

How to do (or not to do). . .

Measuring mental health in a cost-effective manner

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Mental health has been found to contribute significantly to the global burden of disease. This has raised the profile of mental health in developing countries. Many countries still do not have mental health policies, nor do they incorporate mental health in their primary care package. Community mental health profiles are needed to inform policy. There is a demand for more studies of mental health and the inclusion of mental health measures in more general, comprehensive, population-based health surveys. This article reviews the use and performance of a World Health Organization-endorsed instrument known as the Self-Reporting Questionnaire 20 items (SRQ20). The paper concludes that the high face and criterion validity, ease of use and suitability for administration by lay workers support the use of the SRQ20 as a cost-effective instrument with which to measure community mental health.

Key words: SRQ20, mental health, developing countries, cost-effective, measurement

Introduction

Until the early 1990s debates about health in developing countries were largely limited to communicable or infectious disease, especially malaria, diarrhoea and tuberculosis. In 1993, the World Bank and the World Health Organization (WHO) produced a new method for measuring the burden of ill health, which not only considered mortality but also took morbidity into account (World Bank 1993). This new form of analysis ('Global Burden of Disease') raised the profile of mental health because it found that mental health problems, although directly causing very little mortality, are responsible for a significant share of morbidity. In terms of the cost to society and the effect on the well-being of suffering individuals, the contribution of mental ill health to overall morbidity is of crucial importance. In 2001 mental disorders accounted for 13% (up from 12% in 2000) of the world's burden of disease and this figure is expected to increase to 15% in the year 2020 (WHO 2002). According to the *World Health Report 2001*, neuropsychiatric disorders account for nearly one-third of all disability in the world (when measured by Disability-Adjusted Life Years) (WHO 2001a).

The main contributor to the mental ill-health burden is depression, which, along with anxiety and somatic complaints, affects one in three people within their lifetime (WHO 2001a). There is a striking difference by gender, with women being particularly vulnerable to common mental disorders. Mental ill health is second only to cardiovascular disease as a source of burden of disease from non-communicable diseases in women in developing countries, causing 15% of the total (Blue and Harpham 1994).

Although mental health problems can often be successfully treated, many people do not get the care they need because of the associated stigma, a lack of resources (personal finance and/or medical-system wide) and a lack of national mental health care policies. In Africa and the Western Pacific region, only 48% of countries have mental health policies (WHO 2001b). One of the WHO's goals is to promote mental health policy at a country level. Access to prevalence data is critical to the success of these programmes, to the formulation of cogent national mental health policies and to the assurance of specific annual budget allocation to mental health.

The need for a cost-effective measure of mental health, particularly in developing countries, has increased over the last decade because of the realization of the contribution mental ill health makes to the burden of disease. Additional impetus is added by the growing evidence of the substantive and consistent link between poverty and mental illness (Patel 2001), and the recognition that there are feasible actions within primary care, public health and community development realms with which to address the problem. These three factors have prompted more studies of mental health *per se* and, perhaps more importantly, the addition of mental health measures in comprehensive, population-based studies of health and well-being (for example, the international longitudinal study of child poverty – www.younglives.org).

This paper reviews and recommends a method for measuring mental health that is low-cost (in terms of time and level of human resource needed) and effective (interpreted as high validity [specificity and sensitivity]). It assumes that populations of interest may have low literacy and little

infrastructure, making phone interviews and self-completion questionnaires infeasible and face-to-face interviews a necessity. The authors have used the method in a wide range of countries and their comparative experiences are drawn upon in the paper.

The development of the SRQ20

The Self-Reporting Questionnaire 20 items (SRQ20) is derived from four psychiatric morbidity instruments from a wide variety of cultural backgrounds. It was developed by Harding et al. (1980) for a WHO collaborative study to screen for common mental disorders in primary health care. The WHO formally recommends the SRQ20 in its 1994 manual, which also reviews a number of SRQ20 studies and reports the validity and reliability of the instrument (WHO 1994). Table 1 presents the SRQ20, which can be self-administered but which, in low-income population-based studies, an interviewer usually administers. The SRQ20 is not a substitute for, or equivalent to, a clinical diagnosis. It indicates probable cases of mental disorder. ‘Competing’ instruments include the General Health Questionnaire (GHQ) and the Revised Clinical Interview Schedule (CIS-R).

The order of the 20 questions can be adapted to suit cultural contexts. For example, if the question about contemplation of suicide is believed to be highly sensitive, it is wise to place this question at the end of the instrument.

The SRQ20 reflects the multidimensional nature of ‘mental illness’. Factor analyses have shown that one group of the questions taps into a somatic factor (headaches, appetite, digestion, sleep); another into depressive/anxiety symptoms (frightened, unhappy, cry, worthless); while a third captures a more cognitive/decreased energy factor (can’t think or make decisions, work suffering, can’t enjoy daily activities) (Sen et al. 1987; Iacaponi and Mari 1989; Tafari et al. 1991).

The SRQ20 has been used as both a mental health screening instrument at an individual level, and as a way in which to establish the mental ill health prevalence in a community. The authors of this paper have used the SRQ20 to give added depth and dimension to their studies of broader social health issues, including: social exclusion (Hamid 2001); social capital (Thomas 2003); social capital and youth violence (Harpham et al. submitted); reproductive health (Reichenheim and Harpham 1991; Jaswal 1995); socioeconomic status (Ludermir and Lewis 2001); and the social constructions of mental health (Aidoo 1998).

The application of the SRQ20

Two major steps are required in the application of the SRQ20: cross-cultural adaptation (including translation) and decision about the cut-off score used to determine probable cases/non-cases of mental ill-health. The instrument is available in at least 21 language translations (see Table 3), which have been adapted to local cultural meanings and norms. Translations will need to be checked and revised where the context is different (for example, in urban vs. rural settings) or updated to account for modifications in language. Careful evaluation of concepts, translation, piloting and independent back-translation is required when there is no translation available. As yet there is no repository of all the various translations of the questionnaire, although the WHO, Geneva has many of them.

The WHO manual (1994) gives instructions on how to determine a cut-off point. If this has not previously been done in a similar cultural setting then empirical validation against a sample of in-depth psychiatric interviews is required. Interviews with at least 30 cases from the SRQ20 (using a common cut-off of 7/8) and 30 non-cases should be used. The person performing the in-depth psychiatric interview should be ‘blind’ to the results of the SRQ20. For the ‘golden standard’

Table 1. Self-Reporting Questionnaire 20 – English version [30-day recall period]

1. Do you often have headaches?	Yes/No
2. Is your appetite poor?	Yes/No
3. Do you sleep badly?	Yes/No
4. Are you easily frightened?	Yes/No
5. Do your hands shake?	Yes/No
6. Do you feel nervous, tense or worried?	Yes/No
7. Is your digestion poor?	Yes/No
8. Do you have trouble thinking clearly?	Yes/No
9. Do you feel unhappy?	Yes/No
10. Do you cry more than usual?	Yes/No
11. Do you find it difficult to enjoy your daily activities?	Yes/No
12. Do you find it difficult to make decisions?	Yes/No
13. Is your daily work suffering?	Yes/No
14. Are you unable to play a useful part in life?	Yes/No
15. Have you lost interest in things?	Yes/No
16. Do you feel that you are a worthless person?	Yes/No
17. Has the thought of ending your life been on your mind?	Yes/No
18. Do you feel tired all the time?	Yes/No
19. Do you have uncomfortable feelings in your stomach?	Yes/No
20. Are you easily tired?	Yes/No

Source: WHO (1994).

criterion, a local psychiatrist's opinion of the presence of clinically significant mental disorder is appropriate.

Table 2 shows the cut-off points used in a selection of studies among low-income urban populations in developing countries whose results are reported below, and the rationale for choosing that cut-off point. Some studies had to empirically validate the SRQ20 against in-depth psychiatric interviews because there was no previous validation in the country, or because previous studies had been in a very different part of the same country. As can be seen, a cut-off point of 7/8 (7 'yes's' a non-case, 8 'yes's' a case) is common. Table 2 also shows the site, age range, sex and sample size of the different studies.

The strengths and weaknesses of the SRQ20 (Table 3) revolve around cost-effectiveness and cultural specificity, respectively. In terms of effectiveness, false positives are a problem in some settings where chronic infections (for example, a parasitic infection) can boost the number of positive responses. In these cases, in-depth psychiatric interviews will determine a higher cut-off point for deciding caseness. For example, in rural Ethiopia, Tafari et al. (1991) used a cut-off of 10/11. As the instrument is used in a growing number of settings the cultural constraint decreases. Weakness number 1 was not encountered by any of the authors, nor was weakness number 3, but none of our studies linked the interview to any form of health service provision.

Application in Zambia (Aidoo 1998) showed that when the SRQ20 was administered in a respectful way, it was unrealistic to force respondents to stop at a 'yes' or 'no'. Given the sensitive nature of the subject, respondents often volunteered lengthy explanations and in several cases the female respondents expressed relief at being able to 'open their hearts' to the interviewer.

In Pakistan (Hamid 2001) the SRQ20 was administered as one part of a three-part questionnaire. The first two parts were about the social exclusion of women and the control

they have over their fertility. Both contained personal and sensitive questions. The SRQ20 was at the end of the interview, as is common practice. By this stage, the women had developed some rapport or degree of intimacy with the interviewers and felt relatively at ease answering questions about their feelings. Women's lives as a whole were assessed in this study, and the women responded to that. Unlike other community surveys where respondents can be suspicious, wary or uninterested, these respondents were found to be keen to share their feelings, perhaps because the real issues in their lives were addressed and discussed. Once the women felt at ease, they expressed gratitude at being given the opportunity to voice their feelings and it was felt to be a therapeutic experience for them. Interviewers were trained to counsel (give advice) and refer women, not only for depression and anxiety, but also for physical health problems, as the survey provided the women with a vital contact with a community/health worker. Provision of such referral, when appropriate, is a key ethical issue.

In Durban and Lusaka (Thomas 2003), the lay interviewers were trained to listen sympathetically and to refer the respondents to appropriate resources, such as rape counselors, welfare agencies and health centres. The age, gender, sensitivity and confidentiality training (regarding ethical approval and informed consent) of the interviewers were factors that influenced the respondents' freedom of response.

In India (Jaswal 1995), respondents, especially those in low-income groups, rarely immediately answered with a 'yes' or 'no'. They tended to describe the symptom and this helped to clarify if they had understood the question in the expected manner. For example, to question 18, 'do you feel tired all the time', respondents sometimes answered that collecting and carrying water home from a communal water source was tiring. Interviewers then clarified that the question relates to feeling tired beyond what is expected in everyday work. Similarly, with question 12 on decision making, as women were not normally expected to make decisions at home, clarifying illustrations were necessary. The researcher gave decisions

Table 2. Study designs

	Reference							
	Reichenheim (1991)	Jaswal (1995)	Ludermir (2001)	Aidoo (1998)	Hamid (2001)	Thomas (2003)	Thomas (2003)	Harpham et al. (in press)
Site	Rio de Janeiro	Bombay	Olinda	Lusaka	Lahore	Durban	Lusaka	Cali
Age range	15–35	16–45	15+	20–40	17–45	16–40	16–40	15–25
Sex	F	F	M/F	F	F	F	F	M/F
n	460	660	621	323	650	250	253	1060
Prevalence (%) of probable mental ill-health	36	18	35	34	42	37	28	26
Cut-off score	7/8	7/8	5/6	6/7	7/8	7/8	7/8	7/8
Reason for cut-off score	Previously validated in Brazil	Empirical validation	Empirical validation	Empirical validation	Assumed neighbouring country (India) cut-off	Previously validated in Zambia	Previously validated in Zambia	Previously validated in Colombia

Table 3. Strengths and weaknesses of SRQ20

Strengths	Weaknesses
1 High face validity: appears to assess relevant symptoms of mental ill-health	Potentially offensive questions; especially 'feel worthless' and 'have you considered suicide'
2 Reasonable criterion validity: sensitivity ranges from 63–90%; specificity from 44–95% (tested against in-depth psychiatric interviews) (WHO 1994)	Measures both presence of symptom and respondent's inclination to report the symptoms (Kebede et al. 1999)
3 Available in many languages* and cut-off point has been established in many settings	Respondents may answer yes if they perceive an advantage in being in the sick role (false affirmatives) (Kortmann and Ten Horn 1988, De Jong 1987)
4 Quick – typically 10 minutes, but interviewers may need to counsel distressed respondents	If no cut-off has been established in same translation (version) with similar populations/communities then comparison with in-depth interviews needed to determine cut-off
5 Suitable for use by lay interviewers given appropriate training in sensitivity, counselling and referral	Difficult to measure reliability (repeatability), if the two observations are separated by more than 30 days
6 Respondents often express positive feelings about having been asked these questions. Women in particular often say 'that is the first time anyone has asked me how I feel'	30 day recall period might incur recall bias among some respondents (WHO recommended period for general, common, physical morbidity is 14 days)
7 Useful as both an instrument of measurement of community mental health and individual mental health screening	Differential misclassification: women and less educated tend to false positives; men and more educated tend to false negatives (Araya et al. 1992, Ludermir and Lewis 2001)
8 Can stand alone, although best in conjunction with a broader questionnaire, to help establish rapport between interviewer and respondent	Need to develop a protocol for referral to services/help
9	Standard instruments like the SRQ20 are criticized by cultural epidemiologists for being inappropriate (Weiss 2001)
10	Does not provide or suggest a diagnosis

*The SRQ-20 has been translated from English into Afrikaans, Amharic, Arabic, Bahasa Malaysia, Bengali, Filipino, French, Italian, Hindi, Kashmiri, Kiswahili, Marathi, Njanja Lusaka, Portuguese, Shona, Siswati, Somali, South Sotho, Spanish, Urdu, Vietnamese and Zulu.

about what food to cook, what clothes to wear or what snacks to prepare for her child as examples. Different population groups may need clarifying statements on different questions. For example, the elderly may need clarification on digestion questions.

When used as a self-response schedule, respondents are required to decide 'yes' or 'no' alone. It might be that some operational equivalence is lost when the SRQ20 is used in a face-to-face interview, since the interviewer has more responsibility for deciding to code 'yes' or 'no'. It is therefore important that interviewers are well trained, and inter-observer reliability tests would be useful.

The results of the SRQ20

While the SRQ20 has been used in hundreds of independent studies (many reported in WHO 1994), we focus here on the eight studies among low-income urban populations in developing countries undertaken by the authors. The studies are used to illustrate the kind of item responses, prevalences and variation researchers can expect when using this instrument. The median and range of affirmative responses received across the eight studies are reported in Table 4.

Prevalence of poor mental health across the sites ranges from 18% to 42%. The individual studies discuss significant social risk factors for their particular populations. It should be noted that the ultimate reporting of the SRQ20 is not meant to be broken down into single items, but reported as a

synthetic, dichotomous 'case' or 'non-case'. From a psychometric perspective, items do not stand for themselves but rather for the 'content space' that makes up the construct the test is meant to measure (Nunnally 1995). However, researchers frequently examine which items are contributing to a particular pattern of results. The questions with the highest median responses were those related to nervousness, headaches and unhappiness (53, 52 and 44%, respectively). These results duplicate those reported by Araya (1992) in a Chilean study. The questions with the lowest average responses were those about thoughts of suicide and experiencing shaking (13 and 15%, respectively).

While the item responses will vary according to the nature of the population studied, the compilation of the above studies enables future users of the SRQ20 to appraise their results in an internationally comparative manner.

Conclusion

Mental health is more firmly on the international health agenda than ever before. Prevalence data is needed to help inform policy, especially in developing countries where no policy exists and the annual financial allocation to mental health in the budget is non-existent or minimal. Moreover, increasing numbers of general health surveys are including a mental health component. There is a need for a cost-effective measure that can be used across populations that have various levels of infrastructure and literacy. The interviewer-administered and quick SRQ20 has proven itself to be robust.

Table 4. SRQ20 results*

Question	Median (minimum, maximum) of % respondents answering 'Yes'
1. Often have headaches	54 (27, 68)
2. Poor appetite	27.5 (20, 39)
3. Sleep badly	27 (10, 48)
4. Easily frightened	43 (26, 49)
5. Hands shake	16.5 (8, 30)
6. Feel nervous, tense or worried	55 (38, 78)
7. Poor digestion	20 (6, 40)
8. Have trouble thinking clearly	33.5 (8, 43)
9. Feel unhappy	45.5 (32, 59)
10. Cry more than usual	23 (17, 45)
11. Find it difficult to enjoy daily activities	28.5 (6, 38)
12. Find it difficult to make decisions	38 (10, 48)
13. Daily work/study suffering	19.5 (11, 29)
14. Unable to play a useful part in life	21.5 (7, 42)
15. Lost interest in things	28 (10, 42)
16. Feel worthless	18 (6, 37)
17. Thought of ending your life been on your mind	14 (6, 24)
18. Feel tired all the time	31 (18, 63)
19. Uncomfortable feelings in your stomach	29.5 (20, 45)
20. Easily tired	32.5 (25, 61)

*Across the eight studies included in Table 2.

It has a relatively high validity and well over 10 years' history of application in at least 20 countries. The SRQ20 is a cost-effective way to measure mental health.

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Biographies

Trudy Harpham is Professor of Urban Development and Policy at South Bank University, London. She has published major texts on

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