Survey 2021

MENTAL HEALTH OF TIBETAN REFUGEES IN INDIA

Gift of the United States Government

THE TIBET FUND

SANGATH

ཀ་ཤག་ཀག། སྤེན་སྒྲིང་སྦེན་པ་ཚེ་རིང་། KASHAG

PENPA TSERING
SIKYONG

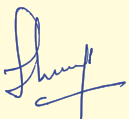
FOREWORD

I welcome the publication of the findings of the 2021 Survey of the Mental Health of Tibetan Refugees in India, an initiative of the Central Tibetan Administration's Department of Health (DOH). This report is the fruition of years of hard work and the contribution of many. I take this opportunity to thank the DOH and its Mental Health Desk, the United States Department of State's Bureau of Population, Refugees and Migration (PRM), members of SANGATH, health professionals and every individual who contributed to this survey, including those who took part in it.

Physical and mental health are equally essential components of a healthy life. However, despite growing understanding backed by scientific research on the effect of the lack of one of these factors-physical and mental- and on the other, mental health is often tucked away in a blanket of ignorance, misunderstanding, stigma and misinformation.

The 2021 survey of 3307 Tibetans (adults) from Tibetan settlements across India, the first of its kind, quantifies mental and substance use problems in our community. Recommendations of this report reflect the reality that a lot has to be done to promote emotional well-being and prevent mental health problems, but more urgently, to improve access to quality mental healthcare.

The administration remains committed to improving and strengthening the healthcare system and looks forward to continued dialogue on this crucial issue. However, our fight against mental health and substance use cannot be secured only by the efforts of the Central Tibetan Administration. We all must come together and support our fellow Tibetans enduring mental health problems, help dispel the stigma surrounding it and provide services as per the need of the community.



Penpa Tsering
Sikyong / Health Kalon

Central Tibetan Administration, Dharamshala, Distt. Kangra, H.P. 176215, India
sikyong@tibet.net Off: (91) 1892 223548, 222218, 222713

Message

Tashi Delek! It is a historic step in the history of the Department of Health, CTA for successfully completing the very first mental health prevalence survey report in the Tibetan adult population in India. For this, I congratulate everyone who has given their time, money, efforts and support to the completion of this report.

This report will help us understand the mental health status of Tibetan refugees in India and some of the factors that contribute to mental instabilities. It will also pave and guide us people in the decision-making for designing appropriate plans, measures, programs and projects aiming towards the bigger picture of better mental health for all of us.

In addition to this survey, the mental health program of DoHe undertakes various prevention and intervention programs such as providing medical and counseling treatment support, improving access to treatment through telepsychiatry, training healthcare professionals on mental disorders and counseling, networking, and collaborating with youth groups and community leaders to promote mental healthcare awareness, with financial support from PRM, U.S and technical guidance by Sangath.

Without the constant assistance and guidance of the mental health desk's advisors, Geshe Lhakdor, Dr. Tsetan Dorji Sadutshang, Dr.Tsewang Tamdin, and Dr. Carol Weingarten, the activities of the program would not be as significant as they currently are.

Moreover, without the professional and expert knowledge and guidance from Sangath, especially Dr. Abhijit Nadkarni and his team, this survey and many other mental health activities will only be a dream.

Lastly, our nurses and staff in the settlements selflessly collected the survey data despite the risk posed by the COVID-19 pandemic and walked the path laid out by our advisors, bringing the mental health program to life and making gradual changes in the lives of the vulnerable Tibetans in India.

The Department of Health, CTA views the mental health as equally vital as physical health and will not only continue to but try to do more in building an emotionally healthy society. And for that goal, every one of us has the responsibility to have the clear understanding of the mental health crisis and by considering the importance of emotional hygiene, one must invest in the emotional well-being of ourselves, our family, our school, our working environment and our community.

Thank you

Mr. Palden Dhondup
Secretary
Department of Health, CTA
Dharamsala

EXECUTIVE SUMMARY

Although the prevalence and burden of mental health problems in India is reasonably well documented, there is a limited understanding of the mental health needs of Tibetans living in India. In the absence of reliable and detailed information about the problem, it is challenging to formulate and implement effective policies and programmes to address the issue. In order to bridge this evidence gap, the Central Tibetan Administration commissioned a survey to understand the mental health of Tibetans living in India. The primary objective of the survey was to assess the extent of mental health problems and substance use, and examine mental health help seeking behaviours. To achieve this objective, a cross sectional survey was conducted among a representative sample of adults residing in the various Tibetan settlements in India. A number of measures were administered to collect data needed to answer the survey objectives. All procedures that were followed were designed to ensure optimum quality, high research standards, and adherence to ethical principles during data collection and analysis. Data was analysed to generate prevalence estimates. One in ten participants screened positive for depression and those with depression experienced significant disability. One out of five participants were currently using some substance- the commonest being alcohol and tobacco, followed by cannabis. The prevalence of current experience of physical violence was 2.1% and of verbal violence was 5.5%. Women were more likely to report symptoms that are believed to be culturally determined expressions of distress such as fullness in the back, shifting pain in the body, and experiencing 'nerves'. Overall, help seeking for symptoms of depression as well as substance use was low, and it was generally sought most from family, followed by friends. This report makes it evident that mental health problems and substance use are quite prevalent in the Tibetan settlements in India. However, access to appropriate care is limited. An appropriate response to this problem will require strategic investment, optimum allocation of resources, development of services which are accessible within the communities, training of human resources, ensuring uninterrupted supply of medicines, robust system of monitoring, planned

capacity building and, most importantly, a coordinated, multi-stakeholder response. This survey represents the first comprehensive scientific approach to explore and document the mental health of Tibetans living in India and to utilise the evidence for informing policies and programmes. Overall, data from this survey indicate that there is need of fresh thinking and innovative solutions to reduce the burden of mental health problems and substance use in the Tibetan settlements in India.

Lead Investigator:

Dr Abhijit Nadkarni

Associate Professor of Global Mental Health, London School of Hygiene & Tropical Medicine

Director, Addictions Research Group, Sangath, India

Research Team:

Ngawang Tenzin, Deputy Secretary, Department of Health, CTA

Tsering Yangdol, Mental Health Program Coordinator, Department of Health, CTA

Shreya Nagvekar, Addictions Research Group, Sangath, India

Ethel D'souza, Addictions Research Group, Sangath, India

Field Team from Tibetan Primary Health Centres and Clinics in India:

Name	Designation	Name	Designation
Dawa Chodon	Mainpat Nurse	Tashi Tsomo	Dalhousie
Dolma Lhamo	Kullu Nurse	Tenzin Choedon	Bir Nurse
Kunga Chonzin	Sonada Nurse	Tenzin Dheden	Kamrao Nurse
Lhakpa Bhuti	Dholanji Nurse	Tenzin Lhadon	Sarah Nurse
Namkhang Lhamo	Kollegal Nurse	Tenzin Minlag	Delhi Nurse
Nyima Yangzom	Tuting Nurse	Tenzin Sangmo	Tuting Nurse
Pema Tsering	Poanta Nurse	Tenzin Tsephel	Ladakh Nurse
Phurba Dolma	Tenzingang Nurse	Tenzin Choedon	Odisha Nurse
Sangay Choezom	Mundgod Nurse	Tenzin Zomkyi	Shimla Nurse
Sangyal Dolma	Sataun Nurse	Tsering Wangmo	Hunsur Nurse
Sithar Tsering	Tsopema/Pondoh	Tsethar Dolma	Tezu Nurse
Tashi Dolma	Dekyiling Nurse	Wangthen Lhamo	Miao Nurse
Tashi Samdup	Herbertpur Nurse	Tsewang	Dekyiling Nurse

We would like to thank the following team members at Sangath who trained the Tibetan nurses in data collection and other related research topics- Ethel D'souza, Danielle Fernandes, Godwin Fernandes, Ankur Garg, Devika Gupta, Pranali Kundaikar, Subhash Pednekar, Shravani Rangapuri, Seema Sambari, and Miriam Sequeira. We would like to thank Dr Carol Weingarten, Faculty Scholar of the Center for Spirituality, Theology and Health at Duke University, for her unstinting support to this survey, and more broadly to the mental health initiatives for the Tibetan community in India.

We would also like to thank Dr Tsetan Dorji Sadutshang, private physician of H.H. The 14th Dalai Lama and the Chief Medical Officer of Delek Hospital and Dr Takako Suzuki for providing relevant cultural and contextual insights on mental health problems in Tibetan communities.

The survey was funded by the United States Department of State's Bureau of Population, Refugees and Migration (PRM).

This report is an output from the survey to examine the mental health burden in Tibetan Settlements in India which was commissioned and funded by Department of Health, Central Tibetan Administration in India.

Suggested Citation:
Nadkarni A. (2022) Mental health of Tibetan refugees in India. Goa: Sangath and Central Tibetan Administration.

Published by :
Dept. of Health, CTA
in the interest of Public Health

List of Abbreviations

Alcohol, Smoking and Substance Involvement Screening Test: ASSIST

Central Tibetan Administration: CTA

Hopkins Symptoms Checklist: HSCL

Major Depressive Disorder: MDD

Missing Values: MV

Patient Health Questionnaire: PHQ-9

Post-Traumatic Stress Disorder: PTSD

Standard Deviation: SD

World Health Organization: WHO

WHO Disability Assessment Schedule 2.0: WHODAS 2.0

Table of Contents

INTRODUCTION 11

RATIONALE 13

SCOPE 14

TIMELINE 14

RESEARCH QUESTIONS 14

OVERALL AIM 15

Specific Aims 15

METHODS 15

Design 15

Settings 15

Participants 17

Eligibility 17

Tools 17

Sample size 19

Procedures 19

Ethics 21

FINDINGS 22

Sample 22

Socio-demographic characteristics 24

Mental disorders 31

Depression 31

Substance use 32

Violence 35

Idioms of Distress 37

Help seeking 37

WAY FORWARD 38

Recommendations 38

APPENDICES 47

Consent form 47

Questionnaire 50

REFERENCES 69

"Hard times build determination and inner strength. Through them we can also come to appreciate the uselessness of anger." ***- His Holiness the Dalai Lama***

Introduction

The World Health Organisation (WHO) defines health not just as the absence of disease or infirmity but includes physical, social, spiritual, and mental health. The importance of mental health to the holistic conceptualisation of health is underlined by the oft used maxim, “there is no health without mental health.”

Mental and substance use disorders contribute to a significant level of morbidity and mortality. These conditions can affect everyone, irrespective of age, gender, and socioeconomic status, although some groups are at a greater risk for certain disorders (e.g. depression during pregnancy and immediately after child-birth). Additionally, there is a close and strong association between mental disorders and a range of non-communicable diseases (e.g. diabetes, cardio-vascular diseases) and other highly prevalent risk factors such as domestic violence. Nonetheless, mental disorders are caused and sustained by a complex interaction of biological, socio-economic, environmental, and cultural factors such as employment, education, and poverty. Similarly, they can lead to long term impact on the individuals and their families, such as reduced productivity and earning potential, homelessness, and domestic violence, all of which result in an overall poor quality of life. This is further complicated by the stigma associated with mental disorders, leading to delay in accessing care, discrimination, neglect and marginalisation, and violation of human rights. Finally, access to care for individuals with mental illness are limited due to limited awareness, availability, accessibility, and affordability of appropriate services.

During the past few decades, there have been some attempts to examine the mental health issues among the Tibetan population in India. In a survey of 330 adolescents living in a Tibetan refugee enclave in rural North India, 21% were identified to have moderate or severe anxiety, with older adolescents at a greater risk than younger adolescents[1]. In a study of Tibetan refugees in Dharamsala, 20% of the refugees with history of being tortured and imprisoned met criteria for post-traumatic stress disorder (PTSD). Previously imprisoned refugees reported more traumatic events, especially torture and deprivation, and more anxiety compared to refugees who had not been

imprisoned. However, both the groups were similarly high in terms of depression and number of somatic complaints[2]. In a cross-sectional survey of 319 school students at the Tibetan Children's Villages in Northern India, adolescents who escaped from Tibet to India were compared to ethnic Tibetans born and raised in exile. Adolescents born in Tibet had significantly higher depressive and anxiety symptom scores compared to ethnic Tibetans born in exile. Female adolescents and those with limited contact with immediate family had higher depressive and anxiety scores[3]. In a retrospective cohort study of 35 refugee Tibetan nuns and lay students who had been arrested and tortured in Tibet matched with 35 controls who had not been arrested or tortured, the prevalence of symptom scores in the clinical range for both cohorts was 41.4% for anxiety symptoms and 14.3% for depressive symptoms. The torture survivors had a statistically significant higher proportion of elevated anxiety scores (but not depression scores) than did the non-tortured cohort[4]. In a study of 769 Tibetan refugees arriving in Dharamsala, India (2003-2004), findings indicate that distress increased significantly with greater trauma exposure. However, despite a high prevalence of potentially traumatising events, levels of psychological distress were extremely low. Coping activity (primarily religious) and subjective appraisals of trauma severity appeared to mediate the psychological effects of trauma exposure[5]. Finally, in an exploratory survey to determine the prevalence of PTSD and major depressive disorder (MDD) in children who escaped from Tibet and found refuge in Tibetan settlements in India, 61 randomly selected children from four group homes of the Tibetan Children Village, in Dharamsala, India, were interviewed for symptoms of PTSD and MDD. 11.5% of the children met DSM-IV criteria for PTSD, and the same proportion met criteria for MDD. Children who had arrived from Tibet more recently (in the previous 18 months) showed a greater prevalence of PTSD than children who had been refugees longer[6].

However, the validity and generalisability of most of these studies is limited by the small sample sizes. Additionally, the foci of many of these studies have been children and young people; and primarily restricted to examining trauma and its after-effects. Additionally moving beyond prevalence and some examination of risk factors, there

has been no exploration of data on mental health care utilisation, disability, impact, stigma, and the overall impact on individuals and families.

Recent anecdotal reports from the Tibetan settlements indicate the emergence of problems such as depression, alcohol and drug abuse, and suicidal behaviours. However, our understanding of these emerging public health problems in the settlements is limited by the unavailability of good quality data. This, in turn, impairs the development of mental health services and strengthening of health systems required to achieve high standards in the quality of care available to individuals with mental illness. Good quality data is a pre-requisite to develop strong mental health programmes. This includes not only information on the prevalence and patterns of mental disorders, but also information related to service utilisation, and burden and impact on the individual, health systems and society. In the absence of such information, it is difficult to organise a health systems response to strategically respond to the needs through well-designed policies and programmes.

Tibetan Culture and Mental Illness

Tibetan culture maintains a deep and powerful integration of the spiritual, mental and physical. Thus the Tibetan healing tradition respects these influences and also places a premium on the doctor-patient relationship. The underlying cause of different illnesses find its root cause in Ignorance and proximate cause in 'the three principal energies—*loong, tripa* and *baekan*', with the understanding that to be in good health all these energies have to be balanced. When any of these three energies is increased, decreased or disrupted from its normal proportion by factors such as unwholesome diet and lifestyle, it leads to disorders. Mental health problems are seen to be caused by destructive emotions, spirits, physical injuries, and mostly an imbalance of *loong.* Treatments of mental health problems include several methods such as traditional medication and therapies, mantra recitation, meditation, and cultivation of warm-heartedness.

Rationale

Under the Department of Health's psychiatric medication and counselling financial reimbursement program, 125 individuals with depression, anxiety, schizophrenia, or bipolar affective disorder are being supported in 22 settlements across India. This

number is counter to the commonly held belief that Tibetans do not suffer from mental disorder. However, data such as this has its limitations, and for the planning, development, implementation, monitoring, evaluation and strengthening of mental health services within the Tibetan settlements in India, it is important to clearly map the burden of mental disorders within the settlements across the country. Hence, this survey was identified as a priority and was commissioned by the Central Tibetan Administration (CTA). Recognising the need for high quality valid, generalisable, and reliable data, the survey aimed at understanding the burden of mental health problems in a representative population from the settlements.

Scope

The scope of the survey was delineated based on discussions between the CTA and Sangath. The survey was aimed at being representative of the Tibetan population in India by including all the settlements in the country. The survey focused only on adults as the first step towards understanding the burden of mental health problems in the settlements. It was decided to exclude children and adolescents at this stage because of the lack of experienced field research teams to investigate complex health issues in that population. Finally, it was decided to examine only the most common mental health problems in the community (e.g., depression, anxiety, substance use disorders) that are of public health concern, and the most common correlates based on evidence (e.g., violence) or contextual relevance (e.g., spirituality).

Timeline

Research questions

The research questions that we aimed to answer through this survey include the following:

1. What is the prevalence of mental and substance use disorders in refugee or stateless Tibetan adults living in India?

2. What are the socio-demographic and other correlates of mental and substance use disorders in refugee or stateless Tibetan adults living in India?

Overall aim

The overall aim of this study was to identify the burden of mental health and substance use problems in refugee or stateless Tibetan adults living in India.

Specific Aims

1. To determine the prevalence of common mental disorders and trauma related psychological problems,
2. To determine the prevalence of alcohol use, alcohol use disorders, and tobacco use,
3. To determine the prevalence of illicit substance use and substance use disorders,
4. To examine the sociodemographic predictors or correlates of the mental and substance use disorders specified above,
5. To examine the relationship of the mental and substance use disorders described above with other correlates such as disability, work performance, etc.

This report deals with specific aims 1, 2, and 3; and specific aims 4 and 5 will be dealt with through more detailed analysis for peer reviewed publication.

Methods

Design

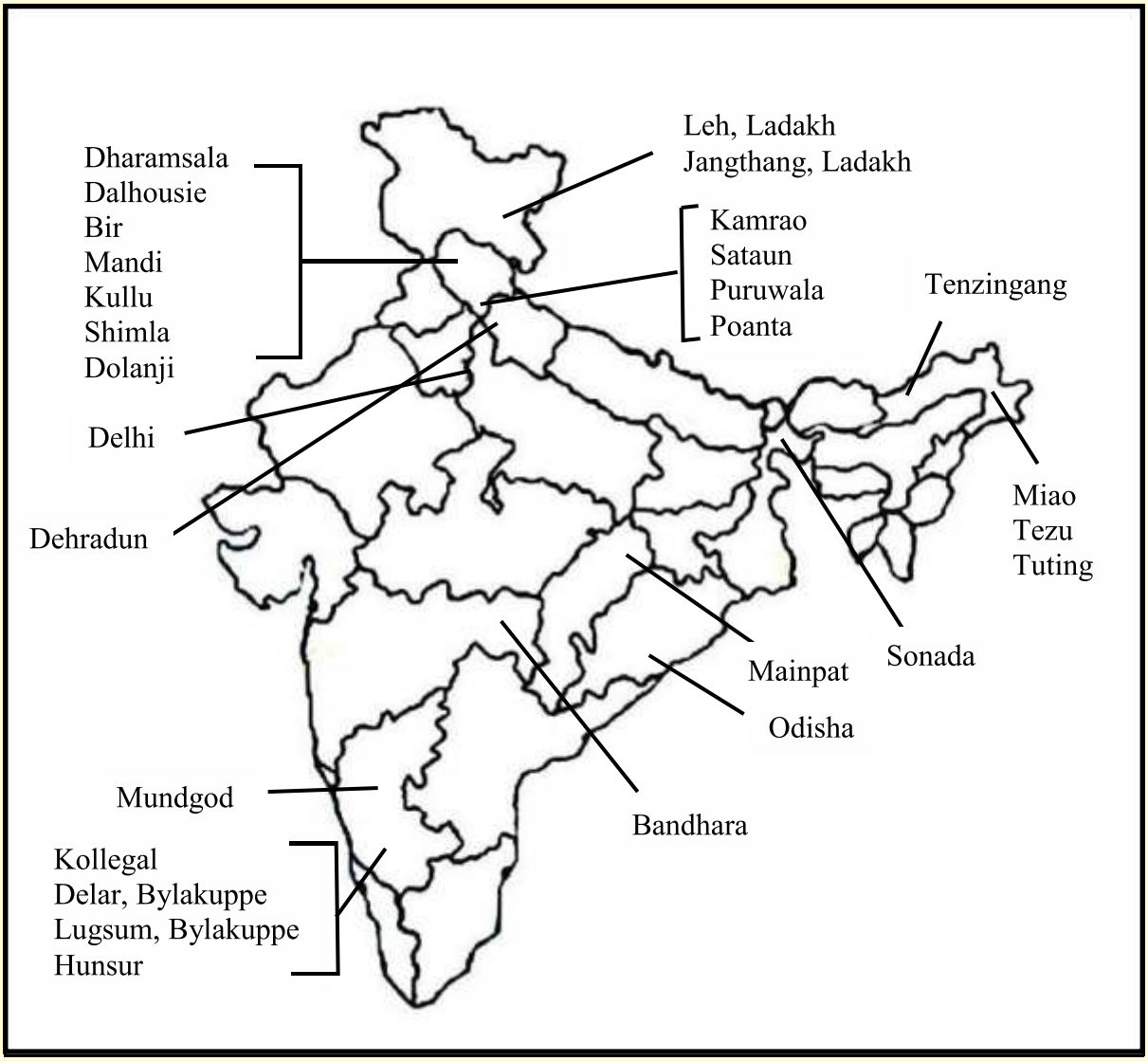
Cross-sectional household survey.

Settings

Since the escape of His Holiness the Dalai Lama to India in 1959, there has been an exodus of Tibetan refugees and many have settled across 35 Tibetan refugee settlements in India. These settlements, broadly classified as agriculture-based, handicraft-based, and cluster communities, are situated all over India with 16

settlements in North India, 11 in North-East India, five in South India, and three in Central India. The Tibetan refugee population in each settlement ranges from 200 to 8000 individuals. In these 35 settlements, there are 64 schools under the Department of Education, CTA; and seven hospitals, five primary health centres, and 17 clinics under the Department of Health, CTA. Each settlement has numerous camps and a regional settlement office which overlooks the overall welfare of the respective settlement. The main sources of livelihood of Tibetan refugees in India are agriculture, handicraft, and makeshift winter sweater selling businesses.

The figure below shows the list of settlements in which data were collected for this survey.



Participants

The participants were selected through systematic random sampling, stratified by settlement and gender. The participants were selected through random selection in two strata, i.e. settlement (10% of the adults in the settlement) and gender (distribution reflecting proportion of males and females in that particular settlement).

Eligibility

For inclusion in the survey one had to be an adult (>18 years) stateless or refugee Tibetan residing in India. We excluded those who were unable to communicate because because of a medical problem or disability.

Tools (Appendices):

Data was collected using the following self-report questionnaires:

1. Baseline **sociodemographic** data: We collected information about age, gender, religion, marital status, employment status, education status, place of birth (India, outside India), date of arrival in India if born outside India, name of settlement, number of times shifted from settlement (if any), and household income.
2. **Depression** was assessed using the validated 9 item Patient Health Questionnaire (PHQ-9)[7]. The PHQ-9 is an instrument for making criteria-based diagnoses of depressive disorders in primary care and has been validated in India[8]. The PHQ-9 score can be used to generate five categories, where a cut-off point of 0–4 indicates no depressive symptoms, 5–9 mild depressive symptoms, 10–14 moderate depressive symptoms, 15–19 moderately-severe depressive symptoms, and 20–27 severe depressive symptoms.
3. The Hopkins Symptoms Checklist (HSCL) is a symptom inventory which measures symptoms of **anxiety** and **depression**- 10 items for anxiety

symptoms and 15 items for depression symptoms. The HSCL has been validated for use in Tibetan populations[9].

4. We collected data about **interpersonal violence**- both verbal and physical- by asking questions from the WHO Multi-country Study on Women's Health and Domestic Violence. These included questions about being insulted or humiliated in front of other people, being intentionally scared or intimidated, being threatened to hurt them or someone they care about, slapped or thrown something at them that could hurt them, pushed or shoved about, hit with a fist or anything else that could hurt them, kicked, dragged or beaten up, choked or burnt on purpose, and threatened to use or actually use a knife or other weapon against them. We collected information whether any of this had happened in the past 12 months and the frequency of occurrence.
5. Using bespoke questions, we sought information on from whom they **sought any support or help** after experiencing the violence, and reasons for not seeking help if they did not.
6. **Disability** was measured using the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0),[10] a tool to measure functional impairment and disability. The WHODAS has been validated for use in India[11].
7. **Substance use and abuse** was measured using the WHO's Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)[12]. ASSIST is a questionnaire that screens for all levels of problem or risky substance use in adults. It consists of eight questions covering tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (including ecstasy) inhalants, sedatives, hallucinogens, opioids, and 'other drugs.' The ASSIST has been validated for use in India[13].
8. Bespoke questions were used to explore **help seeking** amongst those who used substances and experienced the symptoms examined in the PHQ-9.
9. Bespoke questions were used explore the prevalence of three culturally appropriate **idioms of psychological distress**: fullness in the abdomen, shifting pain in the body, and experiencing 'nerves' in the past one month.
10. **Religiosity/spirituality** was assessed using questions from Bhutan's Gross National Happiness Survey (2015)

A rigorous translation and back translation protocol was followed to translate these questionnaires from English to Tibetan. The English questionnaires were first translated into Tibetan by two professional translators. A mutually agreed version of the translated questionnaire was then back-translated into English by two other translators who were not in the research team. The near-final version was agreed upon by all the translators and the research team before it was pilot tested and finalised. The interviews were conducted in Tibetan or the local language spoken in the respective region.

Sample size

A formal sample size calculation was not done as the study was not designed to test a hypothesis. According to the House Hold Listing Data (Year 2017) collected by the Department of Health, CTA, there were 42,650 Tibetan refugees/stateless persons living in households in India and who could be contacted by the Department of Health nurses in India. We planned to recruit 10% (approximately 4000) of this population for the survey.

The table below gives the precision (95% Confidence Intervals) of our potential findings (informed by evidence from India) to detect various prevalence rates, given the available sample size (n=4000).

Disorder	Prevalence rate[1]	95% CI[2]
Depression	2.7%	2.2-3.3
Trauma related psychological problems	0.2%	0.1-0.4
Alcohol use disorders	4.6%	4.0-5.3
Illicit substance use disorder	0.6%	0.4-0.9

[1]National Mental Health Survey of India 2015-16; [2]Projected for Tibetan sample of 4000

Procedures

Data were collected by the nurses based in the various settlements. We trained 24 such nurses over a five-day intensive participatory training which included didactic lectures, demonstrations, and role-plays. The nurses were trained by experienced researchers from Sangath. The topics covered during the training included information

about the survey, basics of mental health, understanding basic research designs, research ethics, principles and procedures of consenting, research interviewing skills, all the tools in the questionnaire, data management and security, preparing for an interview and documentation, and managing complex presentations such as domestic violence and suicidality.

Each potential participant was given an information sheet to read and the content was discussed with them. If individuals could not read, the content of the information sheet was read out to them. The information sheets and consent forms were provided in the participants' preferred language, i.e. Tibetan or English. The scope and purpose of the study and potential risks and benefits were explained to potential participants. It was explained to participants that they could withdraw from the study at any time. As the interviews were conducted by the nurses, who also provide care to some of the potential participants and/or their families, there was a possibility that some participants would feel covert pressure to consent. To prevent this, it was repeatedly made clear to them that their refusal to consent would not compromise their current or future healthcare in any manner. The participants were encouraged to contact the research team or the chairperson of the ethics committee to discuss any concerns they may have related to participation in the study. Details of these individuals, including modalities to contact them, were provided in the information sheet. During the consenting process, the researcher addressed any questions regarding the study that the participant may have. Written consent was the default option and verbal consent was obtained only if the participant was illiterate. A signature of the participant on the consent form was considered as a formal validation of their decision to participate. For illiterate participants, their thumb impression on the consent form in the presence of a witness indicated formal consent to participate.

The data collection was done using paper and pencil questionnaires. During data collection, the nurses were regularly followed-up through phone calls to monitor their progress and identify challenges faced. The data collection was delayed due to the first and second wave of COVID-19 pandemic and the subsequent lockdowns in India. Supervision and monitoring of data entries happened via emails and phone calls between the teams at Sangath, the Department of Health, and the nurses in the settlements.

The following procedures were adopted to ensure the confidentiality of participants:

1. A unique participant code was assigned to each study participant to anonymise identifying or sensitive information collected during the study. This unique participant code was recorded on the questionnaire used to collect data. No identifying information was recorded on the questionnaire. A separate document was created to link the unique participant code with identifying information. This separate document had restricted access (i.e. only designated research staff).
2. Any written records consisting of identifying information or sensitive information were stored in a secure locker. Access to such information was restricted only to the appropriate members of the study team. In general, all documents, both in written or digital format, were stored securely in either a secure locker or server or a computer or laptop accessible through a security code.
3. All staff responsible for collecting, managing, and analysing the data were trained in research ethics, data management procedures, and regulations.
4. The anonymised data were entered locally into an Excel database by the nurses who administered the questionnaires or DOHe staff assistants to these nurses. Data entry was done in parallel with data collection. The encrypted database was then transferred to Sangath through a secure cloud server at the end of each week on a Friday afternoon.

Ethics

The Ethics Committee of Men-Tsee-Khang Institute, Dharamsala approved the survey in November, 2019. In each settlement, before starting data collection, the nurses had a pre-identified referral pathway to be used if any survey participants needed additional medical, psychological, and social support. The referral pathway sheet consisted of name, addresses, and contact information of neighboring psychiatrists and hospitals, psychologists and counselors, settlement officer, and women led local NGO members. In addition, for those who screened positive or expressed varying degrees of psychological distress, the nurse's contact number was provided and they were informed about the department of health's psychiatric and counseling reimbursement financial aid program.

"Just as we teach people physical hygiene to help preserve their physical health, for a happy and peaceful mind, we need to teach people about emotional hygiene— how to tackle their destructive emotions."

- His Holiness the Dalai Lama

Findings

Sample

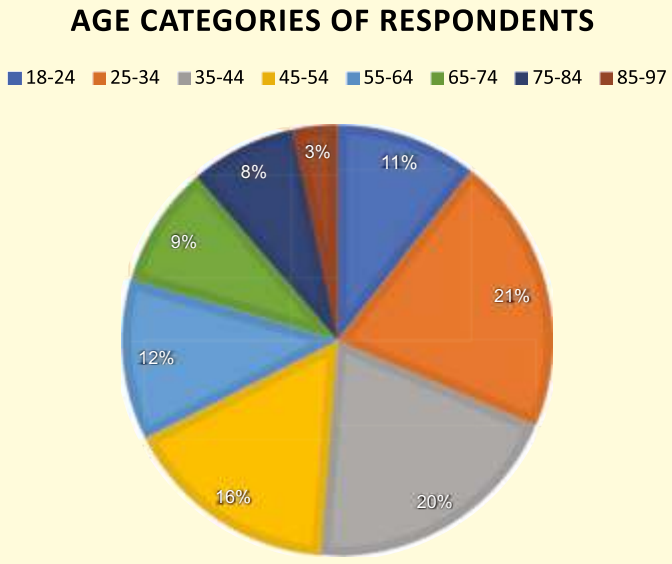
We planned to approach 3,920 participants with the expectation of a 10% refusal rate. The table below describes the planned and actual recruitment across the settlements.

S.No.	Settlement	Planned recruitment accounting for 10% refusal	Actual recruitment	Percentage
1	Bandhara	90	64	1.94
2	Bir	109	104	3.14
3	Bylakuppe	402	264	7.98
4	Clementown	90	89	2.69
5	Dalhousie	36	23	0.70
6	Dharamsala	165	161	4.87
7	Dholanji	350	282	8.53
8	Hunsur	21	19	0.57
9	Kamrao	159	157	4.75
10	Kollegal	15	16	0.48
11	Kullu / Dhobi	329	239	7.23
12	Ladakh	97	55	1.66
13	Ladakh Jangthang	430	415	12.55
14	Khera & Lakhanwala	168	169	5.13
15	Mainpat	61	54	1.63
16	Manduwala	93	66	2.00
17	Miao	17	17	0.51
18	Mundgod	143	143	4.32
19	Odisha	372	363	10.98
20	Pandoh	194	189	5.72
21	Poanta	31	28	0.85
22	Puruwala	46	25	0.76
23	Raipur	54	34	1.03
24	Rajpur	26	21	0.64
25	Rewalsar (Mandi)	21	21	0.64
26	Samyeling (Delhi)	23	24	0.73
27	Sataun	132	68	2.06
28	Shimla	15	15	0.45
29	Sonada	61	60	1.81
30	Tenzingang	34	34	1.03
31	Tezu	54	39	1.18
32	Tuting	82	20	0.60
33	Total	52	29	0.88

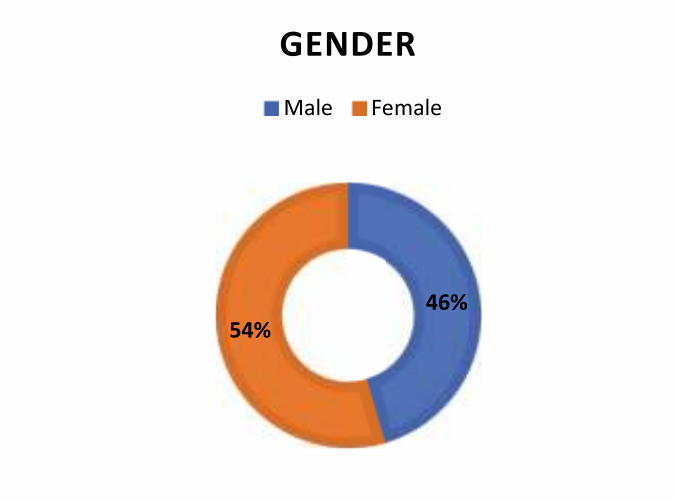
Overall, 3,307 respondents participated in the survey. Some of them did not respond to some survey instruments or some parts of the survey instruments.

Socio-demographic characteristics

The mean age of the respondents was 46.93 years (SD 18.98), with a range of 18 years to 97 years. Majority of the respondents were in the age group between 25 to 54 years. 1795 (54.4%) participants were female and the rest were males.

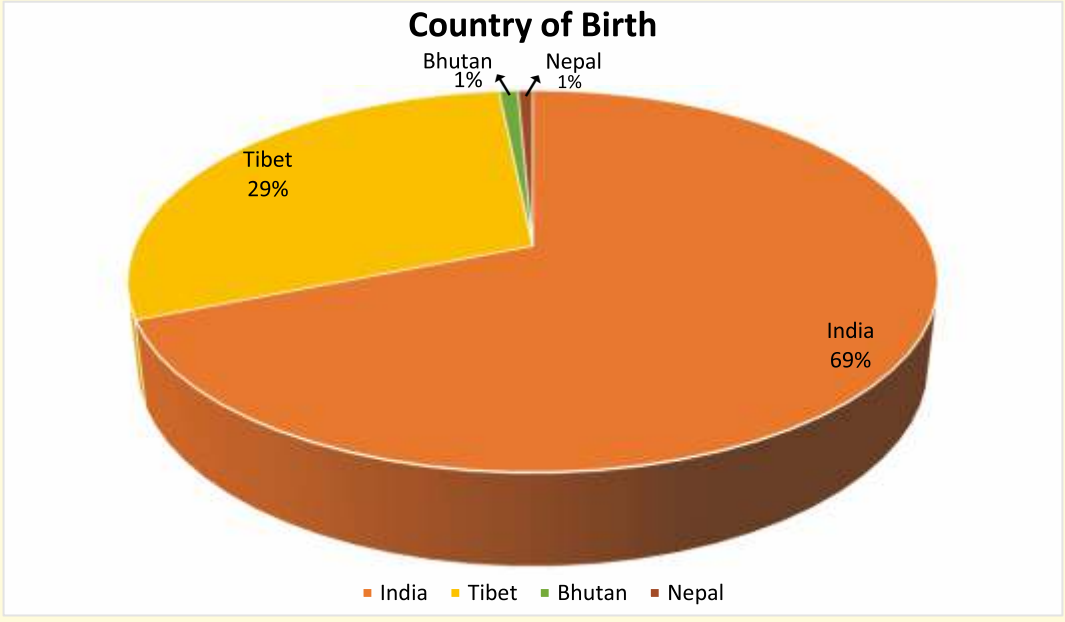


Age group in years	N	%
18-24	347	10.6
25-34	683	20.8
35-44	651	19.9
45-54	532	16.2
55-64	397	12.1
65-74	299	9.1
75-84	260	7.9
85-97	110	3.4
Missing values (MV)	28	



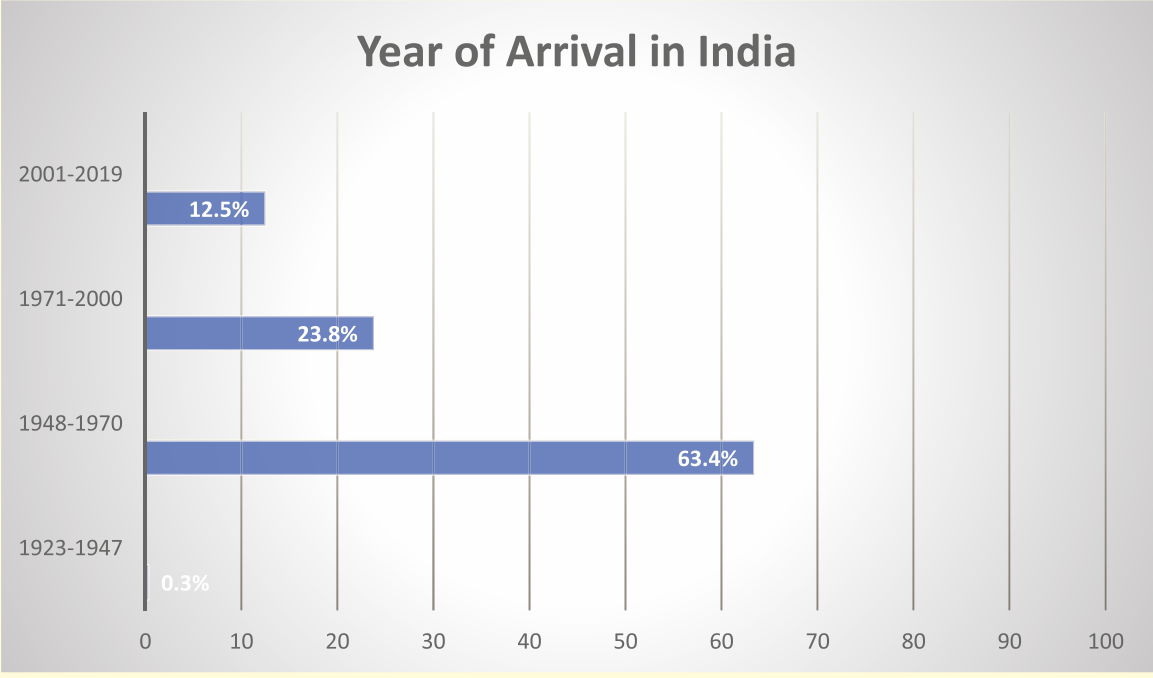
Gender	N	Percentage
Male	1,505	45.6
Female	1,795	54.4
MV	7	

Country of birth	N	Percentage
India	2,276	69.0
Tibet	971	29.4
Bhutan	30	0.9
Nepal	23	0.7
MV	7	



Two thirds of the respondents were born in India, almost a third were born in Tibet, and the small remainder were born in Bhutan or Nepal. Of those who were born outside India, two thirds arrived in India between 1948 to 1970 and almost a quarter arrived in the subsequent three decades. Almost a third of the respondents have shifted settlements in India. A majority have shifted settlements only once and the rest have moved settlements twice or more.

Year of arrival in India	N	%
1923-1947	3	0.3
1948-1970	558	63.4
1971-2000	209	23.8
2001-2019	110	12.5

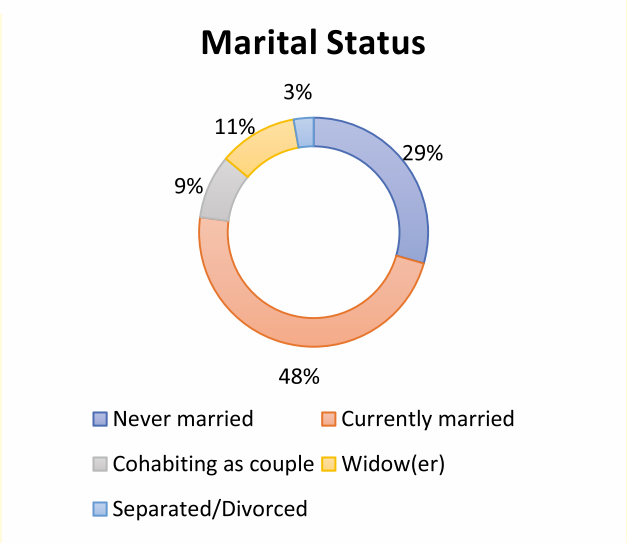


Shifted settlement	N	%
No	2,374	71.9
Yes	927	28.1
MV	6	

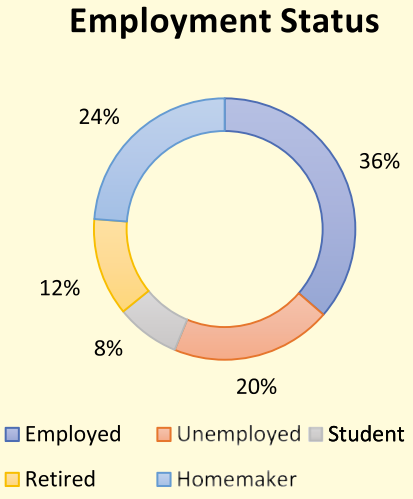
Shifted settlement	N	%
Moved once	512	55.3
Moved twice	214	23.1
Moved three to five times	166	17.9
Moved more than five times	34	3.7
MV	1	

More than half of the respondents were either married or co-habiting as a couple, while almost a third were never married. Slightly more than a third of the population were in employment; and almost a third were either unemployed or retired. Almost a third had no formal education while the rest had at least some education – ranging from primary to post graduate. Almost a third of the respondents had no income and for half the respondents the monthly household income ranged from INR 5,000 to INR 50,000.

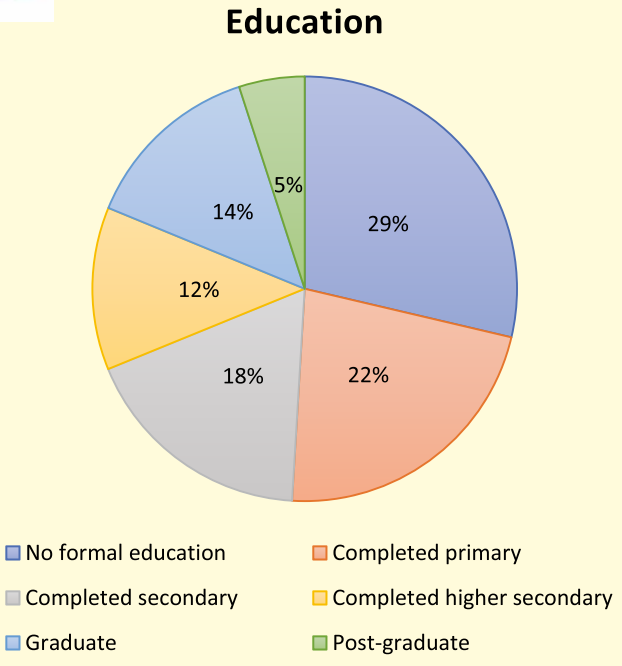
Marital status	N	%
Never Married	961	29.4
Currently Married	1,558	47.7
Living with someone as a couple	295	9.0
Widow/Widower	361	11.1
Separated/Divorced	92	2.8
MV	40	



Employment	N	%
Employed	1,199	36.3
Unemployed	662	20.1
Student	260	7.9
Retired	398	12.1
Homemaker	781	23.7
MV	7	



Education	N	%
No formal schooling	933	28.7
Completed Primary	725	22.3
Completed Secondary	582	17.9
Completed Higher Secondary	403	12.4
Graduate	450	13.8
Post-Graduate	164	5.0
MV	50	



Monthly household income (INR)	N	%
No income	672	31.4
<500	7	0.3
501 to 1000	50	2.3
1001 to 5000	314	14.7
5001 to 10000	472	22.1
10001 to 50000	578	27.0
50001 to 100000	25	1.2
100001 to 500000	8	0.4
500001 to 1000000	7	0.3
>1000001	5	0.2
MV	1169	

Almost all of the respondents were Buddhist, with a miniscule proportion being from Bon, Christian, or Hindu faiths. 37% of respondents reported being very spiritual and 53% as moderately spiritual. 19% pray several times a day and 38% recite prayers once a day. 72% never practice meditation. 41% visited temples or other spiritual places a few times per week or more, while 55% visited only on certain occasions. 73% regularly considered Karma in the course of their daily lives. 90% reported that religious practices gave them peace of mind. The mean number of times that the respondents spent attending religious/spiritual teachings in the past year was 5.5 times (SD 29.3) ranging from none to 365 times.

Religion	N	Percentage
Bon	18	0.6
Buddhist	3,262	98.9
Christian	3	0.1
Hindu	17	0.5
MV	7	

How spiritual do you consider yourself to be?	N	Percentage
Very	1,223	37.1
Moderately	1,756	53.2
Somewhat	282	8.6
Not at all	39	1.2
MV	7	

Does any religious practice give you peace of mind?		
	N	Percentage
No	322	9.7
Yes	2,975	90.2
MV	10	

How often do you recite prayers?	N	Percentage
Several times a day	610	18.5
Once a day	1,236	37.5
A few times a week	650	19.7
Only on certain occasions	699	21.2
Never	105	3.2

MV	7	
How often do you practice meditation?	N	Percentage
Several times a day	78	2.4
Once a day	192	5.8
A few times a week	147	4.5
Only on certain occasions	514	15.6
Never	2,369	72.0
MV	7	

How often do you visit temples and places of spiritual importance?	N	Percentage
Several times a day	687	20.8
Once a day	18	0.6
A few times a week	653	19.8
Only on certain occasions	1,809	54.8
Never	133	4.0
MV	7	

Do you consider Karma in the course of your daily life?	N	Percentage
Regularly	2,416	73.2
Occasionally	647	19.6
Rarely	182	5.5
Not at all	54	1.6
MV	8	

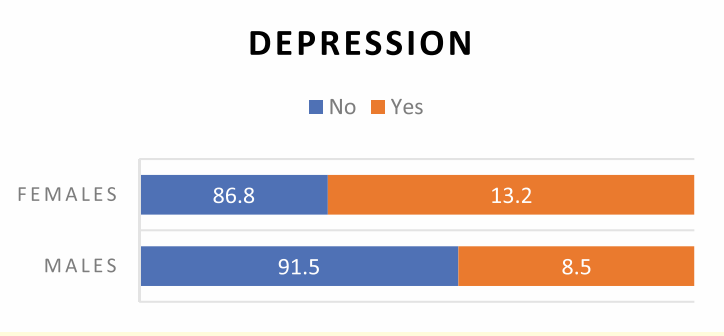
Mental disorders

Depression

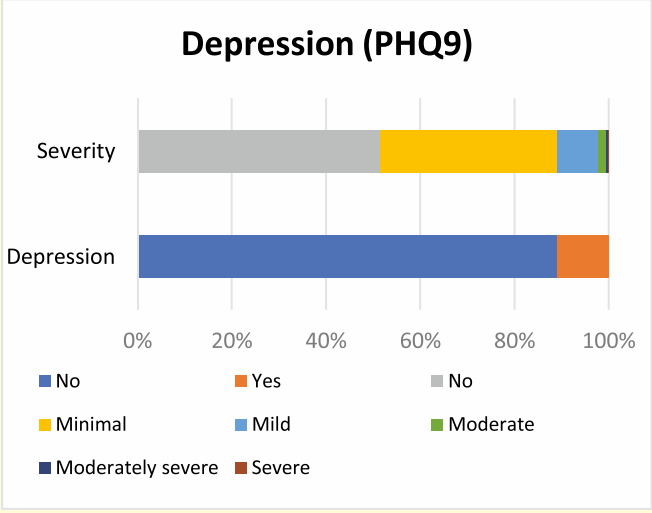
The mean score on PHQ9 was 1.6 (SD 2.7). As per PHQ9, 11.0% (95% CI 10.0-12.2) of respondents screened positive for depression (PHQ9 score ≥5). 8.9% had mild depression and 2.1% had moderate to severe depression. Note that depression rates are often reported for PHQ9 moderate to severe depression categories alone; survey results for these categories (2.1%) can be is consistent with depression rates reported for other populations. A significantly greater proportion of females had depression compared to males (13.2% vs 8.5%; p<0.001).

Disability (WHODAS score) in those with depression was significantly greater compared to those who did not have depression.

Depression	N	%
No	2,925	89.0
Yes	363	11.0
MV	19	



Depression	N	%
None	1,689	51.4
Minimal	1,236	37.6
Mild	293	8.9
Moderate	50	1.5
Moderately severe	17	0.5
Severe	3	0.1
MV	19	

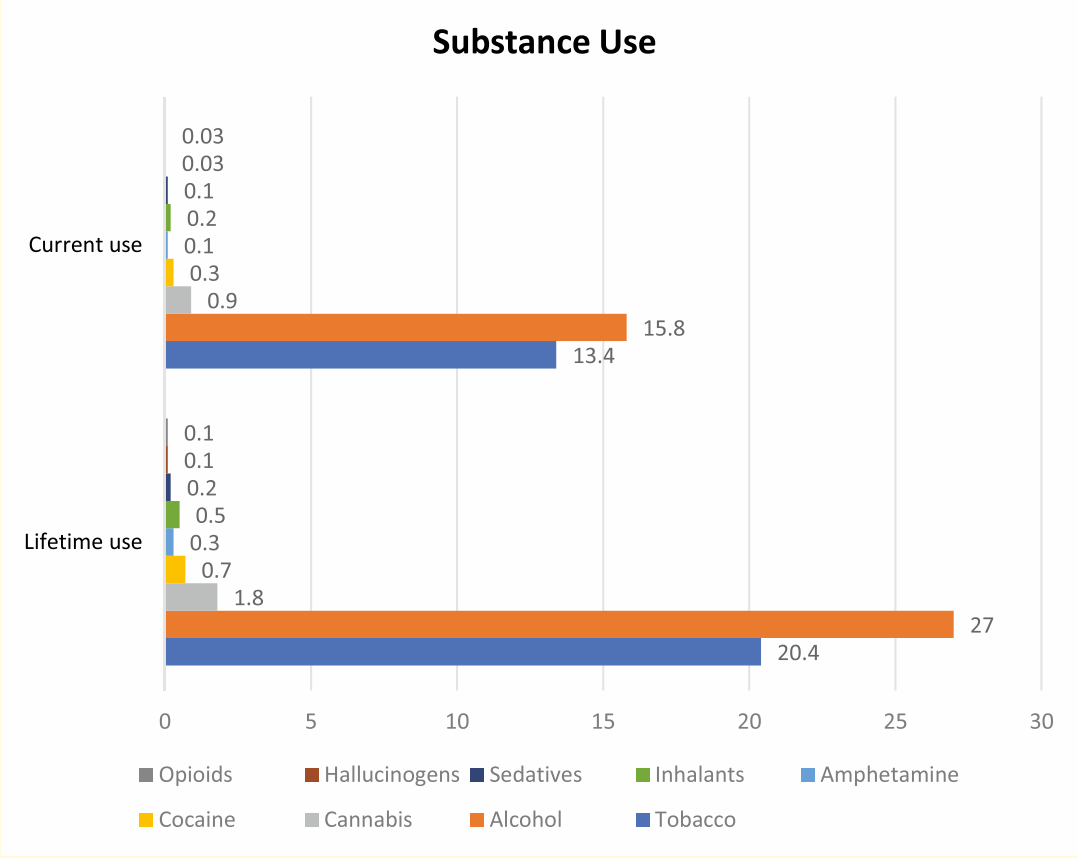


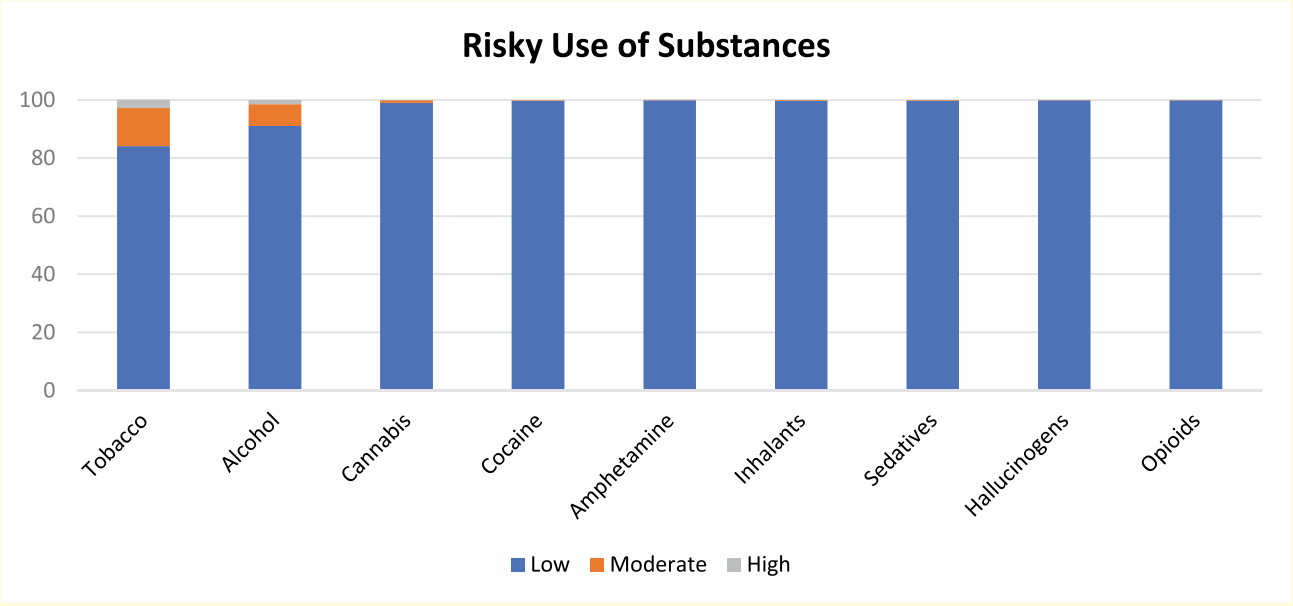
Disability			
Depression	Mean WHODAS	SD	p
			<0.001
No	6.6	12.3	
Yes	26.1	22.6	

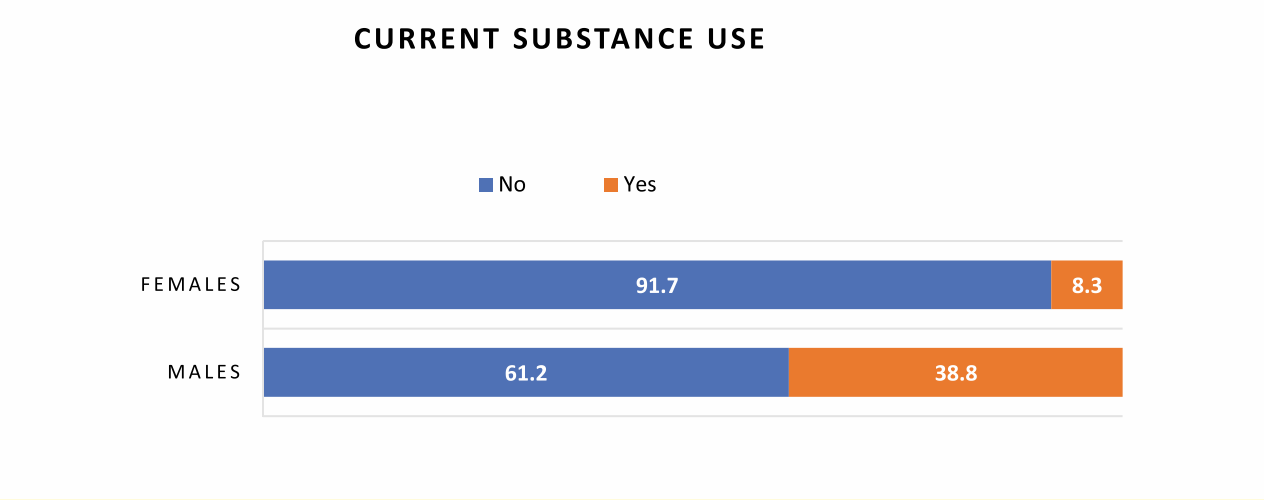
Substance use

The prevalence of lifetime (ever use) substance use of any type was 32.9% (95% CI 31.3-34.6) and current use (past 3 months) was 22.2% (95% CI 20.8-23.7). The commonest substances used included alcohol and tobacco, followed by cannabis. Risky use was primarily centred around alcohol and tobacco use. A significantly greater proportion of men were current user of substances than women (38.8% vs 8.3%; p<0.001).

"Addiction, at its worst, is akin to having Stockholm Syndrome. You're like a hostage who has developed an irrational affection for your captor. They can abuse you, torture you, even threaten to kill you, and you'll remain inexplicably and disturbingly loyal." ***– Ann Clendening***


Substance Use
Current use
0.03
0.03
0.1
0.2
0.1
0.3
0.9
15.8
13.4
Lifetime use
0.1
0.1
0.2
0.5
0.3
0.7
1.8
27
20.4
0
5
10
15
20
25
30
Opioids
Hallucinogens
Sedatives
Inhalants
Amphetamine
Cocaine
Cannabis
Alcohol
Tobacco


Risky Use of Substances
100
80
60
40
20
0
Tobacco
Alcohol
Cannabis
Cocaine
Amphetamine
Inhalants
Sedatives
Hallucinogens
Opioids
Low
Moderate
High



	Tobacco		Alcohol		Cannabis		Cocaine	
	N	%	N	%	N	%	N	%
Low	2,761	84.1	2,989	91.0	3,248	99.0	3,274	99.6
Moderate	427	13.1	244	7.5	31	0.9	7	0.3
High	94	2.9	49	1.5	3	0.1	1	0.03
MV	10		10		10		10	

	Amphetamine		Inhalants		Sedatives		Hallucinogens		Opioids	
	N.	%	N	%	N	%	N	%	N	%
Low	3,277	99.9	3,273	99.7	3,276	99.8	3,281	99.9	3,280	99.9
Moderate	4	0.1	9	0.3	6	0.2	1	0.03	2	0.06
High	1	0.03	0	0	0	0	0	0	0	0
MV	10		10		10		10		10	

Violence

The prevalence of lifetime (ever) experience of physical violence was 8.4% (95% CI 7.5-9.4) and current (past 12 months) experience of physical violence was 2.1% (95% CI 1.6-2.6). The prevalence of lifetime experience of psychological violence was 13% (95% CI 11.9-14.2) and current experience of psychological violence was 5.5% (95% CI 4.8-6.4).

"You are not the darkness you endured. You are the light that refused to surrender."

— John Mark Green

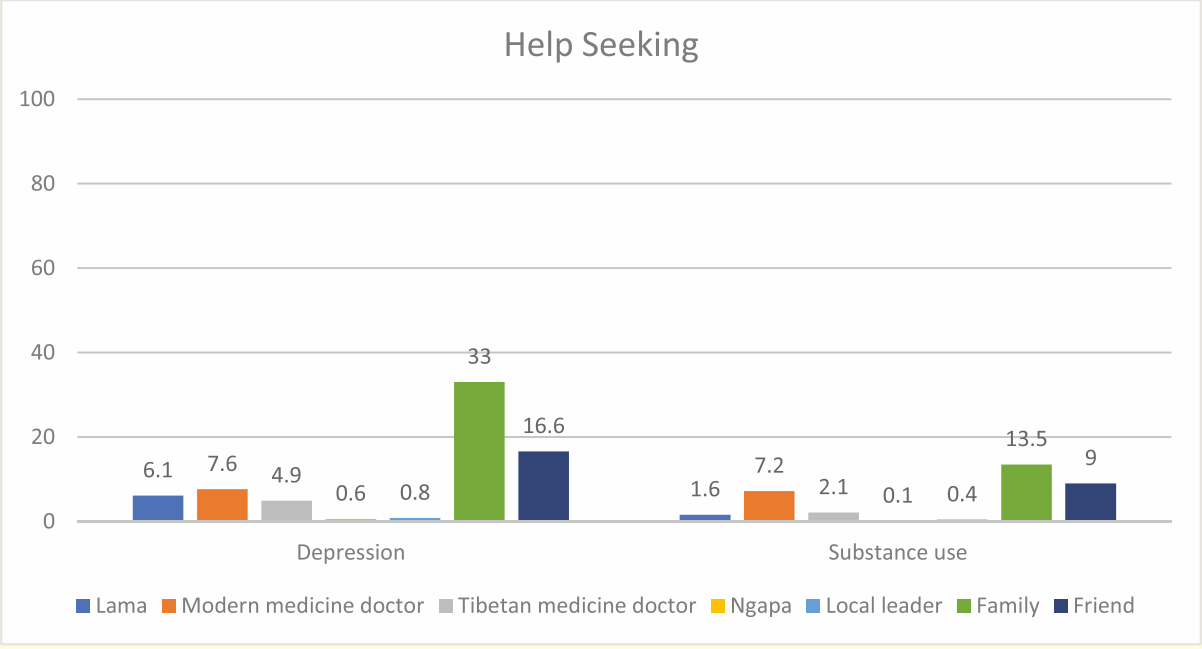

I am dangerous,
Am I mad?
what is wrong
with me?

Idioms of Distress

Some participants reported symptoms which are believed to culturally determined expressions of distress such as fullness in the abdomen (19.8%), shifting pain in the body (10.1%), or experiencing 'nerves' (11.7%) in the past one month. Compared to men, a significantly greater proportion of women reported fullness in the abdomen (22.7% vs 16.4%; p<0.001), shifting pain in the body (11.6% vs 8.5%; p=0.003) and experiencing 'nerves' (13.1% vs 10.1%; p=0.006) in the past one month

Help seeking

Overall, help seeking for symptoms of depression as well as substance use remains low. Compared to those with depression, help seeking in those with substance use is lower. For depression as well as substance use, help is generally sought most from family, followed by friends and doctors practising modern medicine.



Way Forward

Recommendations

The organisation and delivery of culturally-relevant, contextually adapted, comprehensive and integrated mental health services in the settlements will be a challenging but important priority for the CTA. We acknowledge that there will be no single or quick solution to achieve the goal of mental health for all. To achieve the goal, several strategies and activities will need to be integrated into the existing health and allied systems, in a planned and coordinated manner. Any such policies and programmes will have to be data driven and hence we expect the findings from this systematic survey with a standardised methodology to provide the necessary stimulus to develop a realistic and implementable roadmap for developing mental healthcare services in the settlements. The huge burden of mental health problems in the settlements, combined with poor access to evidence-based care, calls for immediate attention by the CTA and we hope that the data from this survey will help to highlight the high priority of mental health in the developmental agenda for the Tibetan community in India.

Based on the findings of this survey and lessons learnt from health systems in India as well as other similar developing countries we would like to make the following recommendations for the consideration of the CTA:

1. In consultation between the CTA and stakeholders in the settlements, there is an urgent need for formulating explicit action plans, to provide the widest possible coverage of mental healthcare to the residents in the settlements.
2. Mental healthcare should be horizontally integrated with other existing healthcare programmes within the settlements. The healthcare teams in the settlements should be provided with specific programme implementation support to enable this integration. Important components of this integration should include screening for common mental disorders, prevention and promotion strategies, and referral services.
3. All settlements should be supported to develop and implement a focused mental healthcare plan that includes specified and defined activity components, responsible agencies, budget requirements, indicators of success, and time lines for implementation.
4. There should be planned capacity strengthening of leaders and other relevant policy makers in mental health and related sectors (e.g. education) at the level of the CTA as well as the settlements. Human resource development for the mental health sector should be systematically planned and implemented over the next 10 years. This includes sensitisation of policy makers and leaders (in the CTA and settlements) in health and related sectors, training all existing and new healthcare workers in programme implementation, and building knowledge and skills of healthcare workers in the settlements to identify and provide care for those with mental health problems.
5. Human resource development will require planning and financing to develop strategic partnerships with other institutions for successful training and hand-holding in the initial stages.

6. Scaling up of mental health services within the settlements will require innovative solutions such as task-sharing with non-specialist health providers and traditional physicians and healers, and leveraging technology based solutions to provide training, allow access to clinical decision support systems, and bridge the last-mile to increase access to mental healthcare.
7. A longer term goal should be the development of more focused programmes to meet the unique needs of other demographic (e.g. children, adolescents, elderly) and clinical (e.g. addictions) groups.
8. Through partnerships with existing and accessible secondary and tertiary mental health centres in the public sector outside the settlements, it is important to create formal stepped care systems of care.
9. It is important to strengthen and maintain an efficient drug logistics system within settlements to ensure last-mile availability of necessary and appropriate psychotropic medications on an uninterrupted basis.
10. Dedicated funding needs to be apportioned for mental health programmes in the settlements with performance based timely disbursal, guaranteed complete utilisation, and streamlined mechanisms for oversight and accountability.
11. Support should be provided to overcome the economic barriers to help seeking for mental health problems. Examples of potential facilitators to overcome such barriers include allowing access to transport, direct payments, payment vouchers for economically weaker patients, and health insurance.
12. A register of mental health service providers (psychiatrists, psychologists, social workers, public and private mental health facilities) should be maintained (and regularly updated) for the area within which each of the settlements are situated.
13. Mechanisms should be established to remedy longstanding disabilities resulting from mental health problems. This could include creating facilities such as day care centres, economic and social protection (e.g. supported housing, unemployment benefits) especially for those with severe mental disorders and the homeless mentally ill, developing facilities for re-skilling, and microfinance schemes for those with mental health problems.

14. Considering the resource limitations allow focusing on a few conditions to begin with, prioritisation of depression and alcohol use disorders is recommended because of the prevalence rates as well as the comorbidity with other communicable and non-communicable diseases.
15. Evidence based interventions that could be considered include psychological interventions such as Behavioural Activation and Problem Solving Therapy for depression, and Brief Interventions based on Motivational Interviewing for alcohol use disorders. These interventions should be culturally adapted using systematic methods to ensure acceptability to the target population.
16. Programs should be designed to build mental health awareness, promote mental wellbeing, and early detection and treatment of common mental disorders such as depression and anxiety.
17. All mental health activities in the settlements should be rigorously, scientifically and continuously monitored with clearly defined processes, indicators and feedback mechanisms to allow continuous improvement of the programmes. A select set of indicators collected through routine systems should be standardised for uniform data collection and monitoring. An external independent evaluation of the mental health programmes in the settlements can be conducted every five years.
18. Further research should be conducted in the settlements to answer priority questions such as burden and impact of mental and substance use disorders in young people, systems research focusing on gaps in programmes, mapping the treatment gap, identifying contextually relevant risk and protective factors, understanding cultural explanatory models of mental health problems and how they intersect with the utilisation of mental health services, and understanding the direct and indirect economic impact of mental health disorders.
19. An Empowered Committee on Mental Health, comprising of professionals from mental health, public health, social sciences, education and related backgrounds should be constituted to provide strategic direction, oversee, support, facilitate, monitor, and review mental health programmes in close collaboration with the CTA.

"Feelings come and go like clouds in a windy sky. Conscious breathing is my anchor."

— ThichNhat Hang

CTA MENTAL HEALTH PROGRAM ONGOING ACTIVITIES

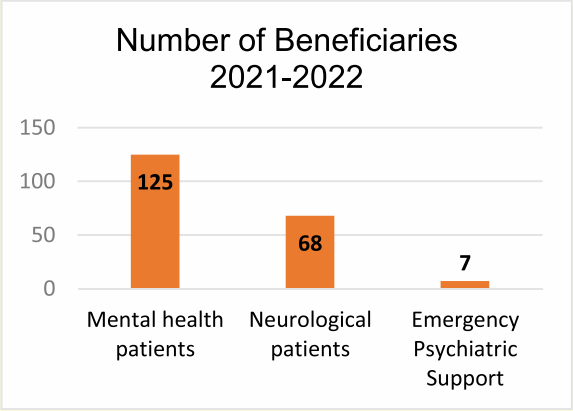
The Department of Health mental health program undertakes the following activities on mental health in the Tibetan settlements in India with support from PRM.

Mental health core committee meeting

The core committee comprises of Geshe Lhakdor, Dr. Tsetan Sadutshang, Dr. Tsewang Tamding, Dr. Carol Weingarten, Dr. Takako, and CTA DOHe Secretary.

Mental health treatment support

a) Mental health medication and counselling treatment support
b) Emergency psychiatric treatment support
c) People below the poverty line are provided 100 % medical treatment support
d) The top three mental health conditions are Depression, Schizophrenia and other psychotic disorder, and anxiety disorder.



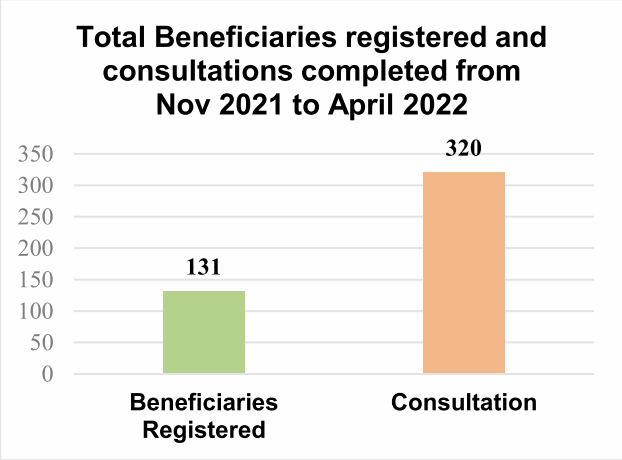
Neurological patient medication treatment support

a) The most common condition being Epilepsy with majority of the beneficiaries being males.

Pilot Telepsychiatry Project - Improving Access through telepsychiatry in Tibetan settlements (IMPACT-T)

a) The primary objective of this project is to improve access to mental health treatment and reduce existing treatment gap in the remote Tibetan refugee settlements in India. It is being piloted at the five southern Tibetan refugee settlements in India, namely Lugsam and Delar settlement in Bylakuppe, Mundgod Doeguling, Kollegal Dhondheling, and Hunsur Rabgyaling.

b) Its implementation started in November 2021 and is done in partnership with Sangath, Goa.



It is very easy. Good audio and video quality. It is very feasible to reach the psychiatrist. As per my experience, nurses and doctor both are well experienced and give treatment as per patient regular need. I am very thankful to be surrounded by the care system
- 32 years, Female, Mundgod

Mental Health Awareness Activities

a) Virtual wellbeing series on different mental health topics targeting youth, healthcare workers, school counsellors being held

b) Awareness in the Tibetan settlements in India

Different participatory activities being carried out in 18 Tibetan settlements in India under the initiatives of nurses.

c) Awareness activities in schools

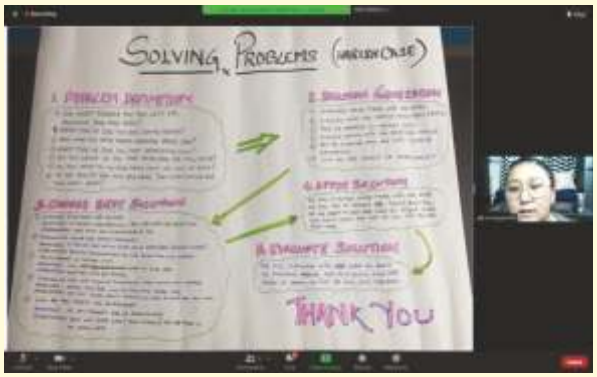
Poster-making, photo, video, and creative arts competition on mental health

d) World mental health day celebration done virtually and in the settlements

Mental Healthcare Training

a) Nurses trained on mental health counselling by Sangath

b) Nurses undergo weekly counselling supervision



c) Tibetan medicine doctors oriented on mental disorder and its treatment by Sangath

d) Basic mental health orientation to community leaders

Appendices

Consent form

SURVEY ON MENTAL HEALTH IN TIBETAN REFUGEES
Department of Health, Central Tibetan Administration (CTA)
Gangchen Kyishong, Dharamsala

Consent to participate in the Survey

Purpose

We invite you to participate in a survey. Your participation in this survey is completely voluntary. You have the right to refuse to participate anytime during the survey. You also have the right to not answer any questions with which you feel uncomfortable.

This study is being conducted by the Department of Health, CTA. Our aim is to understand the status of mental health in Tibetan refugees in India. We are conducting this study in all Tibetan refugee settlements. The Department of Health is initiating efforts to provide increased number of mental health care services in Tibetan settlements in exile. For that, your help through participation in this survey will provide beneficial information for the Department in understanding and planning an integrated mental health care system.

Please review/listen to the following information carefully before you decide to participate.

Procedures

Your participation in this study will include completing an interview conducted in private by a trained researcher (nurse). The interview is expected to take about 30 – 45 minutes of your time.

The researcher will ask for information such as your daily experiences, thoughts and feelings, substance and alcohol use (if applicable), and daily activities. He/she will also ask some basic demographic questions about you like age, gender, education and marital status, etc. that will help us have a holistic understanding of the mental health status of the Tibetan community in India.

Confidentiality

We assure you that the information that you share with us will be kept strictly confidential and will be used only for research purposes. All information that personally identifies you will be kept separately from research materials in a locked cabinet that only researchers have access to. Your name or address will not be included on any record of your interview. No identifying information will be used in any reports or publications that may result from the study.

Risks and Benefits of the Study

By participating in this study and answering our questions, you will not receive any direct benefit. Since the questions will be focused on your personal experiences and behaviors there are possible risks of you feeling upset while answering the questions. However, our researchers are trained to deal with such reactions in a sensitive manner and also refer appropriately if more intensive intervention is required.

Your participation in the survey will help increase our understanding of mental health and substance use problems in our Tibetan society in order to design and implement subsequent prevention and intervention policies and programs related to mental health and substance use problems for our community in exile.

Consent

Your participation in this study is completely voluntary. Your decision to participate or to withdraw will not affect any assistance you are currently receiving or may seek from us for health related problems. If you change your mind about participating during the course of the interview, you have the right to withdraw at any time. Please do not hesitate to ask any questions or to seek clarification.

If you have any questions about the study at any point or need further information, you can contact:

Sponsoring Organization
Ngawang Tenzin
Mental Health Program
DOHe, Central Tibetan Administration
Dharamsala
Email: mhdesk@tibet.net
Phone number: 01892-223486, 223408

Ethics Committee
Tsering Phuntsok
Chairperson of Ethics committee
Men-Tsee-Khang
Dharamsala
Email: rd@men-tsee-khang.org

STUDY ON MENTAL HEALTH IN TIBETAN REFUGEES

CONSENT FORM FOR PARTICIPANTS

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Participant ID: _____

Please tick the appropriate box	**Yes**	**No**
I confirm that I have been adequately explained and have clearly understood the information sheet for the above study and have had the opportunity to ask questions.		
I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.		
I understand that all information I share will be kept in a secure and confidential manner and will not be shared with anyone outside of the research team.		
I consent to being interviewed by the research team member.		
I understand that the findings from this survey might be used to design mental health interventions and policies for Tibetan community in exile.		
I understood the risks and benefits of the current survey.		
I consent that the findings of the current survey be written up for publication and presented at meetings/ conferences.		
I consent to be approached again for any follow up studies arising from this survey.		

Name of Participant	Date	Signature/Thumb Impression

If the participant is not literate, consent must be taken by his/her left thumb impression in the presence of a nominated witness of their choice.

Name of Witness and relationship to participant	Date	Signature/Thumb Impression
Name of person taking consent	Date	Signature

Questionnaire

1. Basic sociodemography

Baseline Sociodemographic Data

DATE: _____

PARTICIPANT ID: _____

INTERVIEWER ID: _____

1. Age: What is your date of birth?

   _____ (DD/MM/YYYY)
   Don't know…… ☐

   (If don't know, ask 2 otherwise skip to question 3)

2. What is your age? (In completed years)
   _____ Years
   Don't know…… ☐
   Refused…… ☐

3. Where were you born?

   India…… ☐ (Skip 4 and 5)

   Outside India…… ☐

   Don't know…… ☐ (Skip 4)

   Refused…… ☐ (Skip 4)

4. If born outside India, specify: _____
5. When did you arrive in India? _____ (Specify year)

   Don't know…… ☐

   Refused…… ☐

6. Settlement name: (Record by observation)

Bhandara.....	☐	Manduwala.....	☐
Bylakuppe.....	☐	Mainpat.....	☐
Bir.....	☐	Miao.....	☐
Clementown.....	☐	Mundgod.....	☐
Chauntra.....	☐	Odisha.....	☐
Dalhousie.....	☐	Pondoh.....	☐
Dekhyiling.....	☐	Puruwala.....	☐
Delhi.....	☐	Poanta.....	☐
Dolanji.....	☐	Raipur.....	☐
Dharamsala.....	☐	Rajpur.....	☐
Hunsur.....	☐	Ravangla	☐
Kullu.....	☐	Rewalsar.....	☐
Kollegal.....	☐	Sonada.....	☐
Kamrao.....	☐	Shimla.....	☐
Ladakh (Jangthang)	☐	Sataun.....	☐
Ladakh.....	☐	Tezu.....	☐
Lakhanwala.....	☐	Tenzingang.....	☐
		Tuting.....	☐

7. Have you moved/shifted before? Yes ☐ No ☐ (Skip 8)

8. If yes, how many times? _____

9. Which gender(s) do you identify with?

Male……. ☐
Female…… ☐
Other: _____ (Please specify)

10. What is your current marital status?

Never Married..... ☐

Currently Married..... ☐

Living with someone as a couple…….. ☐

Widow/Widower..... ☐

Separated/Divorced..... ☐

Refused….. ☐

9. What is your employment status?

Employed full time ☐

Employed part time ☐

Unemployed and currently looking for work ☐

Unemployed and not currently looking for work ☐

Student ☐

Retired ☐

Homemaker ☐

10. Highest level of education:

No formal schooling…….. ☐

Completed Primary……. ☐

Completed Secondary…… ☐

Completed Higher Secondary…… ☐

Graduate……..……. ☐

Post-Graduate…….……. ☐

Refused…….……. ☐

11. Religion: What religion are you?

Bon…….…..... ☐

Buddhist…….…..... ☐

Christian …….…..... ☐

Hindu…….…..... ☐

Muslim…….…..... ☐

None…….…..... ☐

Refused…….…..... ☐

Other (Please specify) _____

12. What is your monthly household income (in Rupees): _____

2. Patient Health Questionnaire (PHQ-9)

1. Over the ***last 2 weeks,*** how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
2. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, get along with other people?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
	☐	☐	☐	☐

Following are some problems that people generally experience in their life. Please read each questions and choose **one** option that suits you the best.

Q. When you have above problems, who do you seek help from? (Select all that applies)

Not ask for help..... ☐

Lama..... ☐

Doctor..... ☐

Tibetan medicine doctor..... ☐

Ngagpa..... ☐

Local leaders..... ☐

Family members..... ☐

Friends..... ☐

Others (Specify): _____

3. Hopkins Symptom Checklist (HSCL-25)

Listed below are some symptoms of strains that people sometimes have.
Please read each one carefully and check the answer which best reflects how much that symptom has bothered you during the **past week.**

		1 Not at all	2 A little	3 Quite a bit	4 Extremely
1.	Suddenly scared for no reason				
2.	Feeling fearful				
3.	Faintness, dizziness, or weakness				
4.	Nervousness or shakiness inside				
5.	Heart pounding or racing				
6.	Trembling				
7.	Feeling tense or keyed up				
8.	Headaches				
9.	Spells of terror or panic				
10.	Feeling restless, can't sit still				
11.	Feeling low in energy-slowed down				
12.	Blaming yourself for things				
13.	Crying easily				
14.	Loss of sexual interest or pleasure				
15.	Poor appetite				

16.	Difficulty falling asleep, staying asleep				
17.	Feeling hopeless about the future				
18.	Feeling blue				
19.	Feeling lonely				
20.	Thoughts of ending your life				
21.	Feeling of being trapped or caught				
22.	Worrying too much about things				
23.	Feeling no interest in things				
24.	Feeling everything is an effort				
25.	Feelings of worthlessness				

Q. When you have above problems, who do you seek help from? (Select all that applies)

Not ask for help..... ☐
Lama..... ☐
Doctor..... ☐
Tibetan medicine doctor..... ☐
Ngagpa..... ☐
Local leaders..... ☐
Family members..... ☐
Friends..... ☐
Others (Specify): _____

4. Culturally appropriate idioms of psychological distress

Listed below are some symptoms that people sometimes have.
Please read each one carefully and check the answer which best reflects how much that symptom has bothered you during the **past week.**

		1 Not at all	2 A little	3 Quite a bit	4 Extremely
1.	Feeling of fullness in the back				
2.	Feeling of nerves being rigid or stiff				
3.	Pain that shifts location				

5. WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include **disease or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs**. Think back over the **past 30 days** and answer these questions thinking about how much difficulty you had doing the following activities. For each questions, please circle only **one** response.

In the last 30 days, how much difficulty did you have in:						
Understanding and communicating						
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.3	Analysing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting around						
D2.1	Standing for long periods, such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do

D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do
D2.5	Walking a long distance, such as a kilometre (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do
Self-care						
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities- Household						
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all of the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities- School/Work						

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5-D5.8, below. Otherwise, skip to D6.1.						
Because of your health condition, in the past 30 days, how much difficulty did you have in:						
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.7	Getting all your work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.8	Getting all your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do
Participation in society						
In the past 30 days:						
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.2	How much of a problem did you have because of barriers or hindrances around you?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.4	How much time did you spend on your health condition or its consequences?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.6	How much has your health been a drain on the financial resources of you and your family?	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days ___
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days ___
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days ___

6. WHO's Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

INTRODUCTION (Please read to participant)

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PARTICIPANT

Question 1

In your life, which of the following substances have you ever used? ***(NON-MEDICAL USE ONLY)***	**No**	**Yes**

Probe if all answers are negative: "Not even when you were in school?"	***If "No" to all items, stop interview. If "Yes" to any of these items, ask Question 2 for each substance ever used.***	
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Question 2

In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7

g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the <u>past three months</u>, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3

b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you <u>ever</u> tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months

Have you <u>ever</u> used any drug by injection? ***(NON-MEDICAL USE ONLY)***	0	2	1

IMPORTANT NOTE:

Participants who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING		INTERVENTION GUIDELINES
Once weekly or less or **Fewer than 3 days in a row**	⇨	**Brief intervention including "risks associated with**
More than once per week or **3 or more days in a row**	⇨	**Further assessment and more intensive treatment**

Q. When you have above problems, who do you seek help from? (Select all that applies)

Not ask for help..... ☐
Lama..... ☐
Doctor..... ☐
Tibetan medicine doctor..... ☐
Ngagpa..... ☐
Local leaders..... ☐
Family members..... ☐
Friends..... ☐
Others (Specify): _____

B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card- substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)

c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
i. Opioids (heroin, morphine, methadone, codeine, etc.)
j. Other – specify:

Response Card (ASSIST Questions 2 - 5)

Never: not used in the last 3 months

Once or twice: 1 to 2 times in the last 3 months

Monthly: 1 to 3 times in one month

Weekly: 1 to 4 times per week

Daily or almost daily: 5 to 7 days per week

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

7. Spirituality

Partcipant ID: Interviewer ID:

Spirituality questionnaire

Following are some questions about spirituality. Kindly select one option that suits you the best.

1. How spiritual do you consider yourself to be? (Instruction for interviewer: Circle the option selected by the participant)

Very	Moderately	Somewhat	Not at all
1	2	3	4

2. How often do you recite prayers? (Instruction for interviewer: Circle the option selected by the participant)

Several times a day	Once a day	A few times a week	Only on certain occasions	Never
1	2	3	4	5

3. How often do you practice meditation? (Instruction for interviewer: Circle the option selected by the participant)

Several times a day	Once a day	A few times a week	Only on certain occasions	Never
1	2	3	4	5

4. How often do you visit local temples and other places of spiritual significance within your community? (Instruction for interviewer: Circle the option selected by the participant)

Several times a day	Once a day	A few times a week	Only on certain occasions	Never
1	2	3	4	5

5. Do you consider Karma in the course of your daily life? (Instruction for interviewer: Circle the option selected by the participant)

Regularly	Occasionally	Rarely	Not at all
1	2	3	4

6. Does any religious practice give you peace of mind? Yes ☐ No ☐ (Skip to 7)

If yes, kindly specify: _____

6.A. How often do you do this practice?

Several times a day	Once a day	A few times a week	Only on certain occasions
1	2	3	4

6.B. How much peace of mind does it give to you?

A lot	Moderate	Somewhat	A little	Not at all
1	2	3	4	5

7. In the past one year, how many times did you attend/receive religious teaching?

No. of times:	

8. Violence

Participant ID: Interviewer ID:

Interpersonal violence questionnaire

In their lives, many people experience forms of violence from partners, close family members, and others including strangers. I would like to briefly ask you about some of these situations if they have happened with you. The following questions are sensitive but we assure you that everything you say will be kept private and will not be disclosed to anyone, including your family members. It is completely up to you whether to provide any information about your partner, other family members or others.

The next questions are about things that happen to many people, and that anyone may have done to you. (Instruction for interviewer: Circle the options selected by the participant)

1	Has anyone, [**specify (optional):** _____] ever done the following things to you?	A) (**If YES continue with B. If NO, skip to next item**)		B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**)		C) In the past 12 months, would you say that this has happened once, a few times or many times? (**After answering C, skip D**)			D) Before the past 12 months, would you say that this has happened once, a few times or many times?		
		YES	NO	YES	NO	One	Few	Many	One	Few	Many
	a) Insulted or humiliated you in front of other people?	1	2	1	2	1	2	3	1	2	3
	b) Did things to scare or intimidate you on purpose (e.g. by the way he/she looked at you, by yelling and smashing things)?	1	2	1	2	1	2	3	1	2	3
	c) Threatened to hurt you or someone you care about?	1	2	1	2	1	2	3	1	2	3

2	Has anyone, [**specify (optional):** _____] ever done the following things to you?	A) (**If YES continue with B. If NO, skip to next item**)		B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**)		C) In the past 12 months, would you say that this has happened once, a few times or many times? (**After answering C, skip D**)			D) Before the past 12 months, would you say that this has happened once, a few times or many times?		
		YES	NO	YES	NO	One	Few	Many	One	Few	Many
	a) Slapped you or thrown something at you that could hurt you?	1	2	1	2	1	2	3	1	2	3
	b) Pushed you or shoved you?	1	2	1	2	1	2	3	1	2	3
	c) Hit you with her/his fist or with something else that could hurt you?	1	2	1	2	1	2	3	1	2	3

	d) Kicked you, dragged you or beaten you up?	1	2	1	2	1	2	3	1	2	3
	e) Choked or burnt you on purpose?	1	2	1	2	1	2	3	1	2	3
	f) Threatened to use or actually used a knife or other weapon against you?	1	2	1	2	1	2	3	1	2	3

(Instruction for the interviewer: If the participant answered NO to all of the above, stop the interview. If they chose YES to any one question, ask question 3 and 4)

The next two questions are about your help-seeking behavior in above situations. (Instruction for interviewer: Circle the option(s) selected by the participant)

3	Who have you told or asked for help about your experience? MARK ALL MENTIONED	NO ONE.....A FRIEND(S).....B FATHER.....C MOTHER.....D BROTHER .....E SISTER.....F UNCLE.....G AUNT.....H HUSBAND/ PARTNER'S FAMILY.....I CHILDREN.....J NEIGHBOUR(S).....K POLICE.....L DOCTOR.....M OTHER HEALTH WORKER(S).....N LAMAS.....O NGO WORKER.....P LOCAL LEADER.....Q OTHER_____ .....R

4	If you did not seek help why did you not seek help? MARK ALL MENTIONED	DONT KNOW/ NO ANSWER.....A FEAR OF THREATS/MORE VIOLENCE.....B VIOLENCE NORMAL/VIOLENCE NOT SERIOUS.....C EMBARRASED/ASHAMED/AFRAID WOULD NOT BE BELIEVED OR WOULD BE BLAMED.....D BELIEVED WOULD NOT BE HELPED/KNOW OTHER PERSON NOT HELPED.....E AFRAID WOULD END RELATIONSHIP.....F AFRAID WOULD LOSE CHILDREN.....G BRING BAD NAME TO FAMILY.....H OTHER _____.....O

References

1. Alexander B, David E, Grills N. **High prevalence of anxiety disorders among adolescent Tibetan refugees.** *Asian journal of psychiatry* 2013; 6(3):218-221.

2. Crescenzi A, Ketzer E, Van Ommeren M, Phuntsok K, Komproe I, de Jong JT. **Effect of political imprisonment and trauma history on recent Tibetan refugees in India.** *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies* 2002; 15(5):369-375.

3. Evans D, Buxton DC, Borisov A, Manatunga AK, Ngodup D, Raison CL. **Shattered Shangri-la: differences in depressive and anxiety symptoms in students born in Tibet compared to Tibetan students born in exile.** *Social psychiatry and psychiatric epidemiology* 2008; 43(6):429-436.

4. Holtz TH. **Refugee trauma versus torture trauma: a retrospective controlled cohort study of Tibetan refugees.** *The journal of nervous and mental disease* 1998; 186(1):24-34.

5. Sachs E, Rosenfeld B, Lhewa D, Rasmussen A, Keller A. **Entering exile: Trauma, mental health, and coping among Tibetan refugees arriving in Dharamsala, India.** *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies* 2008; 21(2):199-208.

6. Servan-Schreiber D, Le Lin B, Birmaher B. **Prevalence of posttraumatic stress disorder and major depressive disorder in Tibetan refugee children.** *Journal of the American Academy of Child & Adolescent Psychiatry* 1998; 37(8):874-879.

7. Kroenke KS, Spitzer RL. **The PHQ-9: a new depression diagnostic and severity measure.** *Psychiatr Ann* 2002; 32.

8. Patel V, Araya R, Chowdhary N, King M, Kirkwood B, Nayak S, et al. **Detecting common mental disorders in primary care in India: a comparison of five screening questionnaires.** *Psychol Med* 2008; 38:221-228.

9. Lhewa D, Banu S, Rosenfeld B, Keller A. **Validation of a Tibetan translation of the Hopkins symptom checklist–25 and the Harvard trauma questionnaire.** *Assessment* 2007; 14(3):223-230.

10. Organization WH. **World Health Organization disabilty assessment schedule: WHODAS II. Phase 2 field trials. Health services research**. 2000.

11. Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S, et al. **Effectiveness of an intervention led by lay health counsellors for depressive and**

anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. *Lancet* 2010; 376:2086-2095.

12. Group WAW. **The alcohol, smoking and substance involvement screening test (ASSIST): development, reliability and feasibility.** *Addiction* 2002; 97(9):1183-1194.

13. Humeniuk R, Ali R, Babor TF, Farrell M, Formigoni ML, Jittiwutikarn J, et al. **Validation of the alcohol, smoking and substance involvement screening test (ASSIST).** *Addiction* 2008; 103(6):1039-1047.