Prevalence of depression, anxiety and posttraumatic stress related symptoms in the Kashmir Valley – a cross sectional study, 2015.

Research Protocol

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Second Version

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MSFH India

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Study period	*June-October 2015*
Study site	10 districts within the Kashmir division - Srinagar, Anantang, Badgam, Bandipore, Baramulla, Ganderbal, Kulgam, Kupwara, Pulwama, Shupiyan.
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- The Department of Psychology at the University of Kashmir.

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List of Abbreviations

DMHP	District Mental Health Plan
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition.
EU	Enumeration Area
FGD	Focus Group Discussion
HPRT	Harvard Program in Refugee Trauma
HSCL	Hopkins Symptoms Checklist
HSCL-25	Hopkins Symptoms Checklist – 25 items
HTQ	Harvard Trauma Questionnaire
HTQ-PTSD-16	Harvard Trauma Questionnaire Post Traumatic Stress Disorder – 16 Item checklist
HTQ-TE	Harvard Trauma Questionnaire Traumatic Events.
ICD	International Classification of Diseases
ICMR	Indian Council of Medical Research
IMHANS	Institute of Mental Health and Neurosciences
INGO	International Non-government Organisation
MH	Mental Health
MINI	Mini-international Neuropsychiatric Interview
MoH	Ministry of Health
MSF	Médecins sans Frontières
NGO	Non-Government Organisation
NMHP	National Mental Health Plan
OCA	Operational Centre Amsterdam
OPD	Outpatients Department
PSU	Primary Sampling Unit
PTSD	Post Traumatic Stress Syndrome
STATA	Statistics and Data Analysis Software
UNCIP	United Nations Commission for India and Pakistan
WHO	World Health Organization

Study Summary

Title: Prevalence of Mental Health problems in the Kashmir Valley – mixed methods research, 2015.

Primary Objective: To estimate prevalence of mental health related problems, specifically depression/anxiety and posttraumatic stress symptoms in Kashmir and to determine the accessibility to mental health services.

Study Design: Mixed methods research design incorporating cross-sectional household survey, clinical psychiatric interviews, key informant interviews and focus group discussions.

Inclusion Criteria: Participants will be included if they can meet the following criteria:

- 18 years of age or older.
- Able to provide informed consent.

Exclusion Criteria: Participants will be excluded from the study if they meet the following criteria:

- Unable to provide verbal informed consent.
- Choose to withdraw their consent.

Intervention: The survey will be conducted in the Kashmiri language by interview enumeration. A sub-sample of the survey population will undergo a mini-international neuropsychiatric interview (MINI) by a trained interviewer. Key informant interviews and focus group discussions will occur concurrently with the household survey.

Sample Size: 4800 probability sampled households from 10 districts, 12 households from each village. A sub-sample of 200 individuals who test positive on validated screening tests will be convenience sampled for formal psychiatric interview (MINI). Two focus group discussions will be held in each district and will be comprised of 8-10 convenience sampled participants.

Primary Outcome Measure:

- Point Prevalence of depression/anxiety and posttraumatic stress symptoms.
- Qualitative data on access to mental health services and perceived needs.

Proposed Partners: The household survey will be conducted in collaboration with:

- Department of Psychology at the University of Kashmir.

Introduction

This section will provide a contextual overview of the proposed study.

The Indian state of Jammu and Kashmir shares a border with China in the north and east and Pakistan in the west and northwest. The state consists of three separate administrative regions; Jammu, Kashmir Valley and Ladakh. The proposed research will be conducted in the Kashmir Valley region only, throughout this protocol therefore the term 'Kashmir' refers to the Kashmir Valley region of the state unless specified otherwise.

Table 1: Kashmir Valley Statistics

Population[1]	6 888 475
Religion	Muslim (97%), Hinduism, Sikh, Buddhism (3%)
Human Development Index[3*]	0.554
Human Development Ranking[3*]	136
Per capita income[*]	Rs 50 641
Unemployment rate[4*]	10% (highest in Northern India)
Total land area[1*]	15 948km^2
Urban Population[1]	2735300 (39.7% of total population)
Population under the age of 15 years[1*]	25.6%
Life expectancy[*]	65.0 Males, 67.0 Females (SRS 2009)
Maternal Mortality Ratio[3*]	200
Infant mortality[2*]	42
Under 5 mortality rate[2*]	52
Literacy Rate for population over 15 years[1]	52% (56% for J&K)

1., 2., 3., 4.
*Statistics for Kashmir valley unavailable, figures representative of the state of Jammu & Kashmir.

1 Political context in Kashmir

Following the partition of India in 1947, the Kashmir valley has been subject to continual political insecurity. Three Indo-Pakistan wars (1947, 1965, 1971) and one Indo-Chinese war (1962), have been followed by an internal resistance movement for self-determination. In 1987, disputes over a state election served as a catalyst for insurgency with the formation of new armed groups. By 1989 the “insurgency” had begun. Repetitive armed attacks on the Indian Government were conducted in Jammu/Kashmir. The Indian government initiated a military response.

The loss of human life, human rights abuses and a resulting context of on-going low-grade conflict has had its impact on Kashmir’s population. According to , since 1947 the majority of the Kashmiri population consider themselves to be living in a state of colonisation and occupation by the Indian state. There remains more than half a million troops in the region, making it the most heavily militarized in the world . As of 2012, approximately 70,000 Kashmiris had lost their lives in the conflict with 10,000 missing persons reported. Frequent confrontations with violence have been reported including displacement, exposure to crossfire, ballistic trauma, round up raids, torture, rape, forced labour, arrests/kidnappings and disappearances .

2 Economic context

The uncertain atmosphere in Kashmir over the past 25 years has prevented outside investment. A nationwide survey conducted by the Ministry of Labour and Employment in 2012-2013 found that Kashmir had the highest youth unemployment across India , with a high percentage of university graduates unemployed. At state level the number of registered job seekers increased 190% from 2008-2013. Employment generating sectors such as commercial agriculture, forestry, fisheries and floriculture have been limited due to the prevailing circumstances in the region. Where Tourism was once the source of employment and economic growth, in the past 25 years this industry has been fractured and undependable. A 2011 report by Mercy Corp reports the risks associated with high youth unemployment including feelings of failure, isolation, lack of social status, delayed marriages and the increase in tensions among disenfranchised young people have been compounded by the impact of future uncertainty related to the conflict. Conflict-related stress, mental illness, suicide and drug addiction; expressions of disappointment, anger and hopelessness are reported to be prevalent in Kashmir's young population .

3 Mental Health in Kashmir

The impact of prolonged exposure to violence on the psychological well-being of the population has been confounded by natural disasters such as the earthquake of 2005 and floods of 2014 . Conflict not only exposes a population to traumatic violent events but also has a negative impact on the social and material fabric of society. Survivors of violence associated with the conflict are also often concurrently subject to other stressors affecting everyday life and livelihood . In Kashmir other confounders include widespread poverty, uncertainty, grief, oppression and fear in addition to high unemployment with limited development of employment generating sectors.

There is a public mental health (MH) crisis in Kashmir due to the compounded impact of long-term low-intensity conflict. The Institute of Mental Health and Neurosciences in the valleys capital, Srinagar, has experienced an increase in outpatient presentations from an average of 100 per week in 1980 to between 200-300 per day in 2013 . Shoib et al. report that the number of suicide attempts increased by more than 250% between 1994-2012.

A number of research studies have been previously conducted in the Kashmir Valley examining the impact of the conflict on the mental health of the population. While these studies have been useful for advocacy and draw attention to the plight of the Kashmiri population, many of these studies are methodologically weak, leaving to question the reliability and representativeness of results.

In 2008 Yaswi and Haque concluded that a 'high' number of victims of war associated trauma suffer from Post Traumatic Stress Disorder (PTSD) symptoms with those reporting personal experience directly related to the conflict suffering from chronic depression. However the nonprobability sample and small sample size of 80 individuals limits the generalizability of results. The tools used included the Beck Depression Inventory and the Everstine Trauma Response Index-Adapted, neither of which has been validated for the Kashmiri context. Other studies have used purposive sampling to target victims of conflict related trauma and assess the presence of psychiatric symptomology in this target group with non-standardised questionnaires . Khan measured mental health outcomes in 390 probability sampled urban households in 4 administrative regions of Srinagar. Among the sample 58% of households had experienced verbal violence and 32% physical violence related to the conflict. While the author does not state what tools were used in the survey he concludes that 46% of the sample reported anxiety and 32%, depression. Between 2003 and 2005 Margoob conducted an assessment of mental health status of 2391 probability

sampled individuals within 6 districts of the Kashmiri valley. The MINI screening tool and MINI clinical interview were used to assess psychiatric symptomology and establish a diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) criteria. Prevalence of PTSD was found to be 7% with life-time prevalence rate of PTSD reported at 15%. While the MINI screening tool has not been validated for the Kashmiri context, the strength of this study is in the clinical interviews conducted by psychiatrists. Using the Self Reporting Questionnaire (SRQ) and probability sample of 510 households in 2 districts in the Kashmir Valley in 2005, reported that psychological distress was experienced by 33% of their sample, with one third reporting suicidal ideation. While cut-off scores were adapted from the previously validated Indian SRQ, these were not validated specifically for the Kashmiri context. Research has also been conducted on the impact of natural disasters on mental health in the Kashmir Valley. However, research limitations include small sample size and the lack of use of standardised and validated instruments

In 1999 the District Mental Health Plan (DMHP) was initiated with the intention of staggering a rolling out of community based mental health services in all states of India. The program commenced in Jammu/Kashmir in 2004-2005, however, the 2012 National Mental Health Plan (NMHP), report results from a review of the DMHP, stating it was barely functional in most districts. The 2012 NMHP suggests a renewed commitment by the government of India to address the mental health needs of its population and calls for research which can 'offer insights as well as pathways for change'

Figure 1: Map of the Kashmir Valley

http://en.wikipedia.org/wiki/Kashmir_Valley#mediaviewer/File:Kashmir_border.JPG

4 MSF presence in the Kashmir Valley

Médecins Sans Frontières (MSF), started working in the Kashmir Valley in 2001 with a Mental Health (MH) programme to provide MH support to the Kashmiri population affected by the chronic conflict, this being the entire population to a degree. The program expanded and evolved over time and included a Primary Healthcare (PHC) component in the remote areas of Kupwara district that was started in 2007. In 2012 it was decided to close the PHC programme and the MH programme refocused on the (more urban and more affected by the "civil unrest") districts of Srinagar and Baramulla. MSF now work regularly in Ministry of Health hospital locations in Srinagar city, Baramulla town, Pattan, Bandipora and Sopore town. MSF's focus on the populations mostly affected by conflict remains the aim of our medical presence.

A community survey conducted by MSF in the districts of Badgam and Kupwara in 2005 reported exposure to high levels of direct confrontations with violence with 85.7% of respondents reporting exposure to crossfire, 82.7% experienced roundup raids, 66.9% reported witnessing torture, 13.3% and 11.6% reported exposure to rape and sexual violence (respectively), 16.9% of participants reported having experienced arrest or kidnapping, 33.7% participated in forced labour and 12.9% experienced torture. One third of study participants reported symptoms of psychological distress . This study was subsequently published in the journal *Conflict and Health* and has been repeatedly quoted by the media and other parties when discussing mental health in Kashmir.

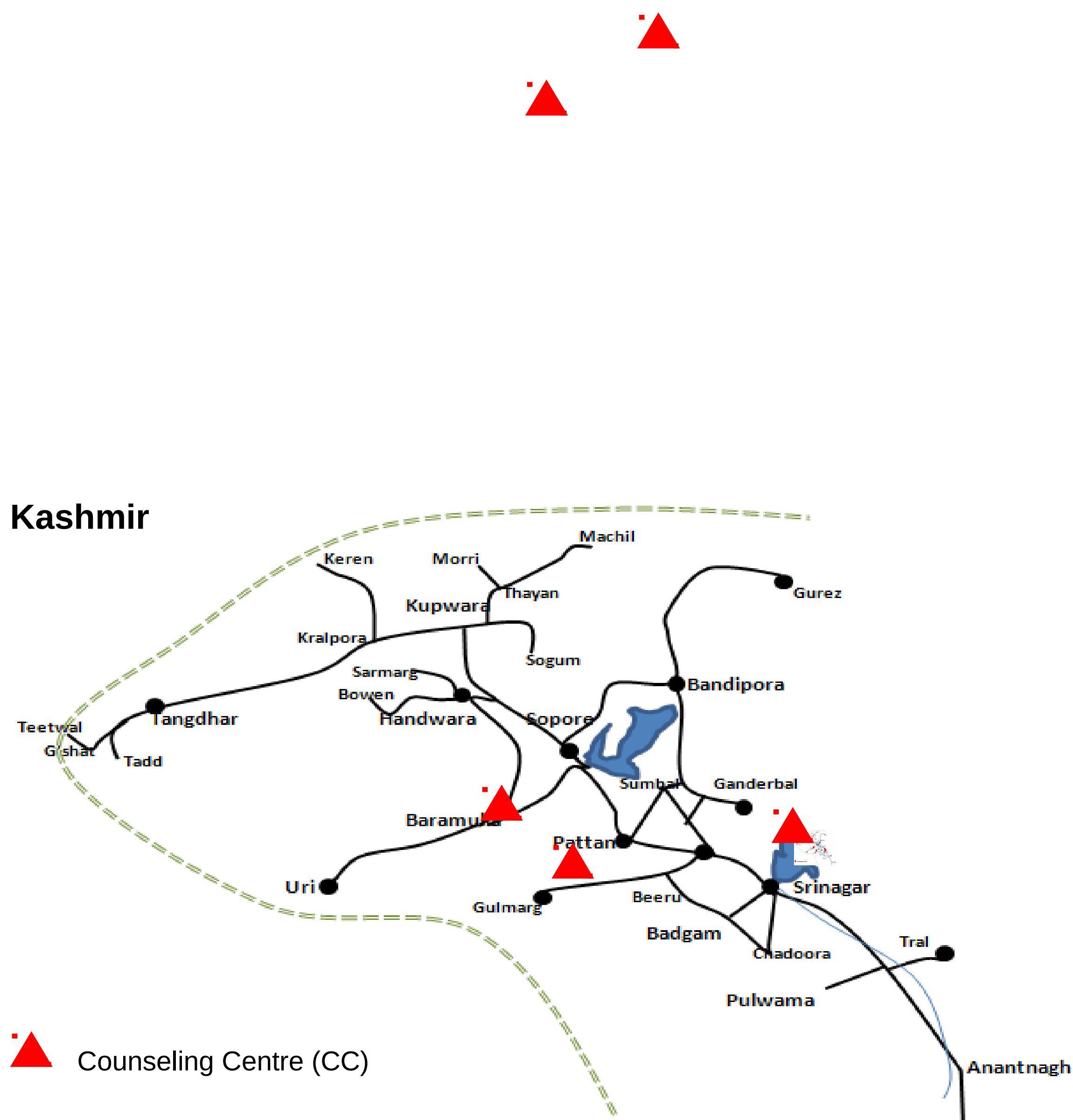
4.1 Current MSF program in Kashmir

In 2014 the focus of MSF programing in Kashmir includes the following components

- Individual counselling;
- Provision of 'Psychological first aid (PFA)' to hospitalized victims of trauma directly related to violence;
- Community outreach activities;
- Advocacy and communication highlighting the mental health situation and needs in Kashmir.

MSF provides counselling in six strategic locations illustrated in Figure 2; Two hospitals within Srinagar city, Baramulla District Hospital, Sopore District Hospital, Bandipora District Hospital and Pattan District Hospital. A team of three trained lay counsellors and five clinical psychologists provide counselling services at these sites, working alongside the Ministry of Health (MoH) psychiatrists in most locations.

Figure 2: Map of MSF Program Sites



4.2 Program statistics

During 2014 MSF counsellors and clinical psychologists conducted 2426 counselling sessions. Of the presenting complaints, 45% were anxiety related, and 24% mood related, with a further 17% presenting with physical complaints. Precipitating events were dominated by non-violence related incidents (64%) with a further 14% related to domestic discord or violence . This is a common pattern reported by MSF counsellors, who in a free-listing activity identified common domestic issues such as family stress, exam stress, love affairs,

relationship problems, chronic disease, unemployment and financial difficulties as the most common precipitating events for patients attending counselling. However, a caveat was provided stating that the root of all these issues is the trauma experienced by the individual and the family, which is thought to have decreased the populations coping ability when faced with everyday stressors.

Study Rationale

The World Health Organisation (WHO), recognising that "*mental and addictive disorders are among the most burdensome in the world with their burden set to increase over the next decade*" emphasise the need for rigorous population surveys that estimate the prevalence of mental disorders . Representative epidemiological data on psychiatric disorders in the Kashmir Valley is required in order to target limited resources and monitor trends over time. This research will use scientifically robust methods to estimate the prevalence of depression/ anxiety and posttraumatic stress symptoms in the population of the Kashmir Valley. This is the first rigorous population survey conducted with a representative sample of the Kashmir Valley population; findings of this study could have a major influence in mental health care policy planning efforts in the coming years. This is acutely pertinent in a region that has a significant level of unmet needs regarding mental health service organisations, delivery of care and epidemiological research.

Objectives

5 Primary objective

To estimate prevalence of mental health related problems, specifically depression/anxiety and posttraumatic stress symptoms in the Kashmir Valley and to determine the accessibility to mental health services.

6 Specific objectives

- Using validated screening tools determine the percentage of people with depression, anxiety and PTSD symptoms in Kashmir;
- To correlate scores obtained on validated mental health screening tools with individual psychiatric evaluations using the mini international neuropsychiatric interview (MINI);
- To explore local knowledge and perceptions of mental illness in Kashmir;
- To determine the level of access to mental heath services across Kashmir;
- To identify mental health service needs perceived by the Kashmiri community.

7 Goal

To provide an updated insight into current mental health needs in Kashmir, which will help MSF to increase relevance and impact of current activities in Kashmir and to advocate for supportive programming and policy review.

Study design and Setting

8 General design

This is a mixed methods research study incorporating qualitative and quantitative methodology;

1. Cross-sectional household survey based on multistage clustered area probability sample.
2. Clinical interviews using a gold standard psychiatric interview will be conducted with a convenience sample of survey participants scoring above the validated cut-off score on screening instruments.
3. Key informant interviews and focus group discussions exploring knowledge and perceptions of mental health, access to services and perceived community mental health needs.

9 Study setting

The ten districts within the Kashmir division - Srinagar, Anantang, Badgam, Bandipora, Baramulla, Ganderbal, Kulgam, Kupwara, Pulwama, Shupiyan.

10 Study population - Quantitative

The target population for the survey is defined as all 18 years old and over residents of private households in the Kashmir Valley. This definition excludes people living in non-private dwellings, residents of institutions or hospitals, prison inmates and others not residing in private households.

10.1 Sample size

The target population are all those over the age of 18 years living in the Kashmir Valley. Given that this is the first representative population survey of mental health across the Kashmir Valley a prevalence rate of 40% was assumed for the sample size calculation. Adopting a precision of estimate of 6%, an alpha error of 0.05 and design effect of 2 an estimated sample size of 480 households per district was calculated. In order to allow comparisons across districts and taking into consideration the heterogeneity between villages, 40 clusters in each district will be randomly selected, 12 households will be interviewed in each enumeration area. A non-response rate of 10% was considered in this calculation. One household member 18 years orover, in a randomly selected household will be interviewed.

10.2 Sampling Frame

The sampling frame for selection of households used in the study is provided by the list of 2011 Census Enumeration Area's (EA's) for each of the study districts, with the number of households defined under administrative units called 'sub-districts'. At the first stage of sampling a list of the sub-districts in each district and the number of households in the sub-district will be listed. 40 sub-districts will be selected as the Primary Sampling Units (PSU's) using Probability Proportional to Size , which will be based on the number of households living in each sub-district at the time of Census (2011). The second stage will consist of selecting a sample of Secondary Sampling Units (SSU's) from each PSU. A list of villages/towns in each chosen sub-district will be collated and 1 village/town will be randomly selected as the SSU. The third stage-sampling unit in the multistage sampling will be the household.

Prior list dependent method
In the context of the Kashmir Valley where village heads keep a list of resident households, the prior-list-dependent method (PLD) with random number tables will be used to select sample households. A population census was carried out in 2011, at which time household lists were updated. The team supervisor will be required to sit with the village elder and further update the household list to only include the households eating and sleeping in the

village at the time of data collection. Using the updated household list and a unique random number table for each SSU, the supervisor would select 8 households for interview.

In Urban settings households will be selected using the random selection of GPS points. The house closest to the selected GPS point will be approached to participate in the study. Any sensitivity associated with GPS sampling will be mitigated by clear explanation to the urban authorities. This will be conducted as part of the pre-survey security assessment.
The final stage requires the selection of individuals for interview. Information regarding the number of people aged 18 years or more living in the household will be collected via the household head demographics questionnaire. One person recorded, as over 18 years will be randomly selected and asked to participate in the study..

10.3 Participant selection and enrolment

Initial consent will be gained from the household head. The information sheet will be read to the household head and any questions answered. Once the household head has consented for his/her household to participate a short demographic questionnaire will identify individuals in the household over the age of 18 while also providing important demographic information about the household.

One randomly selected household member over the age of 18 years residing in the selected household and meeting the inclusion criteria will be asked to participate in the study. The information sheet will be read to the individual by the enumerator, the study explained and questions answered in the appropriate language, the information sheet will remain with the participant. The consent form will then be signed and the participant enrolled in the study. Consent for participation in the MINI interview will be included within the main consent form so as to avoid any issues with an individual being singled out.

10.4 Inclusion and exclusion criteria

*Inclusion Criteria**:** Participants will be included if they can meet the following criteria:*

- 18 years of age or older.
- Able to provide informed consent.
- Present at the time of the survey.

Exclusion Criteria: Participants will be excluded from the study if they meet the following criteria:

- Unable to provide verbal informed consent.
- Choose to withdraw their consent.

10.5 Withdrawal of study participants

Participants who meet the exclusion criteria listed above will be removed from the analysis and the reason recorded accordingly. This will not impact on their access to care and treatment.

The interviewee may stop the survey or MINI interview at any time. The person does not have to give a reason for stopping the interview. In the case the interviewee stopped the survey or MINI interview due to emotional distress they will be counselled by the trained enumerator and if necessary referred to the best available mental health and psychosocial support worker. Referral to appropriate mental health support services will also be offered at this time.

11 Subsample for MINI psychiatric interviews

Following the recommendation by DeJong and Steel that clinical interviews be included in mental health prevalence studies a subsample of 20 individuals from those scoring above the Kashmiri validated cut-off scores will be selected from each district (providing a total sample of approximately 200). Restrictions imposed by remote access and limitations on resources prevent a true random sample of individuals scoring above the cut-off on screening instruments.

Two trained clinical psychologists will be embedded with different research teams at various times throughout the data collection. Following administration of the interview an automated tally of the respondents score on the screening tools will be visible on the electronic data collection tablet. Enumerators will identify individuals scoring over the pre-validated cut-off score and ask if they would be willing to undergo a MINI psychiatric interview.. A trained clinical psychologist will then visit these individuals reconfirm consent has been obtained and conduct the MINI interview. When the sample size of 20 is completed for a districtMINI interviews will cease to be offered.

These interviews will test the robustness of the screening instruments to identify persons with likely mental health problems when implemented in a household survey. On cessation of the MINI interview the participant will be asked for their view on areas for prioritisation and possible interventions for mental health services in the Kashmir Valley.

The ***Mini International Neuropsychiatric Interview*** (MINI) is a short structured diagnostic interview, designed for epidemiological studies and based on the DSM-IV and the International Classification of Diseases (ICD) . The MINI is a reliable and valid diagnostic tool, reportedly widely used by psychiatrists in Kashmir and has been used previously in psychiatric epidemiological studies in the Kashmiri context . The administration of the interview takes about 20 minutes and has been validated against other standardised diagnostic interviews, including the Composite International Diagnostic Interview (CIDI) and the Structured Clinical Interview for DSM Disorders (SCID).

12 Participant selection and enrolment for qualitative interviews

Qualitative data collection will consist of a combination of key informant interviews and focus group discussions (FGDs). Key informants will be selected from individuals working in mental health in the Kashmir Valley and community leaders from sampled sub-districts and villages.

Snowball sampling will be used to identify participants for focus group discussions and key informant interviews, with the use of the village elders as the primary point of contact. In each district 2 focus group discussions will be held, issues associated with mental health in the community, perceived needs, and access to services will be explored. In respect of the culture in Kashmir and to help facilitate discussion focus groups will be defined according to gender with 1 male and 1 female focus group conducted in each district, with 8-10 participants in each group.

Data collection and Analysis

This research uses multiple methods to explore the prevalence of depression/anxiety and posttraumatic stress symptoms and access to mental health services.

13 Qualitative Data Collection

Qualitative data will be obtained via key informant interviews and focus group discussions in order to gain insight into the lived experiences and perceived mental health needs of the Kashmiri population. The qualitative arm of the study is not intended as a separate in-depth qualitative study on mental health in Kashmir but rather as a complementary research method to more broadly investigate the research questions.

Few qualitative studies on mental health in conflict-affected countries have been undertaken; predominantly such studies have a strong quantitative focus. Therefore it is not possible to approach data with a set of conceptual categories. Pre-constructed interview guides will be used only to stimulate discourse. Prior theoretical expectations will be avoided and all inferences will be grounded in the data collected. Data collection and analysis will occur simultaneously and inform each other. Themes and concepts constructed from the analysis will guide decisions such as information sources .

Verbal consent will be sought from all participants for interview and data to be audio recorded with mp3 technology ensuring an accurate and complete verbatim record of both researcher's questions and participant responses. In the case where a participant refuses consent for audio recording, data collection in these interviews will rely on note-taking and post-interview reflections. The researcher will document the demographics of interviewees, observations, reactions, impressions and other significant contextual information in an interview journal. Interview journals are recognised as a useful source of supplementary information . The interviews will be transcribed and then translated from Kashmiri to English.

14 Qualitative Data Analysis

Analysis of qualitative data will be based on thematic analysis where data is coded, sorted and organized . The purpose of the analysis will be to identify themes from the data that are rooted in the reality of the lived experience of mental health needs and service provision in the context of the Kashmir Valley.

Continual referencing back to the data during analysis ensured that the analysis process is firmly grounded in the actual data. After regaining familiarity with the data “open” coding will be conducted in order to identify new ideas, relationships, patterns between experiences of mental health/illness. Once primary categories and relationships are developed the transcripts will once again explored in depth in a second stage of coding. During this stage connections between categories and relationships will be identified and existing codes sub-categorized into minor themes. This process is known in the literature as 'axial coding' or the practice of making connections . In this way more specific experiences concerned with perceptions of mental health needs and access to service will be given a title or name. The final stage of coding then gathers minor themes into major themes. Strauss and Corbin (1990) describe this phase as the process by which all categories are then structured around a central or 'core' category . Transcripts will be re-examined and quotes selected that illustrate each of the identified themes.

During this coding process common themes will be identified with respect to participants experience of mental health issues, health seeking behaviors and perceived service needs.

15 Quantitative Data Collection

DeJong identifies two criteria that are necessary for a rigorous mental health assessment. The cross-cultural validation of instruments and the use of validated clinical interviews to establish a mental health diagnosis. Quantitative methods for this research include the use

of a household survey incorporating validated screening tools. In addition, a sub-sample of survey participants who score above the validated Kashmiri cut-off point on the screening tools will be selected for clinical interview using the mini-international neuropsychiatric interview (MINI) to determine whether the individual does have a psychiatric illness as defined by the DSM-IV.

15.1 Village Elder Questionnaire

A short questionnaire will be administered by the team leader to the village elder, asking specific information about the village, including presence of local healer in the community, distance (in walking minutes) to a primary health care centre, pharmacy and hospital.

15.2 Household Survey Questionnaire

The household survey questionnaire will be administered to a randomly selected household member 18 years or over. A separate household demographics questionnaire will be administered to the household head in order to capture specific demographic details of the household. The survey is broken up into the following sections;

1. Household Demographics - to be administered to the household head.
2. Individual questionnaire - all members of the household 18 years and over.
    a. Additional demographic details
    b. Difficulty in completing daily activities
    c. Problems of daily life
    d. Substance use
    e. HSCL-25 culturally adapted, translated and validated tool.
    f. Coping strategies
    g. Traumatic Events
    h. HTQ-PTSD-16 culturally adapted, translated and validated tool.

15.2.1 Household Demographics

This brief questionnaire administered to the household head is based on census demographic data, the purpose being to allow comparison of data across households. Data on each member of the household includes their position/relationship in the household, age, gender, marital status, literacy, education status and employment.

15.2.2 Individual demographics

This section asks for additional information specific to the individual being interviewed, including main activity, number of days per week they are engaged in employment.

15.2.3 Difficulty in completing daily activities

A list of common daily activities for men and women in Kashmir was constructed in June 2014 using free-listing exercises in groups representing individuals from various demographic backgrounds. During March 2015 further free-listing will be conducted to ensure an exhaustive list. The activities listed in the questionnaire in the appendix of this document may therefore be further adapted prior to translation. The respondent is asked how much difficulty they have experienced completing each task in the past month. The items are rated on a 6 point likert scale, the categories of response include; 'no difficulty', 'very little', 'a moderate amount', 'a lot' 'cannot complete the task', 'don't normally do this'.

15.2.4 *Problems of daily life*

A list of problems of daily life experienced by men and women of different ages and demographic backgrounds will be compiled using free-listing exercises in March 2015 and included in the questionnaire in order to gain data on the daily stressors Kashmiri people face in their everyday lives. Such stressors are now recognised by researches as a significant determinant of mental health in conflict-affected societies .

15.2.5 *Substance Use*

Substance use has received increasing attention in Kashmir, although substance use is not accepted by society and is against religious beliefs the use of tobacco, cannabis, alcohol, benzodiazepines, opiates and inhalants have been reported as increasing in the state of Jammu and Kashmir . The relationship between substance use and mental health is bi-directional. Substance use in conflict-affected populations is widespread and has been linked to health, social and protection issues, which are detrimental to mental health . It is recognised that mental health problems can lead to alcohol and substance abuse when these substances are used as a form of self- medication .

The formulation of questions related to substance abuse have been widely discussed with key informants and members of the community. They have been formulated with an opt out option to allow for non-participation in these questions if the respondent does not want to answer them, in this way we illicit answers only from those who feel comfortable answering questions about drug use and thereby increase the quality and reliability of our data on this highly sensitive topic.

15.2.6 *Screening Tools for Mental Health Disorders*

The Hopkins Symptoms Checklist for Depression and Anxiety (HSCL-25) and the Harvard Trauma Questionnaire Post Traumatic Stress Checklist (HTQ-PTSD-16) are reported as the most commonly used instruments in conflict-affected contexts for measuring depression, anxiety and post-traumatic stress disorder .

The ***Hopkins Symptoms Checklist for Depression and Anxiety*** was originally designed by Parloff, Kelman and Frank at Johns Hopkins University in the 1950s . The HSCL-25 was created specifically for detecting anxiety and depression in the primary care setting. It is composed of 25 items with 10 items assessing symptoms of anxiety and a further 15 assessing symptoms of depression. Rating is via a 4-point Likert scale with categories of response being: 'never or no', 'sometimes', 'often', 'always'. Three scores are calculated from the responses; the depression score is the average of the 15 depression items and the anxiety score is the average of the 10 anxiety items. The total score is the average of all 25 items and has been shown in several populations to be highly correlated with severe emotional distress of unspecified diagnosis while the depression score is correlated with major depression as defined by the DSM-IV.

The ***Harvard Trauma Questionnaire,*** developed by Mollica et al. , measures exposure to specific traumatic events in addition to emotional symptoms with a recognised association to trauma. The HTQ consists of 4 parts; part one asks about specific traumatic events, part 2 is an open-ended description of the most traumatic events, part 3 looks specifically at head injury and part 4 includes 30 trauma symptoms . The first 16 items of part 4 were derived from the DSM-IV criteria for posttraumatic stress disorder. This 16-point checklist is often used in isolation as a screening instrument for symptoms of PTSD (HTQ_PTSD-16). The checklist is comprised of 16 items rated on a 4 point Likert scale, similar to the HSCL the categories of response include; 'never or no', 'sometimes', 'often', 'always'. The DSM-IV PTSD score is calculated from averaging the scores, with a higher score suggesting an increased probability of PTSD . The 16-item checklist of part four of the tool has been

culturally adapted and translated and is being validated for the Kashmiri population in a separate research project due to be completed in April 2015. The validated cut-off score will be used in analysis for the present survey.

Part one of the HTQ will also be included in the survey questionnaire; qualitative cultural adaptation is necessary to ensure the traumatic experiences listed are relevant to the Kashmiri population. During March 2015 further free-listing will be conducted to ensure an exhaustive list, the experiences listed in the questionnaire in the appendix of this document may therefore be further adapted prior to translation.

The HSCL and HTQ have been translated into over 30 languages and have often been used in tandem in cross-cultural research, specifically in conflict-affected contexts . It is important to note that these instruments are used as screening tests to facilitate detection of probable cases; therefore they express the likelihood of mental disorder. A clinical diagnosis can only be made following clinical interview.

15.3 Translation of Questionnaire into Kashmiri

The questionnaire will undergo translation into Kashmiri and back translation to English by a panel of experts from the University of Kashmir following principles described by van Ommeren . The tools will be pilot tested with a sample of 20 individuals randomly selected from one administrative area in Srinagar in order to identify areas for further revision.

16 Quantitative Data Analysis

Enumerators will enter household survey data directly into an electronic data collection system on android tablets. Electronic data collection saves time by providing results immediately and obviating the need for double data entry and cross-checking. A study conducted by King et al. found that electronic data collection for a large scale household survey using android-based technology saved time, provided more accurate geographical coordinates, increased accuracy of data entered while also incurring a cost considered comparable to that of data entry and cross-checking of standard paper-based questionnaires.

Data will be exported daily into a main database and then exported into STATA or similar statistical software, cleaned and analysed using the same. Descriptive analysis will be used to provide an overview of general findings and demographic characteristics. The screening tools will be tallied to determine a scoring below or above the Kashmiri validated cut-off for each instrument. New variables will be coded for the following 5 categories;

1. Those scoring higher than cut-off for the HSCL anxiety related symptoms,
2. Those scoring higher than cut-off for the HSCL depression related symptoms,
3. Those scoring higher than cut-off for the HTQ PTSD related symptoms,
4. Those scoring higher than cut-off for both the HSCL and HTQ.

Using these variables, prevalence estimates can be calculated for each district and for the Kashmir Valley.

Using results from the sub-sample of MINI interviews calculation of effect size will be used to estimate the strength of relationship between the HSCL-25 and Depression/Anxiety diagnosis according to the MINI , and the HTQ-PTSD-16 and PTSD MINI diagnosis . Concurrent validity coefficients will be obtained using Pearson's correlations and internal consistency calculated using Cronbach's alpha.

Potential Bias/ Limitations

Population based surveys are generally geographically representative of the general population, although groups that may be at high risk of psychiatric morbidity (such as sex workers, displaced people, army, police, prisoners etc) may not be included in the sample frame due to the fact that their living arrangements (group quarters) may not fall under those defined under the household survey. It is recognised that estimates derived from a rigorous population based survey are expected to under-estimate the true prevalence. However the extent to which this bias is likely to impact on results depends on the size of these high risk groups and the extent to which psychiatric morbidity exceeds the level of the normal population. To measure this, further research is required.

A source of bias thought to have a potentially greater impact on estimates is related to nonresponse of participants, either because they refuse to participate, are absent from the household, or become distressed during interview leading to an incomplete interview and exclusion from analysis.

1. Nonresponse due to households not being at home will be minimized by conducting the survey in rural areas in the months of September – December after harvest season, maximizing the number of people who will be present in the household.
2. Nonresponse, due to refusal to participate, will be minimized by training enumerators to be thorough in explaining confidentiality, the purpose of the study and how data will be used.
3. Interviewee distress will be minimized by thorough training of enumerators in interviewing techniques, recognizing early signs of distress and how to manage these effectively.

Should non-response occur, the type of non-response will be recorded on the front page of the interview sheet and examined further during analysis.

A further source of error could be related to inconsistency between interviewers resulting in measurement error. This will be minimised by training of enumerators including practice interviews with a non-probability sample from an area in Srinagar. Inter-rater reliability between psychiatrists performing the clinical MINI interviews will be ensured by using the same psychiatrists that were used during the validation study where inter-rater reliability was tested and ensured prior to carrying out the validation.

A special caveat is required with respect to the impact significant events have on research outcomes, which may bias results. During the planning stages of this research study six districts in the Kashmir Valley experienced flash flooding on the 6th of September 2014 with subsequent landslides that has been estimated to have caused 5 000 Crore rupees (USD 815 million) in damage to the Jammu & Kashmir economy. While trajectories of mental illness after a natural disaster are not well researched a systematic review conducted by Santiago et al. found that the median prevalence of PTSD increased immediately following a non-intentional traumatic event (30%), decreasing dramatically at 3 months (18%), with further decline noted at 6 months (13%). Onset of PTSD after 3 months represented a small proportion of total PTSD cases (3.5%). Fewer empirical studies examine the impact of disasters on depression and anxiety, although studies conducted in Honduras following Hurricane Mitch and in Vietnam following Typhoon Xangsane reported higher rates of major depressive disorders (MDD) than PTSD in affected populations.

By delaying data collection until September 2015 it is felt the risk of inflated prevalence rates due to the 2014 floods will be mitigated to some extent. However, the potential impact of damage to homes and livelihoods on the mental health of the affected population must be

acknowledged, therefore estimates from this survey in affected districts will most likely be influenced by the impact of this disaster.

Ethical issues

The MSF ethical review board and the ethical review board at the Government Medical College in Kashmir will review the study protocol and it will not be implemented unless approval is obtained from both.

17 Direct Benefits

A direct benefit relates to the strengthening of MSF's current programming by providing essential information from which current activities can be reviewed with respect to relevance and effective targeting of at-risk groups.

Similarly dissemination of results will help inform other actors, such as, the Ministry of Health, psychiatric departments in hospital, the university of Kashmir and other organizations involved in mental health care in the Kashmir Valley.

Direct benefit to the individual participant is limited to the overarching benefit to the population as a whole.

A comprehensive survey using a validated screening tool will provide a scientifically robust baseline for which future research will benefit.

18 Indirect Benefits

The collaboration between MSF, the Department of Psychiatry at the IMHANS and the Department of Psychology at the University of Kashmir will strengthen these relationships, and increase MSF’s credibility with these institutions

Contribution to research on mental health issues, policy making and planning in a context experiencing both protracted conflict and natural disasters.

Creation of knowledge base for advocacy to promote coherent policies and programming in mental health in addition to baseline data as a reference for future studies.

19 Direct Risks

Potential for further psychological stress related to answering sensitive questions about traumatic experiences felt by participants. Risk mitigations strategies include;

- Selection of enumerators from psychology students at the University of Kashmir and individuals with prior survey enumeration experience (ie census enumerators).
- All potential enumerators will receive training by psychiatrists at the IMHANS on how to ask sensitive questions and provide assistance to a distressed interviewee.
- Discontinuation of the interview if distress is observed, and referral to appropriate mental health support services.
- Regular briefings will be held with enumerators throughout the research process to identify issues and provide further training as required.

20 Indirect Risk

Risk associated with the perception by respondents and other stakeholders that the research outcomes will result in the widespread provision of MH services by MoH or MSF programs within the short term, within the region. Clear communication with stakeholders will assist in harmonising perceptions and expectations.

21 Consent form

In order to ensure each participant provides informed consent, and in recognition of low literacy levels, a participant information sheet and consent form will be read out by the interviewer in a language with which they are familiar, and the main aims, format and implications of the study explained to participants. Participants will be informed regarding their right to withdraw from the study at any time without penalty and issues concerning confidentiality and consent will be upheld in accordance with ethical research standards .

Templates for the consent form and an information sheet are provided in the appendix of this document. These will be translated into Kashmiri and the information sheet will remain within the household after conducting the interviews. No incentives or inducements will be provided to any respondents.

22 Data Handling and Record Keeping

Questionnaires will not identify the participant in any way; use of identification numbers will ensure anonymity in data analysis. The participant's age, gender and demographic characteristics will be used as identifying features for analysis; this will be explained to participants at the same time consent is sought.

Confidentiality is paramount and no information about individual participants or their household members will be accessible to any individuals not directly involved in data entry, participant identifiers will not be included in results and disseminated reports. The research team will be required to sign a non-disclosure and privacy form stating that they will not discuss information about individuals participating in the study outside of the research team. The research team will ensure the ethical principles of beneficence, non-maleficence, justice, autonomy and respect of persons are adhered to throughout the study.

All data will remain anonymous throughout the data entry and analysis process. Nominal data will not be distributed outside the study location, or appear in any report or publication.

Participant names will only be known by the clinical psychologists and psychiatrists involved in the study. The primary investigator will have access to the identification numbers in order to link data from the clinical interviews and screening instruments, these codes will be safeguarded at MSF facilities for the duration of the study. The codes will not be made available to collaborating organisations.

Collaboration

This study will be carried out by MSFH-India in collaboration with the Department of Psychology at the University of Kashmir.

MSFH-India is the principal investigator and study sponsor, responsible for the funding. MSFH is in charge of the field part of the study, the analysis and report writing. Permission for publication must be obtained from MSFH-India.

Study data will belong to MSFH-India, but can be made available to collaborators on written request, according to the MSF data sharing agreement.

Responsibilities

Institute	Responsibility	Person	Position:
MSFH-India, New Delhi	Funding for the study	Akke Boere	Head of Mission
MSFH-India, New Delhi	Drafting of initial study protocol Ensuring submission for ERB approval from MSF and Kashmir Dissemination Report writing	Dr. Simon Janes	Medical Coordinator
MSFH-India, Kashmir	Provide study sites Provide 2 clinical psychologists to participate as research assistants during the survey. Preparation of data collections tools and forms.	James Cheasty	Mental Health Officer
MSFH-India, Kashmir	Provide MSF vehicles and drivers as required. Logistical support as required.	Liesbeth	Project Co-ordinator
MSFH-India, New Delhi	Drafting of initial study protocol Coordination of study at field level Preparation of data collections tools and forms Data Analysis, report writing and manuscript drafting	Tambri Housen	Principal investigator
MSFH-Amsterdam	Drafting of initial study Protocol Technical Epidemiology Guidance Data Analysis, report writing and manuscript drafting	Annick Lenglet	Epidemiologist
MSFH-Amsterdam	Drafting of initial study protocol Technical Mental Health guidance and report writing	Giovanni Pintaldi	Mental Health Advisor
MSF Manson Unit, London	Technical support to statistical aspects of the study design, support in data analysis and manuscript drafting	Cono Ariti	Senior Research Analyst - Statistician
Department of Psychology at the University of Kashmir.	Ensure ethics approval from the University of Kashmir Assist with preparation of research tools, review and approval of study design Provide 20 psychology students to act as enumerators for the household survey Cultural adaptation and translation of screening tools. Translation of support documents and abridged final report. Collaborate in manuscript drafting	Dr Showkat Shah	Head of the department of Psychology

23 Timeframe in the field

	2014							2015											
	June	July	Aug	Sept*	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Concept Paper	#																		
Construction of Draft Questionnaire		#																	
Construction of Research Protocol and Ethics		#	#			#													
Submission to Ethics Review Boards									#	#									
Preliminary Research - Instrument Validation							#	#	#	#	#								
Questionnaire translation and pre-testing										#	#								
Sampling design and sample selection												#							
Design of data entry program for tablets										#	#								
Data analysis Planning										#	#								
Recruitment of staff															#				
Training of Enumerators																#			
Data Collection																#	#	#	
Data entry, cleaning and analysis																#	#	#	
Final Report																			#
Dissemination																			#

* The time-table was affected by flash flooding in the Kashmir Valley during September 2014

Dissemination Plan

Printed and electronic versions of the final report will be provided to all partners involved in the research and relevant ministry's and departments responsible for mental health services in Kashmir. Other interested parties will be provided with electronic versions only.

Results of the research will also be communicated to the study sites via an abridged translated version of the final report. These will be distributed to the district leaders with the request that they be given to the participating sub-district leaders and village leaders.

Manuscripts will be drafted based on the methodology and results for submission in peer-reviewed scientific journals. Examples of proposed manuscripts include;

Housen, T[a], Shah, S[c], Ariti, C. 2015. *Mental health needs of a state in turmoil: voices from Kashmir.* Peer Reviewed Journal.

Housen, T[a], Shah, S[c] , Ariti, C. 2015. *Mental health in a conflict affected population: individual and contextual risk factors for depression and anxiety disorders.* Peer Reviewed Journal.

Housen, T[a], Shah, S[c] , Ariti, C. 2015. *Post traumatic stress disorder in Kashmir: A cross-sectional community survey.* Peer Reviewed Journal.

Housen, T[a], Shah, S[c] , Ariti, C. 2015. *The epidemiological sandwich: mixed methods research in psychiatric epidemiology.* Peer Reviewed Journal.

a. On behalf of the Médecins Sans Frontières working committee - Dr. Simon Janes, Annick Lenglet, Giovanni Pintaldi, Shabnum Ara,
b. On behalf of the Kashmir University working committee -

Budget

Since the initial budget was proposed in 2014, the survey methodology has been updated and new expenditure items identified. This budget reflects expected expenditure with an anticipated commencement date of 6th September 2015

INR – Indian Rupee **Updated Budget 2015**

Description	Cost INR	Quantity	Survey Period days	Updated Budget	Updated Budget	Comments
Human resources						
International Staff						
Principal Investigator				INR 0.00	0.00 €	Currently employed by MSF-OCA India
Additional Logistician		1	4months		3,500.00 €	
National Staff						
Enumerator Remittance	250	40	50	INR 500,000.00	7,000.00 €	40 Enumerators for 8 weeks data collection (40 days) increased with sampling modifications - a
Interviewer Remittance	250	5	30	INR 37,500.00	525.00 €	Initial budget included Psychiatrist remittance, however for the survey the decision was made t the qualitative co,mponent
Back-up enumerators	250	5	10	INR 12,500.00	175.00 €	Back-up enumerators will require payment during training (2 weeks)
Research Assistant	50000	1	3	INR 150,000.00	2,100.00 €	Full-time local research assistant to assist the epidemiologist in quality control and other respo methodology 3 months
SUB TOTAL				700,000.00 €	13,300.00 €	
Running costs						
Training Costs	500	1	10	INR 5,000.00	70.00 €	Room Covered by University of Kashmir - only food costs
Communications, newspaper adds announcing survey	30000	1	1	INR 30,000.00	420.00 €	Pre-survey advertising and radio interviews
Telephone costs	300	20	2	INR 12,000.00	168.00 €	300 INR credit top up each for Team Leader (x10), Driver (x10) per month
Sim Cards for tablets/Wifi Hotel	400	40	1	INR 16,000.00	224.00 €	Each enumerator will receive 400INR to use his/her own personal phone as a hotspot for data tr
Daily Lunch for teams	120	55	40	INR 264,000.00	3,696.00 €	Lunch will be supplied by a local hotel and picked up each morning
Accommodation for team in Baramulla	500	25	15	INR 187,500.00	2,625.00 €	Recruiting enumerators from each district will minimise accommodation costs, required where
Cargo Costs	10000	1	1	INR 10,000.00	140.00 €	Transport costs for materials from Delhi to Srinagar
SUB TOTAL				524,500.00 €	7,343.00 €	
Material costs						
Translation of Surveys				INR 0.00	0.00 €	Covered by the university of Kashmir
Translation of Training manuals				INR 0.00	0.00 €	Covered by the university of Kashmir
Smart pads for data collection	7500	40	1	INR 300,000.00	4,200.00 €	40 tablets with protection cases and anti-glare screens
Stationary				INR 0.00	0.00 €	Extra stationary - clipboards, pens, other documents
ID cards	50	50	1	INR 2,500.00	35.00 €	MSF ID cards for enumerators
Backpacks/ bags	700	45	1	INR 31,500.00	441.00 €	Carry bags or backpacks for enumerators and interviewers
Consent and Information sheets	2	3500	1	INR 7,000.00	98.00 €	
Paper questionnaires				INR 10,000.00	140.00 €	Back up paper questionnaires for each car in case of issues with tablets
USB car chargers	900	10	1	INR 9,000.00	126.00 €	charging tablets in case of low battery
Multiplugs for charging tablets (4 sockets)	1000	10	1	INR 10,000.00	140.00 €	
SUB TOTAL				INR 370,000.00	5,180.00 €	
Transport						
National flights to study location (Del-Srin)	8000	5	1	INR 40,000.00	560.00 €	
Study cars (each car 2200/day)	2200	4	40	INR 352,000.00	4,928.00 €	Four hire cars inclusive of driver and fuel - MSF have 6 cars available for use
Drivers	622	6	40	INR 149,280.00	2,089.92 €	MSF has 5 cars but require drivers for these cars - hire car includes driver
Fuel (Deisel)	8640	10	2	INR 172,800.00	2,419.20 €	8640INR/car/month fuel consumption based on 1000km/month/car

SUB TOTAL				INR 714,080.00	9,997.12 €	
Dissemination						
Final Report and Abridged report printing	300	5	1	INR 1,500.00	21.00 €	**final report for submission to university, and MoH - others will be sent electronically**
Abridged final report	5	300	1	INR 1,500.00	21.00 €	**final abridged report for each participant village**
Presentation of Results	0	0	0	INR 0.00	0.00 €	**covered under flights - 1 flight to srinagar to present**
Distribution of Abridged report	2200	1	5	INR 11,000.00	154.00 €	**1 car for 5 days to distribute abridge report to district administrator to deliver to villages (2 distr**
Miscellaneous					1000.000 €	**unforseen expenditures**
SUB TOTAL				INR 14,000.00	1196.00 €	
TOTAL				2,322,580.00 €	37,016.12 €	

Mental Health Survey Household Head- Kashmir 2014

Instructions for Tablet in green

Pre-Survey Information for the Interviewer **HH questionnaire number |4|4|5|_(This will be entered by the interviewer)**

These questions will be programmed on to a tablet and administered electronically with checks and controls to mitigate recording errors.

Section 1: Basic information **SPECIAL CODES 98 respondent does not know 99 no answer**

Question code	Question	
L1	*District	Drop down of all 10 Districts
L2	*Sub district	I will have a list printed and they can type in the code
L3	* Block	I will have a list printed and they can type in the code
L4	* Village	I will have a list printed and they can type in the code
L5	Size of locality (from community leader)	1. Less than 100 inhabitants
		2. 101-300 inhabitants
		3. 301-1000 inhabitants
		4. 1001-5000 inhabitants
		5. More than 5 000 inhabitants
L6	Area	Urban
		Rural
L7	Name of interviewer	(they will have individual codes which they will type in)
L8	Interview date (automated)	|__|__| date |__|__| month
	Interviewer start time (automated)	|__|__|:|__|__|
	Interviewer end time (automated)	|__|__|:|__|__|

Identify the household

L9 Record the correct code in the column	L10 Reason given for consent being refused
1. Household Head Consented to be interviewed **2.** Nobody at home **3.** Household next door selected for interview **4.** HH member not at home but another member of HH randomly selected and consented to be interviewed **5.** Refused Consent → **L10** **6.** House not found **7.** Other (specify)	1. Not enough time 2. HH head not present to give consent 3. Refused and did not want to give a reason 4. Other (please type in reason for refusal)

Here there needs to be an option to continue or to save and exit – this way we keep a record of the households that refused consent and why, or HH that could not be located – important for analysis.

We appreciate you giving permission to interview a member of your family. Before we do so we would like to ask you a few questions about your household. The information we collect is for our research only and will not be shared with anyone else.

DRAFT

DRAFT

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FOR THE HOUSEHOLD HEAD

Section 2: Household Demographics[all individuals in the household, start with household head] SPECIAL CODES respondent does not know [98] no answer [99]

HHH1	**At this time how many people live in this household?** ***A household member is someone who has lived in the household for more than 3 months in the past 12 months.***	|__|__| persons

HHH2 We will go thru each member of the household one at a time and ask some questions about their age, gender, occupation etc	HHH3	HHH4	HHH5	HHH6
1. Household head 2. Spouse of household head 3. Child of household head 4. Sister/brother of Household head 5. Grandchild of household head. 6. Parent of Household head 7. Other relatives 8. Other non-relatives	Record in years. If less than 1 year record as <1	1. Female 2. Male	1. Not Married 2. Married 3. Separated / Divorced 4. Widowed 5. Half Widow	1. Muslim 2. Hindu 3. Buddhist 4. Christian 5. None 6. Other
Nontas can there be a drop down where the interviewer can choose who this person is as per the categories above – then it goes thru each of the following questions and when it gets to **HHH9** it then asks if they want to add another person – if yes it starts again at this drop down list – if no it moves on to the question **HHH10** about making sure they have included everyone.				

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HHH8 (highest level reached)	HHH9 What is the main activity of each member of the Household?
1. No formal schooling 2. Primary 3. Middle School 4. High School 5. 12th/ higher secondary 6. Graduate 7. Post-graduate 8. Vocational 9. Other	1. Employed 2. Self - employed 3. Contract worker (labor) 4. Unpaid work on family farm/ business 5. Student 6. Unemployed 7. Home duties 8. Too young to work or retired

To make sure I have a complete listing of all persons in the household ask the following question and add any people not previously mentioned

HHH10. Are there any other person(s), such as small children, infants, or old person that we have not listed? *A household member is someone who has lived in the household for more than 3 months in the past 12 months.*
YES/NO Option (if yes, return to the drop down list HHH2)

HHH11	**Who is the main earner in the household? *[Is it possible to generate a drop down list with a summary of age and gender from the initial list made above?]* If the household has no income from anywhere type 0 in the answer box.**	|__|__|

HHH12	HHH13
To what degree does the family depend on others for living	**Does your family have at least two meals a day?**
1. Are you self supportive (don't need any extra help). **2.** Are you nearly self-sufficient (get some help from others) **3.** Are you highly dependent on charity but have some additional income of our own. **4.** Are you totally dependent on assistance from others.	1. Always (7 days per week) 2. Sometimes (3-5 days per week) 3. Rarely (1-2 days per week) 4. Never

HHH14	**Has anyone in your family suffered from a mental illness?**	1. Yes 2. No

HHH15	**Did the mental illness stop them from carrying out their normal daily activities?**	1. Yes 2. No

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HHH16	Do you know about the radio show Alaw Bay Alaw	1. Yes 2. No	If yes then a new question should pop up	How often did you use to listen to Alaw Bay Alaw?	1. I didn't listen to it 2. Sometimes 3. Always

HHH17	Do you know about the television show Alaw Bay Alaw	3. Yes 4. No	If yes then a new question should pop up	How often did you watch Alaw Bay Alaw?	4. I didn't watch it 5. Sometimes 6. Always

Thank you for your time, now we would like to randomly select one person over the age of 18 years from your household to interview.

Now, using the household list you must randomly select one individual over the age of 18yrs). (is it possible to automatically generate a drop down list with age/gender of the household members listed above – this could be restricted to those reporting an age over 18years or just include everyone if easier and the interviewer can select those over 18years)

Then a box or circle next to each person's details so the one randomly selected can be marked as such.

Ask to see this person and Now explain the research using the consent information sheet.

Appendix 2 Mental Health Survey Participant- Kashmir 2014

FOR THE PARTICIPANT **HH questionnaire number |_|4|4|5| (automatically generated from above if possible)**
Individual questionnaire number |__|__|__|__| (is it possible to automatically generate from the HH number with an "I" in front eg I445

Make sure you have read the information sheet and have a signed consent form – Read the following statement
"It is important we have some privacy for our conversation because some of the questions may be sensitive"

L11 Record the correct code in the column	**L12 Reason given for consent being refused**
1. Individual consented to be interviewed **2.** Individual not at home **3.** Individual Refused Consent → **L10** **4.** Other (specify____________________)	1. Not enough time 2. Refused and did not want to give a reason 3. Other (please type in reason for refusal__________)
L13 In the case of refusal of consent or absence of randomly selected member of the household another member of the household >18 years was randomly selected	1. Yes 2. No

Participant Demographics (PD) SPECIAL CODES respondent does not know [98] no answer [99]

PD1	***PD2***	***PD3***	***PD4***	***PD5***
Gender	**Age (in years)**	**What is your main activity**	**If employed – How many days a week do you work**	**What is your main employment activity?**
1. Female 2. Male		*1.* Employed → *PD4* *2.* Contract worker → *PD4* *3.* Self Employed → *PD4* *4.* For all answers below → PD6 *5.* Unpaid work on family farm/ business *6.* Student *7.* Unemployed *8.* Home duties *9.* Too young to work or retired	Record the number of days	Refer to Industry codes and record the correct code below (These I will have a as a laminated separate list they will carry with them and type in)

PD6 In general how would you say your physical health is
1. Excellent 2. Good 3. Ok 4. Poor 5. Very Bad

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Section 5: Daily Activities

I am going to read a list of activities and duties. These are task and duties that other Kashmiri's have told us are important to them. For each one I am going to ask you how much difficulty you have in completing this task compared to other men/women your age. Take a look at this picture (show then the visual cue card) and let me know which picture shows how much difficulty you have with each activity. If you do not normally do this activity please tell me.

SPECIAL CODES respondent does not know [98] no answer [99]

	In the past month how much difficulty have you had in completing these tasks?	**None**	**Very Little**	**A moderate amount**	**A lot**	**Cannot do**	**I don't normally do this**
DA1	Employment	0	1	2	3	4	5
DA2	Cooking	0	1	2	3	4	5
DA3	Providing for the family	0	1	2	3	4	5
DA4	Looking after family affairs and problems	0	1	2	3	4	5
DA5	Caring for family members	0	1	2	3	4	5
DA6	Household work	0	1	2	3	4	5
DA7	Manual labour/ agricultural work	0	1	2	3	4	5
DA8	Pray	0	1	2	3	4	5
DA9	Studying	0	1	2	3	4	5
DA10	Giving advice to other community members	0	1	2	3	4	5
DA11	Exchanging ideas with others	0	1	2	3	4	5
DA12	Having harmonious relationships with husband/wife and family	0	1	2	3	4	5
DA12	Bringing up children correctly	0	1	2	3	4	5
DA14	Sympathising with others	0	1	2	3	4	5
DA15	Visiting and socialising with others in the community	0	1	2	3	4	5
DA16	Asking for and getting help when you need it	0	1	2	3	4	5
DA17	Making decisions	0	1	2	3	4	5
DA18	Taking part in family activities or events	0	1	2	3	4	5
DA19	Taking part in community activities or events	0	1	2	3	4	5
DA20	Attending mosque	0	1	2	3	4	5
DA21	Attending shrines	0	1	2	3	4	5
DA22	Attending religious gatherings	0	1	2	3	4	5

Nontas the pics below we will laminate and print as a separate thing that interviewers can give people to hold throughout these questions and they can point to the picture that is most relevant – so don't worry about including them in the tab.

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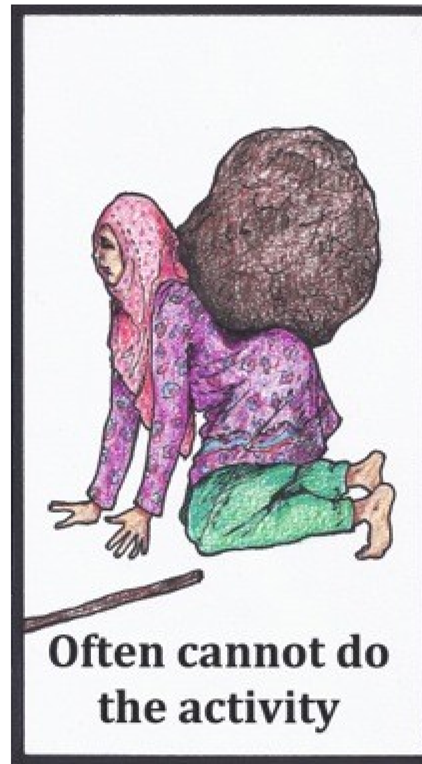
Non-Verbal Response Card for Kashmiri Functioning Questions

0

1

2

3



4

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DA22	**In the past 4 weeks how much of the time did you have to <u>cut down</u> on what you did and did not get as much done as usual because you had 'tension' or 'parishani'**	1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time
DA21	**In the past 4 weeks how much of the time were you <u>totally unable to carry out</u> your normal daily activities because you had 'tension' or 'parishani'**	1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

Problems of Daily Life

PDL1 Can you tell me the main problems you face in daily life? **(don't read the list just mark the ones the person mentions)** **Needs to be a list with circles for each so interview can tap the ones that are relevant**	
1. Not enough money 2. Life is too expensive 3. Unemployment 4. No job security 5. Technology – abuse of internet/phones 6. Nothing to do – sitting at home 7. Social breakdown so people keep to themselves now 8. Lack of social interaction 9. Domestic violence 10. Substance Abuse 11. Tension or Pareshani 12. Poor physical health of self 13. Poor physical health of another family member	

Now in Kashmir, people face many problems and some take medicines to help them relax and sleep.

DX1	*DX2*	*DX3*
Do you take medicine to help you relax and get a good sleep?	**Who recommended you take this medicine?**	**For how long have you been taking this medicine?**
1. Yes 2. No	1. Doctor 2. Traditional Healer (Pear Sahib) 3. Friend 4. Family member 5. Other	1. One week or less 2. Less than one month 3. 1-3 months 4. 3-6 months 5. 6months – 1 year 6. 2years 7. 3years 8. >3 years

As you may be aware, many people in Kashmir have Tension or Pareshani, some of these people take other medicines or substances to help them relax and cope with life. As people working in mental health we understand how these substances are used by people to make them feel better for a period of time, we also understand how dangerous these substances are on people's health. There are not many services available to help people in Kashmir with addiction problems. We hope our survey can bring more attention to this important issue that is affecting many Kashmiri households. But to do this we need to know how widespread the problem is in Kashmir. We understand this is a sensitive topic and many people do not want to talk about these issues. We want to remind you that your name or your family's name is nowhere on this questionnaire, it is not recorded by any of us and everything you tell us will be mixed together with what other people tell us, so that no-one will know what you have said.

Now we would like to ask your assistance to find out more about addiction problems in Kashmir.

DX4	*DX5*	*DX6*
Do you feel comfortable to tell us about drug use in your community?	**Have you ever used any of the following substances, now or in the past? (if relevant circle more than one)** **Have a yes/no option for each**	**Has a family member ever used any of these substances now or in the past? (if relevant circle more than one)** **Have a yes/no option for each**
1. Yes 2. No → *go to HSCL questions*	1. Brown Sugar (Medicinal Opiods) 2. Chalas (Marijuana) 3. Cough Syrup 4. Spazmo proxafin 5. Alcohol 6. Other (name)	1. Brown Sugar (Medicinal Opiods) 2. Chalas (Marijuana) 3. Cough Syrup 4. Spazmo proxafin 5. Alcohol 6. Other (name)

DX7
Do you know of someone in your community who uses any of these substances? (if relevant circle more than one) **Have a yes/no option for each**

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1. Brown Sugar (Medicinal Opiods)
2. Chalas (Marijuana)
3. Cough Syrup
4. Spazmo proxafin
5. Alcohol
6. Other (name)

Administer validated Diagnostic tool for depression/ anxiety / PTSD / Trauma

Can the answers be added and divided by the number of questions for each tool and shown at the completion of the whole interview.
. HSCL Anxiety Score = HSCL1-10/10, HSCL Depression Score = HSCL11-25/15.
Read out the instructions in Bold and Italics to the respondent

Anxiety Symptoms – Hopkins Checklist **I *will read a list to you. Can you please tell me how often you have experienced these items in the Last 4 weeks***		کینہہ نہ یا زہینہ **Keheen ne zehaen ne** *Never or No*	کنہِ ساعتہ **Kuunisaati** *Sometimes*	اکثر **Aksar** *Often*	ہمیشہ **Hameesha** *Always*
HSCL1	ژُہی ما چھِو ہنگہ تہ منگہ کھوژان Patmaev tcoerav haftav paethee **Tueh ma tcheiv hanghte mangae khoecaan** In the last four weeks how often where you suddenly Scared for no reason	1	2	3	4
HSCL2	توہہ ماچھِو خوف باسان Patmaev tcoerav haftav paethee **Toehi ma tchu khoof basaan** In the last four weeks how often did you feel Fearful	1	2	3	4
HSCL3	توہہ ماچھِوگھش یا گیور ہیو باسان Patmaev tcoerav haftav paethee **Toehi ma tchu gushya gyoor hue bassan** In the last four weeks how often did you feel Faintness	1	2	3	4
HSCL4	توہہ ما چھِو پنُن پان ویسریومُت ہیوباسان/ژُہی ما چھِو بامبران Patmaev tcoerav haftav paethee **Toehi ma tchu panun paan vaesroemuth hue basaan/Tueh ma tcheiv bambraan** In the last four weeks how often did you feel Nervousness	1	2	3	4
HSCL5	دِل ما چھِو ژَلان/دِ ل ما چھِوراوان Patmaev tcoerav haftav paethee **Dilma tchu caelaan/ dilma tchu ravaan** In the last four weeks how often did you feel your Heart pounding or racing fast	1	2	3	4
HSCL6	تھر تھر ما چھو ووتھان Patmaev tcoerav haftav paethee **Thar thar ma tche vothaan** In the last four weeks how often did you feel Trembling	1	2	3	4

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HSCL7	بے چینی ما چھو باسان Patmaev tcoerav haftav paethee **Bechanee ma tchu basaan** In the last four weeks how often did you feel Tense	1	2	3	4
HSCL8	کلہٕ دودما چھِو کران Patmaev tcoerav haftav paethee **Kali doad ma tchu karaan** In the last four weeks how often did you feel Headaches	1	2	3	4
HSCL9	توہہِ ما چھِو منز تیتھ وہمہٕ باسان زبہٕ ما مر ونی Patmaev tcoerav haftav paethee **Toehi ma tchu manzih tueth vahmeh basaan ze beh mareh vaeni** In the last four weeks how often did you feel Episodes of terror or panic	1	2	3	4
HSCL10	جسمس ما چھ بے قراری باسان زتُہی چھِونہٕ اکسے جایہٕ درانی / کنہٕ جایہِ درانی Patmaev tcoerav haftav paethee **Jismas ma tche bekararee basaan zeh tueh tcheiv neh aksee jayeh daranee / kunih jayeh daranee** In the last four weeks how often did you Feel restless, can't sit still	1	2	3	4
Depression Symptoms – Hopkins Checklist					
HSCL11	توہہِ ما ہنگہٕ تہٕ منگہٕ پنُن پان خطاوار /قصوروار باسان Patmaev tcoerav haftav paethee **Toehi ma hanghtemangae panun paan khatahvaar / kasoorvaar basaan** In the last four weeks how often did you Blame yourself for things	1	2	3	4
HSCL12	توہہٕ ما ہنگہٕ تہٕ منگہٕ وَدن ہیویوان Patmaev tcoerav haftav paethee **Toehi ma hanghtemangae vadun hue yevaan** In the last four weeks how often did you Cry easily, for no reason	1	2	3	4
HSCL13	توہہِ ما جنسی خواہشن منز کمی باسان Patmaev tcoerav haftav paethee **Toehi ma jinsee khahishan manz kamee basaan** In the last four weeks how often did you feel Loss of sexual interest or pleasure	1	2	3	4
HSCL14	توہہِ ماناوومیدیٖ ہش باسان Patmaev tcoerav haftav paethee **Toehi ma naumeedi hish basaan** In the last four weeks how often did you feel Feeling hopeless about the future	1	2	3	4
HSCL15	غمگین ما چھِو روزان (سورے زَن دزان ہیو باسان) Patmaev tcoerav haftav paethee **Gamgeen ma tcheiv rozaan (soeri zaneh dazaan hue basaan)** In the last four weeks how often did you feel Sadness	1	2	3	4

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HSCL16	توہِ ما چھو پنن پان کُن ظون باسان/پرژھیون باسان Patmaev tcoerav haftav paethee **Toehi ma tchu panun paan kunzoen basaan/ paercoen basaan** In the last four weeks how often did you feel Lonely	1	2	3	4
HSCL17	توہِ ما خودکشی/پنن پان مارنک خیال یوان Patmaev tcoerav haftav paethee **Toehi ma khodh kashee ya panun paan marnukh khayal yevaan** In the last four weeks how often did you Think about ending your life	1	2	3	4
HSCL18	توہِ ما باسان زنہ مصیبتو نال وولمت Patmaev tcoerav haftav paethee **Toehi ma basaan zaneh museebatoonaalvolmuth** In the last four weeks how often did you have the feeling of being Not free or caught	1	2	3	4
HSCL19	توہِ ما ہنگہ تہ منگہ فکر روزان/باسان Patmaev tcoerav haftav paethee **Toehi ma hanghtemangah fikir rozaan** In the last four weeks how often did you Worry too much about things	1	2	3	4
HSCL20	توہِ ما چھونہ کنہ ستی دلچسپی باسان Patmaev tcoerav haftav paethee **Toehi ma tchae neh kunih seithdilchaspee basaan** In the last four weeks how often did you feel a Loss of interest in things	1	2	3	4
HSCL21	توہِ ما چھونہ پننس پانس کانہہ وقعت باسان/توہِ ما چھو پَنن پان باقیو نش کم پایہِ باسان Patmaev tcoerav haftav paethee **Toehi ma tchae neh panenis paanas khane vukhtee basaan/ Toehi ma tchue panun paan bakeyaev nish kam payee basaan** In the last four weeks how often did you Feel inferior to others, think yourself as worthless	1	2	3	4
HSCL22	بے ہیکتی ما چھو باسان/کم ہیکتی ما چھو باسان Patmaev tcoerav haftav paethee **Behakhtee ma tchu basaan / kamhakhtee ma tchu basaan** In the last four weeks how often did you Feel low in energy, slowed down	1	2	3	4
HSCL23	نیندرمنز ما چھو کنہ قسمچ خلل/دقت یوان Patmaev tcoerav haftav paethee **Neendre manz ma tchu kunih kismich khalal / dikathyevaan** In the last four weeks how often did you experience Difficulty sleeping	1	2	3	4
HSCL24	توہِ ما چھو پرتھ کانہہ کام پہاڑ ہش یا مشکل باسان Patmaev tcoerav haftav paethee **Toehi ma tche praeth kah kaem mushkil basaan/pahaad hish basaan** In the last four weeks how often did you Feel that everything you do is difficult	1	2	3	4

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HSCL25	توہۍ ماچھوبوچھہ کم باسان/مال ما چھے رووِمت Patmaev tcoerav haftav paethee **Toehi ma tche boechee kam basaan / mael ma tchu roevmuth** In the last four weeks how often did you experience Poor appetite	1	2	3	4
KS1*	In the last four weeks how often did you wish you were dead*	1	2	3	4
KS2	In the last four weeks how often have you had stomach upset (**medau doad**)	1	2	3	4
KS3	In the last four weeks how often have you had a burning sensation in your body (**saersee paanas naar vothaan**)	1	2	3	4
KS4	In the last four weeks how often have you had body pain (**saersi paanas dash basasn**)	1	2	3	4
KS5	In the last four weeks how often have you experienced a choking feeling (**Dum Gacaan**)	1	2	3	4

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When you are feeling 'tension' or 'pareshani' what do you do? (let the person talk and mark the ones they mention – do not read as a list)
Will need a circle for each one that can be pressed if relevant.

C1	1. Pray 2. Go to mosque or shrine 3. Talk to friend/family member 4. Take medicine given to me by a doctor 5. Take medicine I buy myself 6. Go to doctor 7. Go to traditional healer (pear sahib) 8. I try to keep busy 9. I want to be alone 10. I go for a walk 11. I cry 12. I become angry/aggressive 13. I take tobacco – smoking/chewing 14. I take other drugs (cannabis, opiods, sniff substances

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S1	**Do you feel safe in your environment?**	1. Always 2. Most of the time 3. Occasionally 4. Never

Life Event Checklist Modified

	I am going to read out a difficult or stressful experience that sometimes happen to people. For each one, I will ask you if it has (a) happened to you personally, (b) you saw it happening to someone else, (c) you know someone who has experienced this or (d) it does not apply to you or anyone you know. **Be sure to consider your entire life (growing up and in adulthood)**	**Happened to me**	**Witnessed it happening to someone else**	**Know someone who this has happened to but did not witness it**	**Does not apply to me or anyone I know**
LE1	Natural disaster (flood, earthquake, snow slide, avalanche, landslide?)	4	3	2	1
LE2	Fire or explosion	4	3	2	1
LE3	Transportation accident (for example sumo, bus, motorbike, car)	4	3	2	1
LE4	Serious accident at work, home or during an activity	4	3	2	1
LE5	Physical assault (being hit, attacked, beaten)	4	3	2	1
LE6	Sexual assault (rape, attempted rape, made to perform a sexual act through force or fear or harm)	4	3	2	1
LE7	An unwanted or uncomfortable sexual experience	4	3	2	1
LE8	Assault with a weapon (for example Being shot, stabbed, threatened with a gun or knife)	4	3	2	1
LE9	Combat or exposure to militant or military attacks (example cross fire, explosion of mines/grenades)	4	3	2	1
LE10	Combat related attacks (round up raids, crackdown, frisking)	4	3	2	1
LE11	Sudden violent death of someone you know	4	3	2	1
LE12	Captivity (kidnapped, imprisoned, abducted, held hostage)	4	3	2	1
LE13	Interrogation or harassment with threats to life	4	3	2	1
LE14	Torture	4	3	2	1
LE15	Friends or family members have disappeared	4	3	2	1
LE16	Sudden unexpected death of someone you know (suicide, accident, natural disaster)	4	3	2	1
LE17	Forced to separate from friend or family members	4	3	2	1
LE18	Life-threatening illness or injury	4	3	2	1

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LE19	Los of property or belongings	4	3	2	1
LE20	Severe human suffering	4	3	2	1
LE21	Any other stressful event or experience (name)	4	3	2	1

Section 4: Post Traumatic Stress Disorder tool Total PTSD Score = PTSD1-16/16

Harvard Trauma Questionnaire Part IV - symptoms of PTSD ***The following are problems that people sometimes have after experiencing hurtful or terrifying events in their lives.*** ***For each problem please state how often you have had it in the last 4 weeks including today.***		کینہہ نہ یا زہینہ **Keheen ne zehaen ne** *Never or No*	کنہ ساعتہ **Kuunisaa ti** *Sometimes*	اکثر **Aksar** *Often*	ہمیشہ **Hameesh a** *Always*
PTSD1	توہہِ ما چھو کنہ حالیہ خوفناک واقہکی خیال یوان تہ یوان Patmaev tcoerav haftav paethee **Toehi ma kuuni haaley khoofnaak vaakaehikh khayal yevaan te yevaan** In the last four weeks how often did you experience Recent thoughts or memories of terrifying or hurtful events	1	2	3	4
PTSD2	توہہِ ما کانہہ خوفناک واقعہ اچھن برونہہ کنہ یوان تہ یوان Patmaev tcoerav haftav paethee **Toehi ma khaneh khoofnaak vaakah aechan bron khane yevaan te yevaan** In the last four weeks how often did you Feel as though these events were happening again	1	2	3	4
PTSD3	تہِی ما چھو کھوژونی خواب وُچھان تہ وُچھان Patmaev tcoerav haftav paethee **Tueh ma tcheiv khoecvin khawab vuchaante vuchaan** In the last four weeks how often did you experience Recurrent Nightmares	1	2	3	4
PTSD4	توہہِ ما چھو پنن پان الگ تھلگ باسان Patmaev tcoerav haftav paethee **Toehi ma tchu panun paan alag thalag basaan** In the last four weeks how often did you Feel detached and withdrawn from people	1	2	3	4
PTSD5	توہہِ ما چھو نہ کینہہ محسوسے گژھان ۔مثلن خوشی،غم،شرارت وغار Patmaev tcoerav haftav paethee **Toehi ma tchune keheehe mahsoosi gachaan (maslaen khushi, gham, shararat)** In the last four weeks how often were you Unable to feel emotions	1	2	3	4
PTSD6	تہِی ما چھو ووٹہ کڈان Patmaev tcoerav haftav paethee **Tueh ma tcheiv voeteeh kadaan** In the last four weeks how often did you Feel jumpy and easily startled	1	2	3	4

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PTSD7	توہہِ ما چھو توجہ /ظون جلدے ڈلان Patmaev tcoerav haftav paethee **Toehi ma tchu tavajah ya zoune jaldi dalaan** In the last four weeks how often did you experience Difficulty concentrating	1	2	3	4
PTSD8	نیندرِمنز ما چھو کنہِ قسمچ مشکلات /دقت یوان Patmaev tcoerav haftav paethee **Neendreh manz ma tchu kuni kismich khalal / dikathyevaan** In the last four weeks how often did you experience Difficulty sleeping	1	2	3	4
PTSD9	توہہِ ما چھو پَنن پان ہمیشہ انجان خوفن خاطرہ تیار ہیو باسان Patmaev tcoerav haftav paethee **Toehi ma tchu panun paan hameshi anjaan khofan khater tayaar hue basaan** In the last four weeks how often were you Constantly feeling and acting ready for any kind of threat	1	2	3	4
PTSD10	توہہِ ما چھو شرارت ہنگہ تہ منگہ آسان یا توہہِ ماچھو شرارت جلدے کھسان Patmaev tcoerav haftav paethee **Toehi ma tchu shararat hanghtemangeh aasan ya toehi ma tchu shararat jaldi khasaan** In the last four weeks how often did you Feel irritable or having outbursts of anger	1	2	3	4
PTSD11	یمو چیزو ستی توہہِ یہ خوفناک واقعہ یاد چھو پیوان تہی ما چھو تمن نش دور ژلنچ کوشش کران Patmaev tcoerav haftav paethee **Yemaev cheezu sieth toehi ye khoofnaak vakah yaad chue paevaan tueh ma tcheiv temaev nish door tcaelnich kushish karaan** In the last four weeks how often did you Avoid activities that remind you of the traumatic or hurtful events	1	2	3	4
PTSD12	امہ خوفناک واقہک کینہہ حصہ ما چھو نہ تہی یادے ہیکانہ پاوِتھ Patmaev tcoerav haftav paethee **Aemi khoofnaak vaakaehikh kehhisee ma tcheiv ne tueh yaade hekaan paevith** In the last four weeks how often were you Unable to remember parts of the traumatic or hurtful events	1	2	3	4
PTSD13	توہہِ ما باسان دوہ دش کین کامہ کارن منز زنہ دلچسپی کم گامژ Patmaev tcoerav haftav paethee **Toehi ma basaan doah dish kaen kaemikaaran manz zaeni dilchaspee kaem gaemic** In the last four weeks how often were you Less interest in daily activities	1	2	3	4
PTSD14	توہہِ ماناوومیدی ہش باسان Patmaev tcoerav haftav paethee **Toehi ma naumeedi hish basaan** In the last four weeks how often did you Feel hopeless about the future	1	2	3	4

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PTSD15	یس خیال یا احساس توہِ یہ خوفناک واقعہ یاد پاوان چھو تہی ما کوشش کران تتھ متعلقنہ سوچنچ /نہ توجہ دنچ Patmaev tcoerav haftav paethee **Yues khayal yaa ehsaas toehi ye khoofnaak vakah yaad pavaan tchu, tueh ma koshish karaaan tath mutlik na sonchnich/ natavajah deenich** In the last four weeks how often did you Avoid thoughts or feelings associated with the traumatic or hurtful experience	1	2	3	4
PTSD16	یتھے توہِ یہ خوفناک واقع یاد پیوان چھو توہِ ما رنگتھے بدلان(توہِ ما تمہ ساعتہ دل ژلان،کلہ دودکران،شانش کھسان،میادس دود باسان،ارکھ پھٹان،تھر تھر ووتھان،گھش گژھان Patmaev tcoerav haftav paethee **Yutheetoehi ye khoofnaak vaakah yaad paevaan tchu toehi ma tchae rangthee badlaan (maslaen toehi ma tchu taemi saate dil tcaelaan, kali doad karaan, schaench khasaan, maedas doad basaan, aerakh fataan, thar thar vothaan, gush gacaan).** In the last four weeks how often did you Did you feel sudden emotional or physical reaction when reminded of the traumatic event?	1	2	3	4

Consequences of Insecurity SPECIAL CODES respondent does not know [98] no answer [99]

S2	Did you choose to move somewhere else because of safety reasons?	1. Yes 2. No
S3	Have you been forced to live somewhere else?	1. Yes 2. No
S4	Have you lost your house because of the conflict/ natural disaster?	1. Yes 2. No
S5	Have you lost your possessions because of the conflict/ natural disaster?	1. Yes 2. No

PD5	**Do you know about the radio show Alaw Bay Alaw**	5. Yes 6. No	**If yes then a new question should pop up**	**How often did you use to listen to it?**	7. I didn't listen to it 8. Sometimes 9. Always
PD6	**Do you know about the television show Alaw Bay Alaw**	7. Yes 8. No	**If yes then a new question should pop up**	**How often did you watch it?**	10. I didn't watch it 11. Sometimes 12. Always

Thank you for participating in the research, we appreciate your time.
Do you have any questions about the questions you have answered or about our research?

Now the scores for the screening tools need to pop up so that the interviewer can see if a MINI interview is required.

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(If the score is over 1.75 for Anxiety, 1.56 for Depression, or over 2.0 for PTSD then ask the person if they mind taking part in a second interview with another member of the team) Explain again that they are offered this because they have answered yes to many of the questions we are interested in. Again stress confidentiality and the freedom to refuse or opt out of the interview at any time. Also restate that the information they are providing is very important for the study and for understanding the situation of people in Kashmir).

If they scored below these markers then thank them again for their participation and move to the next house.

Finally, ask the interviewee not discuss the interview with anyone until we leave the village. This is so that their comments do not affect the answers of others who are yet to be interviewed.

E1	What language was used by the respondent to answer the questions?	1. Kashmiri 2. Urdu 3. Other ------------------------------(type name)
E2	Was an interpreter used?	1. Yes 2. No
E3	Who was the interpreter	1. Member of the team 2. Friend/Relative of Respondent

Appendix 3: Information sheet

The information sheet should remain with the individual after conducting the interviews (currently being translated)

Prevalence of Mental Health problems in the Kashmir Valley – a cross sectional study, 2014.

Thank you for taking the time to listen to our information about this study. We are conducting this study for Médecins sans Frontières (MSF) and the University of Kashmir to find out more about the problems the Kashmiri population is facing with 'Tension'. MSF has been running mental health care projects in some districts in Kashmir since 2001.

We are conducting this study in all 10 districts of the Kashmir Valley and as we cannot visit every village in every district **we are selecting 40 villages from each district** randomly for participation in the study. We are also not able to interview every household so we are randomly selecting 12 households from each selected village, so **it is by chance your household has been chosen**.

We would like to ask you some questions about how you are feeling, such as:

- In the last four weeks have you felt your heart pounding ('tarse rahare')?
- In the last four weeks have you been worrying too much about things ('fiqr')?

The records from this study are private. Only the people who are doing the study can see the answers you give to the questions. We do not ask for your name so there will be no record that you participated in the study.

The **interview will take about 30-40 minutes to complete** and then for a small selection of people across the district, who answer yes to a large number of questions on the initial questionnaire, they will be asked to participate in an additional interview to verify the findings of the first one. You will not get anything, such as money or extra food for being in this survey. Your answers are private and wil not be shared with any other people. Whether you choose to be in the study is up to you. There will be no effect on your family. If you do not understand a question, please ask me to explain it to you. You are free to stop at any time during the interview. If a question makes you uncomfortable, we can skip this question and go to the next question.

Once we have the results of this study, we will send an announcement to the health clinics and you will be able to find out what our conclusions are. **Do you have any questions?** Please feel free to ask us, we are happy to answer all your questions. You can call and speak to us at any time if you want to find out more about this research project.

Team Leader ______________________________, research team leader: Name ________________________

Shabnum:- 9797926774, MSF Clinical Psychologist and Research Associate
Tambri Housen:- 7042297536, MSF Epidemiologist
Dr Magbool :- 9697477779, Director of Psychiatry Institute of Mental Health and Neurosciences
Dr Showkat :- 09419545340, Director of Psychology Kashmir University.

Thank you for your time and participation

Appendix 4: Informed Consent Form

Currently being translated

Prevalence of Mental Health problems in the Kashmir Valley – a cross sectional study, 2014.

Please:

- *Administer the information sheet before seeking consent*

I have understood the above information and my questions have been answered to my satisfaction. **I give voluntary consent for the participation in this study**. I understand that I am **free to stop the interview at any time and it will not have any impact on me or my family**.Date: ¦__¦ ¦__¦ / *2015*

Participants signature/Mark:

____

Interviewer's name:

____

I have explained this research study to the subject
Interviewer's signature:

____

In the case that the participant scored above 1.75 for the HSCL-Anxiety, or above 1.58 for the HSCL-Depression or above 2.0 for the HTQ-PTSD then once again ask there consent to undergo a second interview by another member of the team (Clinical Psychologist). Re-iterate confidentiality and thank them for their co-operation.

The respondent provided consent to undergo a MINI interview

1. Yes
2. No

If No – write a reason

____

____