series (1977). Child mental health and psychosocial development. No. 613, Report of a WHO Expert Committee.



Annex 7

PSYCHOSOCIAL INTERVENTIONS IN PATIENTS
WITH FUNCTIONAL COMPLAINTS

A diagnostic tool has been developed in the course of a SEARO-coordinated multi-centric study to identify patients with functional complaints in primary care settings. (Patients with Functional Complaints: A Diagnostic Tool for their Recognition by Primary Care Physicians. H. Sell *et al*, in preparation.) The evidence collected in the course of this study shows that there may be a group of 'masked depressives' amongst this out-patient group but also a large group with probably a basically 'perceptual' disorder. It may be possible to differentiate such sub-groups by means of the SWBI.

Such sub-grouping may eventually enable us to develop much more specific interventions for the various sub-groups.

It is anticipated that one sub-group will be identified which differs from matched controls, if at all, only on the factor of perceived ill-health. This would probably be a sub-group where a perceptual problem (perception of own bodily functions as somehow threatening, threatened, out of control, or indicative of possible disease) is the only tangible disturbance.

An effective intervention in this patient group may consist of focused counselling on the mechanisms of perception and on the need for acceptance of certain perceived disturbances.

Hypotheses for testing:

- (1) The SWBI is able to contribute to a meaningful sub-grouping or classification of out-patients with functional complaints;
- (2) a substantial proportion of such patients will improve on specific counselling regarding the perceptual nature of the disorders and encouragement for active acceptance; and
- (3) other groups of patients with functional complaints can be identified, for which other specific psychosocial (and pharmaceutical) interventions can also be developed.

Methods:

The SWBI and the GHQ will be administered to a sample of 100 out-patients attending a primary care setting, after they have been diagnosed as functional complaints (FC) using the diagnostic tool developed earlier. Assuming a prevalence of 20 per cent FC cases, this will require

screening of about 500 out-patients above the age of 20 years. The complaints reported spontaneously by the FC cases during the consultation will be recorded by an observer. The SWBI returns of all FC cases will be subject to a cluster analysis.

Through non-parametric probability estimates (e.g., Cochran Test) the relation between the cluster allocation and the combination of complaints will be analysed. This will be done separately for the complaints elicited during the physician contact and by means of the GHQ, permitting an estimate on the likelihood to differentiate the clusters or sub-groups by the respective combination of complaints.

Annex 8

OUTLINE OF A PROTOCOL FOR WORK ON
ADVERSITY AND THE SWBI

Earlier work on the SWBI has shown that negative factors and items are less stable over time than positive ones, i.e., they are probably more likely to be affected by circumstantial changes. In consequence, one would predict that adversity will first affect negative items/factors (phase of denial), and only later in time or only with increased severity of the adversity, would positive items/factors also be affected (phase of hopelessness, demoralization).

Hypotheses:

- (1) Negative items and factors of the SWBI are more readily affected by adversity than positive ones. This will express itself in negative items and factors reacting faster in time after the adversity and reacting to less severe adversities, i.e., those not severe enough to affect positive items and factors;
- (2) this period of selective impact on negative items and factors corresponds clinically with the period of denial following adversity;
- (3) when both negative and positive items and factors are affected by adversity, the person will 'clinically' be classified as being in the state of hopelessness or demoralization;
- (4) reorganization is complete when positive items and factors have returned to pre-adversity levels. With continuing low scores on positive factors, a person would be diagnosed to be in a state of prolonged or chronic demoralization irrespective of the scores on negative factors; and
- (5) it is possible through specific psychosocial interventions to avoid the phase of hopelessness, or at least to shorten it, or to prevent a state of chronic demoralization.

Methods:

Samples will be drawn from the following:

- (1) Parents of a mentally retarded child
- (2) Parents of a drug using son
- (3) Parents of a chronic psychotic patient
- (4) Patients with cancer
- (5) Patients with leprosy.

The adversities will be disclosure of the diagnosis to the parents or patients, as the case may be.

(1) The SWBI will be administered to a consecutive sample of parents bringing their child to a paediatric out-patient clinic until 50 children have been diagnosed as mentally retarded (MR). Out of the probably large pool of parents whose children have a definitely curable condition, 50 parents will be selected who can be matched pairwise to the MR parents, by age, socio-economic status, and number of siblings to the index child.

The SWBI will be administered to both groups of parents at one week, 3 weeks and 3 months after disclosure of the diagnosis. (A longer follow-up will be highly desirable.) The scores for fathers and mothers will be analysed separately.

The data on MR parents (who will be subjected to the interventions routinely applied in the centre concerned) will be compared to a consecutive sample of parents to which specific interventions will be applied. These will consist in contacts to the family by other MR parents, specific counselling on reorganization, some brief training in coping skills, and advice on self-help groups. 'Breaking of the denial' will be avoided.

(2) It is not sure whether sufficient numbers of parents with drug abusing sons can be discovered who are not aware of the problem at the time of a clinic contact. Hypotheses related to the pre-adversity level can, therefore, not be tested in this group.

(3) For parents of a chronic psychotic patient the time of 'adversity' will be the discharge from hospital without the patient having recovered, i.e., when the chronicity of the disorder will be disclosed to them. As controls, parents will be chosen whose child has fully recovered from a schizophrenic or acute psychotic episode of a schizophreniform presentation.

(4) and (5) The cancer and leprosy patients will be paired with those with a curable condition such as under (1) above. Patients with a severe depression will be excluded.

Annex 9

OUTLINE OF A
PROTOCOL FOR WORK ON HEALTHY CHILD DEVELOPMENT

Objectives:

- (1) To develop and validate a simple measure of home risk (in countries or regions outside of Sri Lanka where this already exists); and
- (2) to develop and evaluate the impact on healthy child development of a simple intervention in risk families using a developmental ladder as a tool to sensitize parents towards children's needs.

Hypotheses:

- (1) A set of simple and reliable risk criteria can be developed, similar to those already established in Sri Lanka, through which primary workers can identify families in which children are at greater risk of morbidity and of poor development;
- (2) instructing the mother in the use of a simple developmental ladder to record the child's developmental progress will reduce the risk of morbidity and of delayed development;
- (3) the introduction of the developmental ladder will increase the rate of developmental progress of siblings of the index child as well; and
- (4) the introduction of the developmental ladder will increase the interest for the child's development in the mother.

Methods:

As a first step, a Home Risk Card will be developed, based on the work in Sri Lanka, and its inter-rater reliability and validity established cross-sectionally. Similar to the validation process in Sri Lanka, nutritional status of the children, health compliance (vaccination status, family planning), school drop-out rate, morbidity and developmental status of children will be used as external validation criteria once the inter-rater reliability of the Home Risk Card has been established for the type of workers to be used in the study.

In a second stage a study area will be defined and risk families in this area identified using the Home Risk Card. These risk households will be pair-wise (socio-economic condition, educational status of mother,

number of children) allocated to a control and an experimental group. A further control group will be matched where no risk is identified. Only households with an index child below 12 months will be selected.

At inception and at the index child's age of 18 and 42 months, a full set of evaluation data will be generated, including the developmental and nutritional status of all children under 6 years in the family, data on health compliance (family planning, immunization), incidence of conspicuous morbidity in the index child and a rating of the mother's interest in the development of the child. All measures except the assessment of the child's developmental status but including the Home Risk Card, will be taken at 6-monthly (or 12-monthly) intervals.

The study may have to be extended into higher ages of the index children if differences at age 3-1/2 years between the two control groups and between the 'risk control' and the intervention groups are insignificant since data from Sri Lanka suggest that the major delays in the development of children from risk homes appear between 4 and 6 years of age.

Annex 10

DEVELOPMENT OF AN INTERVIEW INSTRUMENT
FOR MEASURING THE QUALITY OF COMMUNITY LIFE

The promotion of the quality of life in a community is a desirable objective in its own right. But it may also bring substantial benefits to well-being and health and to the health services of that community. Psychosocial interventions for the promotion of health and well-being are now an established part of the mental health programme of the WHO. Such interventions are already being carried out in a number of Member Countries in the SEA Region, aimed at promoting the quality of individual, family and community life. This includes support to self-help groups of parents with mentally retarded children, early stimulation programmes for children from socially disadvantaged families, education for responsible living, and the like. Further, governments as well as nongovernmental organizations, bilateral and multilateral agencies and, in some instances, even the private sector, are involved in a large number of rural and urban developmental programmes which basically aim at improving the quality of individual and community life.

There is now an obvious need to evaluate such interventions. Similarly, some communities are known to be undergoing major changes in their social organization and in the pattern of behaviour typically followed by individuals. However, little is known of the consequences of such changes for the quality of community life. Again, there is a need to have available a method for measuring this quality, sensitive enough to show change over fairly short periods of time.

Review of literature:

We are aware that a number of social scientists have referred to, or implied the existence of, attributes of a community which reflect how well it is integrated and how cohesive are the social forces within it. The pioneering work of Emile Durkheim identified such properties in relation to the prevalence of suicide in different populations. Much later, Leighton's work in Sterling County in North America and with the Yoruba in Nigeria, sought to identify similar properties of a society, specifically in relation to the mental health of its members. The term "sociocultural integration" was used to refer to the many attributes of a society which together constitute the quality of community life within it.

Sociometricians have made considerable progress in the measurement of selected aspects, but to our knowledge there does not exist a simple instrument to measure the quality of community life in a way which is both comprehensive and, at the same time, suitable for use in developing countries. Those which do exist have been developed for use in industrialized societies.

Significance:

In the light of this, it is clear that considerable developmental work is now required to produce an instrument which carries satisfactory reliability, validity and other psychometric or sociometric properties, and which is also capable of being used in diverse cultural settings. The benefits, however, would be considerable. Health personnel in a large number of countries would be able to assess the consequences of psychosocial interventions. But the application is clearly much wider, because a satisfactory instrument could prove a useful tool in the hands of those agencies or organizations undertaking development or aid programmes in developing countries.

Aim:

To construct an instrument for the measurement of the quality of community life, having adequate psychometric and sociometric properties for field use in diverse cultural settings.

Method:

There are eight steps to undertake in this task.

(1) Selection of those facets of community life which contribute to its quality. Examples might include the extent to which the community holds shared beliefs and attitudes, affording help to persons in distress, opportunities for education and the prevalence of violence. Delineation of these facets should be made after consultation with anthropologists and other social scientists familiar with this area.

(2) Construction of interview items which tap these facets.

(3) Early trial administration of these items in several small but contrasted samples of individuals, to determine the acceptability and understandability of the instrument.

(4) Modification of the items in the light of the above.

(5) Development of a scoring method for the responses. The instrument is likely to be administered as an interview rather than by self-completion, to avoid problems due to illiteracy. The scoring must allow for both response bias and social desirability to be minimized.

(6) Further refinement of the instrument, particularly reduction in its size, so that it becomes optimally parsimonious.

(7) Establishing its reliability, both in test-retest and between observers.

(8) Validation. This is a particularly demanding requirement, yet is of the utmost importance for the credibility of future findings. It therefore deserves special attention, for which we propose the following:

The instrument should be administered in its final draft form to two contrasted communities where quality of community life is likely to be conspicuously different. Consensual validation can also be sought, by contrasting these two communities in respect of, say, the prevalence of homicide or suicide and other indicators. Care will have to be taken, however, to avoid tautologies through confounding of variables.

On a longer-term basis, validation can be carried out by longitudinal use of the instrument in a community where a developmental programme is under way.

Preparatory work already achieved:

Consultations with senior health personnel in most Member Countries were undertaken at WHO/SEARO inter-country workshops in 1983 and 1985. These led to the development of draft items for an instrument which fell into two types: those for administration to key informants, and those for heads of households. The draft items are attached as an Appendix.

Further consideration of these suggests that they will have to be combined into a single module; otherwise scoring and interpretative difficulties will emerge, particularly where there is lack of congruence between sources of information. Alternatively, both modules could be developed separately and a decision taken later which of the two has superior psychometric or sociometric properties.

Further developmental work on the instrument is now ready to proceed forthwith.

Site:

This work should be undertaken under the direct supervision of staff who have a close appreciation of the characteristics required of the instrument and of the uses to which it will be put. The site may, however, have to be negotiated according to the availability of a psychometrician/sociometrician.

Tentative time-table:

July and August 1987	Appointment of a research worker (psychometrician/sociometrician). Review of literature. Review of the presently available pool of items.
September 1987	Construction of a further pool of items in consultation with local informants and social scientists.
October, November and December 1987	Pilot testing of the instrument, to be administered by the research worker himself/herself with one assistant.

January and February 1988	Revision of items in the light of this experience.
March to June 1988	Definitive data collection and analysis to yield a Final Draft Instrument at the end of the 12-month period.
July to December 1988	Confirmatory work on reliability; validation study in two contrasted communities.
January to July 1989	Preparation of results for publication in an international refereed journal (e.g., Social Science & Medicine).

Conclusion:

This project is a circumscribed parcel of work in an area where no methods are presumably available, yet where the need for such quantitative evaluation is clearly evident. The potential for application is considerable in evaluation programmes for development in many countries.

If yes, how do they express it? _____

Do people share in each other's unhappiness?

yes () to some extent () no ()

How do they share it? _____

To what extent do they share it?

Not at all () to some extent () a great deal ()

How frequently do they share it?

very rarely () quite often () almost always ()

Do you think that it leads to decrease in unhappiness?

yes () to some extent () no ()

Does it lead to increase in unhappiness?

yes () to some extent () no ()

On the basis of the above information, ask the KP to rate on a 5-point scale how much of sharing of negative emotions leading to decreased unhappiness of all is present in the community as to increase the quality of community life.

'-----' '-----' '-----' '-----'

No contribution

Maximum possible

3. In your community, when there is a health crisis, e.g., sickness, birth of a baby, death in a family, an accident, etc., what do the neighbours do?

Do they generally offer help?

yes () sometimes () no ()

Do they come and help when asked?

yes () sometimes () no ()

If yes, how do they help? _____

Do they, for example, help in bringing a seriously ill patient to the hospital?

rarely () sometimes () almost always ()

Do they help by preparing food or bringing food to the patient in the hospital?

rarely () sometimes () almost always ()

Do they help by looking after the patient's family?

very rarely () sometimes () almost always ()

On the basis of the above information, ask the KP to rate on a 5-point scale how much of help is provided to the sick and his family by the relatives/neighbours as to increase the quality of community life.

'-----'-----'-----'-----'
No contribution Maximum possible

4. In your community, do you have associations such as the following?

Type of Association	If yes		
	Total number of members	Active members	% of active members
(a) Women's groups			
(b) Religious groups			
(c) Health committees			
(d) Sports clubs			
(e) Cultural groups			
(f) Associations for helping disabled, sick or destitute persons			
(g) Voluntary groups to help the poor			
(h) Self-help groups, e.g., of parents with disabled children			
(i) Any other such groups			

On the basis of the above information, ask the KP to rate on a 5-point scale how much do such groups contribute to an increase in the quality of community life.

'-----'-----'-----'-----'
No contribution Maximum possible

5. Does your community receive help from outside institutions or groups such as

YMCA, Rotary Club, Lions Club, etc.

very much () some () none ()

If yes, specify _____

Does your community receive assistance from the government, e.g., in acquiring modern facilities (e.g., "sulabh shauchalaya", i.e., easily available toilet facilities, in India)?

very much () some () none ()

If yes, specify _____

On the basis of the above information, ask the KP to rate on a 5-point scale how much does this help from outside contribute to an increase in the quality of community life.

'-----'-----'-----'-----'
 No contribution Maximum possible

6. In your community, do the following services for intervention exist? If yes, do the people in your community work closely with them?

	yes	no	<u>community involvement</u>		
			strong	some	little/none
(a) Health services	()	()	()	()	()
(b) Red Cross (or equivalent)	()	()	()	()	()
(c) Social services	()	()	()	()	()
(d) Fire brigade	()	()	()	()	()
(e) Voluntary workers	()	()	()	()	()
(f) Cooperative societies e.g., for agricultural products marketing	()	()	()	()	()
(g) Police	()	()	()	()	()
(h) Any others (specify:)	()	()	()	()	()

Overall, would you say that there is mistrust and conflict, OR trust, understanding and mutual cooperation among members of the community as far as the above services are concerned?

Mistrust () not much involvement either way () trust ()

On the basis of the above information, ask the KP to rate on a 5-point scale how much do these services contribute to an increase in the quality of community life.

'-----'-----'-----'-----'
 No contribution Maximum possible

If not, what type of people would not be helped? _____

Why? _____

In case of a disaster, decisions may have to be taken very fast. How would this happen in your community?

by accepted leadership ()

possible only after lengthy discussions ()

not sure whether coordinated action of all would
be possible at all ()

On the basis of the above information, ask the KP to rate on a 5-point scale how much does a feeling of common preparedness or of the capability for joint action contribute to an increase in the quality of community life.

'-----'-----'-----'-----'
No contribution Maximum possible

9. Are there any communal mechanisms to assist families with a disabled family member?

yes () no () doesn't know ()

If yes, specify _____

What happens if someone becomes disabled with old age?

Family's responsibility alone ()

Neighbours/relatives/friends would normally help ()

Community services do assist ()

Specify _____

Do you know of any abandoned children in your community?

yes () no ()

If yes, how many (express per 1000 population)? _____

What does normally happen to these children?

children's home ()

foster parents in the community ()

adoption/fostering outside the community ()

doesn't know ()

Are there any communal mechanisms to help the very poor, destitutes or homeless?

yes () no ()

If yes, specify _____

Are there any groups in your community who do not have access to community facilities like wells or places of worship?

yes () no ()

If yes, specify _____

Are there children who are excluded from going to school?

yes () no ()

If yes, specify _____

On the basis of the above information, ask the KP to rate on a 5-point rating scale how this mutual caring (or lack of it) and the existing degree of equality/inequality contribute to the quality of community life.

'-----'-----'-----'-----'
Disruptive for no contri- maximum possible
the community bution

10. What is your estimate about how many children drop out of school before finishing 5 years of schooling?

Are there many children who run away from school often? _____

How many would you think (per hundred children)? _____

Do you have children in your community who have run away from home, say, in the last year (per 100)? _____

Do you know of cases where children are clearly neglected, beaten very badly or otherwise abused (e.g., kept as domestic servants and not permitted to go to school, made to work very hard, etc.) (per hundred children)?

On the basis of the above information, ask the KP to rate on a 5-point rating scale how much does the fact of children being treated well or badly contribute to the quality of community life.

'-----'-----'-----'-----'
Disruptive for No contri- maximum possible
community bution

11. How do adolescents, say, children between 14 and 18 years, grow up in your community?

Do they sometimes take alcohol or drugs?

many () a few/sometimes () hardly any/none ()

Ask whether the KP can give a number (per 100) _____

Do you know of any adolescents in your community who steal and commit other such offences?

some () hardly any () none ()

Ask whether the KP can give a number (per 100) _____

Are adolescents sometimes involved in violence?

sometimes () rarely () hardly ever/never ()

Do you have any other complaints about the behaviour of youngsters in your community?

yes () no ()

If yes, specify _____

On the basis of the above information, ask the KP to rate on a 5-point rating scale how the way that adolescents grow up in the community contributes to the quality of community life.

disruptive for no contri- maximum possible
community bution

12. In your community, roughly how many thefts took place during the last year (per 1000)? _____

What is the number of crimes with violence during the last year (per 1000)? _____

How many rapes or sexual assaults? _____

Do you have old people who are abandoned by their children?

How many (per 1000)? _____

Do you know of couples with severe marital discord? How frequent do you think this is (per 100 households)? _____

Does it happen in your community that husbands beat up their wives badly?

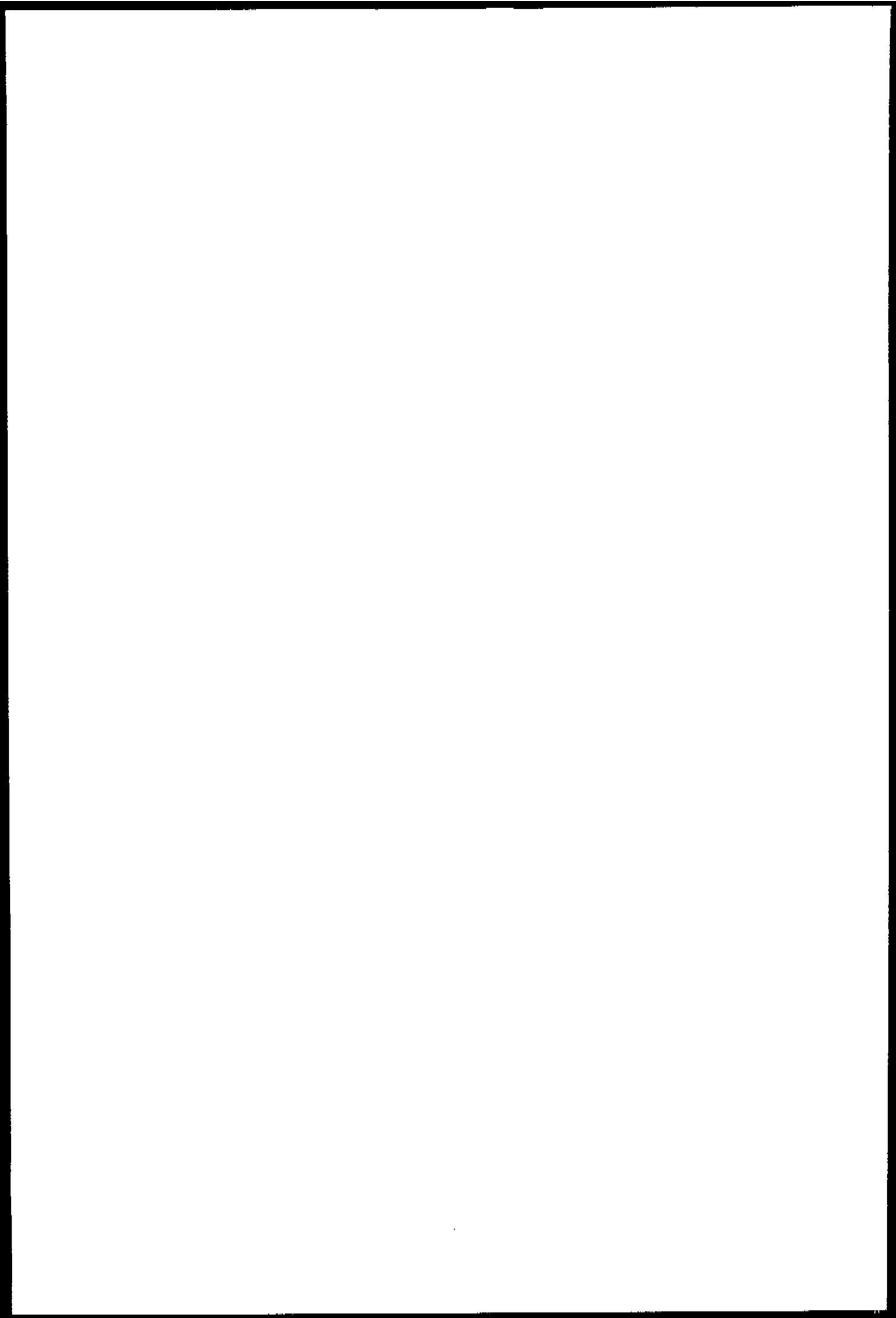
To how many wives do you think this happens (per 100 households)? _____

8. We actively associate with such groups/
associations '___'___'___'___'
9. Many of our relatives/neighbours are active
members of such groups/associations '___'___'___'___'
10. Most of the members actively participate and
contribute to such groups/associations '___'___'___'___'
11. Most of us work together well with such services
like fire brigade, police, etc. '___'___'___'___'
12. We all have a say in the community decisions '___'___'___'___'
13. People here meet each other and take decisions
together, respecting even opposing viewpoints in
most instances '___'___'___'___'
14. There is a free exchange of views on common
matters and nothing is forced upon us from the top '___'___'___'___'
15. Once a decision is reached by the community
as a whole, everyone respects it '___'___'___'___'
16. No one is denied access to the village
council or board '___'___'___'___'
17. Everyone in our community can express his
opinion or make suggestions '___'___'___'___'
18. Group decisions are normally made jointly '___'___'___'___'
19. Group decisions are normally made peacefully '___'___'___'___'
20. If there is a disaster like a drought or
flood, we normally help each other and all
work together in such an emergency '___'___'___'___'
21. In our community we all come to help an
affected person, in case of crisis '___'___'___'___'
22. We normally help each other if someone has a
disabled or mentally retarded person to care for '___'___'___'___'
23. Old people are not neglected in our community '___'___'___'___'
24. If a family has problems to look after a person
disabled with old age, neighbours or friends
normally help out in our community '___'___'___'___'
25. In our community most are willing to help the
poor and destitutes '___'___'___'___'
26. There is not much animosity or jealousy between
different groups of people in our community '___'___'___'___'

27. Disadvantaged groups are suppressed and exploited a lot in our community '-----'
28. Most poor people are just too lazy. It is mostly their own fault '-----'
29. Most disabilities are a punishment for sins '-----'
30. Madness also is mostly due to people's own sins '-----'
31. It is a waste to keep mentally retarded persons alive. It is better for everybody if one lets them die '-----'
32. Everyone in our community has free access to facilities like wells or places of worship '-----'
33. In our community problems like child abuse/ battered child/child neglect are not seen '-----'
34. Our adolescents hardly ever drink alcohol or take drugs '-----'
35. In our community we do not face problems like delinquent behaviour in youngsters '-----'
36. Adolescents in our community do not indulge in violence '-----'
37. Nobody in our community deserts his aged or ill relatives '-----'
38. People in our community do not waste much money on things like gambling '-----'
39. Crimes against women, like rape or indecent assault are very rare here '-----'
40. There are only very few couples in our community who quarrel a lot '-----'
41. Hardly any man batters or abuses his wife in our community '-----'
42. We feel great living in our community '-----'
43. We are a very happy people '-----'
44. We feel no distress living in our community '-----'
45. We do not feel any insecurity in our community '-----'
46. We very much like our children to live and grow up in this community '-----'
47. Living in this community is not a very happy experience '-----'

48. Sometimes we feel very insecure here '-----'
49. We wish our children would go away and live somewhere else '-----'
50. Living in this community can be very stressful '-----'
51. There can be no better community to live in than ours '-----'
52. Given the choice we would again want to be born and live in this community '-----'
53. We have quite an interest here in what is going on in other communities around us '-----'
54. We get a lot of information here on what is going on in other countries '-----'
55. We often visit outside and see different places and meet different people '-----'
56. We believe that such visits to other communities are good for us and for them '-----'
57. There are many good things/habits/customs of other communities '-----'
58. Other communities have many undesirable/bad habits that we would not like our children to know about or imitate '-----'
59. We have a number of relatives living outside '-----'
60. We have many friends living outside '-----'
61. Many people nowadays meet many persons from other countries '-----'
62. Our friends/relatives from outside often pay a visit to us and/or write frequently '-----'
63. We know quite a lot about the living conditions, customs, festivals, etc., of other communities '-----'
64. We have quite a number of festivals, fairs, etc., when different communities get an opportunity to come together and meet each other '-----'
65. We have good friendly relations with our neighbouring communities '-----'
66. We are an open-minded people '-----'
67. Availability of food is not a problem in our community '-----'

- 68. The nutritional status of people in our community is good '---'---'---'---'
- 69. Almost all people in our community can afford to have good nourishing food '---'---'---'---'
- 70. Safe drinking water is easily available for everyone in our community '---'---'---'---'
- 71. One can easily reach a medical or other such facility from any place in our community '---'---'---'---'
- 72. If required, transport facilities are available easily for bringing the patient to the next hospital '---'---'---'---'
- 73. People in our community feel quite safe and secure and go about their business without worry as to what is going to happen next '---'---'---'---'



Annex 11

STUDY ON THE IMPACT OF RECORDING HEALTH PROBLEMS TRI-AXIALLY
ON THE PSYCHOSOCIAL SENSITIVITY OF HEALTH PERSONNEL

Steps:

(1) Collection of base-line data from selected centres. These will include the percentage of cases where any psychological or social problems are recorded (from case records), a selection of items from the item list for work on indicators of psychosocial factors in PHC, such as patients' satisfaction, job satisfaction of staff, perception of the attitudes of clinic attenders and of the community (if the work on indicators is completed, these will, of course, be used), prescribing practices, etc. An estimate will also be recorded of the percentage of clinic attenders likely to have a psychological or social problem. Care will be taken to ensure that the health staff observed will, at that stage, be unaware of the planned study.

(2) A one-day training of the health personnel in the use of the tri-axial recording form. This form will already have been translated into the local language and adjusted to culture. The training is to be done in a group of 14 to 16. There are both theoretical and practical aspects. The concept and methods should be described. In practical sessions the participants are split into groups of 7 or 8. Three to 5 patients are seen by them together and the participants identify psychological and social problems under the supervision of the trainers.

(3) The trained health personnel are then requested to record psychological and social problems in addition to the physical ones according to the international tri-axial recording form, in at least 3 patients per day for 3 months. During the first 6 weeks an investigator will visit the participating staff weekly for further brief training and review sessions.

(If international comparison is desired, cases will have to be randomly selected and this number and the average length of time spent with them should be standardized.)

(4) Six months after the end of the 3-month recording time the observations under (1) are repeated and compared with the base-line data.