

INSTITUTE OF MENTAL HEALTH & NEUROSCIENCES, KASHMIR



Humanitarian Aid and Civil Protection



Mental Health Illness in the Valley

A Community-based Prevalence Study of Mental Health Issues in Kashmir

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Kashmir

Institute of Mental Health & Neurosciences, Government Medical College, Srinagar **ActionAid India**

MENTAL HEALTH ILLNESS IN THE VALLEY: A COMMUNITY-BASED PREVALENCE STUDY OF MENTAL HEALTH ISSUES IN KASHMIR

This study was undertaken by the Institute of Mental Health and Neurosciences (IMHANS), Kashmir, and was commissioned by ActionAid Association with the support of Directorate-General for Humanitarian Aid and Civil Protection (ECHO). The study was principally led by Dr. Arshad Hussain at IMHANS Kashmir. We would like to acknowledge support and guidance received from Prof. Rafiq Ahmad Pampori, Prof. Kaisar Ahmad, Dr. Mohammad Maqbool Dar, Dr. Zaid Ahmad Wani, and Dr. Yasir Hassam Rather. We would also wish to thank from ActionAid Sehjo Singh for her support in the editing of this report, as well as to Naseer Magrey, Shafia Naqshbandi and Tabia Muzaffer for their support. J&K Yateem Trust also extended their logistic support in the field. The cover photo is by Afzal Sofi and cover design by Nabajit Malakar. A special thanks to Tanveer Dar for his entire support in bringing this report.

By

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Foreword

Since the introduction of specified diagnostic criteria for mental health disorders, there has been a world-wide rapid expansion in the number of large-scale mental health surveys providing population estimates of the prevalence of common mental health disorders. Despite a substantial degree of inter-region heterogeneity the findings have consistently confirmed that common mental disorders are highly prevalent globally, affecting people across all regions of the world. However, a majority of mental health disorders continue to remain largely untreated in low and middle-income countries because of access and resource-related barriers. Prolonged large-scale violent conflict further exacerbates the problem by increasing the prevalence of mental illness and by reducing access to care. The State of Jammu and Kashmir has been witness to a conflict for more than 25 years. The fury unleashed by natural disasters (snowstorm, earthquakes and the devastating floods of 2014, to recount a few) during the same time cannot be undermined either. The amount of trauma incurred hence remains anything but hard to imagine. In this socio-political context, it is important and highly relevant for the public policy to know the extent of mental health disorders prevalent in the population.

This community based prevalence research study on 'Mental Health Issues in Kashmir' commissioned by ActionAid India and ably conducted by eminent clinician/ researcher Dr. Arshad Hussain and his associates at the Institute of Mental Health and Neurosciences-Kashmir is a laudable effort and extremely important. The study has been carried using scientific methods and a rigorous process of data collection.

This study has confirmed alarming levels of mental health disorders in the population of Kashmir; 11.3% of the respondents were suffering from a mental health disorder which is significantly higher than the Indian national average. The report has also analyzed the prevalence of mental health disorders across different socio-economic groups and found a higher prevalence among those who were poor, among women, and those who were low educated. The study has also looked into 'active suicidality' which is an associated condition with many mental health disorders and represents a serious situation. It has indicated that active suicidality was found in 9% of the morbid people (those who had any mental illness), and in 1.8% of the total

respondents. The study has also found a disturbing high treatment gap of about 88% with only 6.4% of suffering population having received treatment by a qualified mental health professional (from a psychiatrist).

The report provides a rich analysis of the mental health issues in the Valley. It has also come up with useful recommendations for the state government to consider and has enlisted a number of areas which needs further research and exploration. Given the alarming levels of mental health disorders in the Valley, it is important that the Government initiates some of the comprehensive, community based and sustainable measures to address mental health illness without any further delay. Additionally, the situation also demands the involvement of many NGOs to increase awareness, improve access to services, help people to access food and livelihood entitlements, undertake advocacy, provide counselling, etc.

Although this study has provided a point prevalence of mental health disorders of the adult population in the Valley, one-year and lifetime prevalence estimates would have aided to get a more comprehensive view of the problem. Equally important is to look into mental health issues faced by children. Investigating these aspects with the help of enhanced research support to the team in future will be worthwhile to guide and facilitate development and implementation of comprehensive policies and programmes relevant to address the increasing mental health needs of the people in Kashmir, as well as to contribute to the limited research on mental health in areas of conflict.

> Prof. Mushtaq Ahmad Margoob Ex-HoD of IMHANS-Kashmir

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1. Background of the Study

WHO estimates point out that 1 in 4 people in the world will be affected by mental or neurological disorders at some point of time in their lives. In 2001, it estimated that around 450 million people suffered from such conditions. Further, mental disorders were among the leading causes of ill health and disability worldwide. Just the depressive disorders are considered fourth in the leading causes of global burden of diseases (WHO, 2001). Mental health issues accounted for 12% of the total Disability Life Adjusted Years (years lost due to diseases and injuries) in 2000 (Tabish, 2005). In the United Kingdom over 2.5 lakh people are admitted into Psychiatric facilities each year, and more than 4,000 people kill themselves. According to the NIMH (National Institute of Mental Health, USA) mental disorders are "common in the USA and internationally". Approximately 57.7 million Americans suffer from mental health disorders in a given year and that is approximately 26.2% of adults. However, the main burden of illness is concentrated in about 1 in 17 people (6%) who suffer from a mental disorder also suffer from another mental disorder at the same time (Kessler, et. al, 2005).

A systematic review and meta-analysis of the data published from 1980 to 2013, including 174 surveys cutting across 63 countries, observed alarming levels of prevalence of mental health issues in the population. The paper estimated that almost 17.6% population were suffering from common mental health disorders during the last 12 months preceding the surveys. In fact, the paper also noted that the lifetime prevalence was much higher; 29.2% of respondents were identified experiencing a mental health disorder at some time during their life (Steel et. al, 2014).

Patel and Kleinman (2003) paper gives a different perspective on the distribution of mental health disorders among poor population. Patel and Kleinman reviewed the evidence published since 1990 on the association between poverty and mental health disorders in developing countries. They found that a statistically significant relation exists between mental health disorders and poverty related indicators including low incomes, lack of material possessions, lack of employment, housing difficulties and low education levels. These findings are important and are parallel to a huge research base coming out in support of socio-economic determinants of

health. Even in the context of Kashmir, whatever limited evidence is present on the patterns of mental health issues in the population, it indicates the association of poor socio-economic conditions and mental illness.

Steel et. al (2014) in their systematic review and meta-analysis of the data published from 1980 to 2013 also found a consistent gender differential in the prevalence of common mental health disorders with women having higher rates of mood (7.3% : 4.0%) and anxiety disorders (8.7% : 4.3%) than men during the past 12 months preceding the survey.

In the context of India, not much literature on the issues of mental health disorders has been available, and the published data is very minimal. Ganguli reviewed fifteen epidemiological studies on prevalence of mental illness in India and estimated that the national prevalence rate of all mental health disorders was 7.3% in India. Shizophrenia was prevalent among 0.25% population; affective disorders (including depression, psychotic and neurotic disorders) were prevalent in 3.4% of the population; and anxiety neurosis was prevalent in 1.65% of the population (Ganguli, 2000).

Although treatments are available, nearly two thirds of people who are diagnosed with mental disorder aren't able to seek treatment. The reasons of stigma, discrimination, neglect and inaccessibility prevent people with mental disorders to seek care and treatment. However, in low and middle income countries, mental health services are inadequate and accessibility to mental health services remains a major issue (WHO, 2001).

Mental health is determined by a variety of factors ranging from socio-economic, biological to cultural factors. One of the major factors has been the increasing turmoil across the world. Studies have shown that the presence of armed conflict has a detrimental impact on mental wellbeing of the population because of the exposure to frequent traumatic events as well as due to the indirect effect on socio-economic factors. As a result, in places ridden by conflicts, prevalence of mental health disorders is very high. Jammu and Kashmir is one of the areas that have witnessed armed conflict and research has pointed to an increasing prevalence of mental health disorders.

1.1. Mental Health Issues in Kashmir:

Jammu and Kashmir (J&K) holds a special status in the prominent public imagination for its beauty. But looking beyond the natural beauty that Kashmir is embraced with, it envelops in its shade tremendous sufferings. From a young child to an elderly person, one can see the signs of high levels of stress inside them. At this age when children are expected to enjoy stress free lives they are seen role playing with guns, enacting dead bodies, discussing blood and revenge.

Kashmir has been witness to different phases of violence and conflict, especially over the last two and half decades. As a result, tens of thousands lost life directly to conflict and thousands got disappeared, and many more faced torture and injuries. The freedom of people was curbed with its implications on the people especially women. Many people either lost jobs or were unable to find alternate livelihoods. The killing and disappearances of thousands of people have resulted into new marginalized groups of widow headed households, orphans, elderly without any support, disabled and has also accentuated the marginalization of already marginalized like labour and landless class. Either they lost an earning hand in the family or simply lost work avenues, lost access to forests, to market, and to other places where they could find some work. The exposure of people to violence remains very high in Kashmir with people witnessing cross fires, raids, torture, sexual assaults, forced labour, arrests, maltreatment, disappearances and killings (Schofield, 2000; Jong, 2008). The fear of violence forced many of them to leave their work and be close to their families. In some of the far off and rural areas, the political situation resulted in increased number of children dropping out from schools, which has further entrapped families into poverty. In this context, the NSSO data on higher unemployment rate in the state at 5.3 per cent against a national rate of 2.6 per cent in 2009-10 (Govt. of J&K, 2012-13) doesn't surprise. Although political situation has improved a bit now from what it was in 1990s, Kashmir is still one of the most militarized regions in the world.

In brief, conflict has resulted into many structural constraints and has created many barriers that shape the access of people to employment, livelihood and essential services, thereby, affecting people directly as well as indirectly. This multi-dimensional impact of prolonged conflict is also augmented by other natural disasters that Kashmir has been vulnerable to, including earthquakes and floods, affecting tens of thousands of people across Kashmir with severe loss of life, property, infrastructure, livelihoods, shelters, land, trees, livestock and crop.

The macro data indicates that J&K lags behind in many of the development indicators as compared with rest of India including literacy rate, roads, per capita incomes, agriculture, employment opportunities, etc. Dar (2012) stated, "In 2001, J&K had only 55.52% literacy rate, a 9.3% difference with the Indian level, which stood at 64.84% (RGI, 2001). Recent provisional figures from the 2011 Census continue to show this pattern. A 5.3% difference remains between J&K (68.7%) and India (74%) in literacy rates (RGI, 2011). Further, 80 per cent of the population of the state is dependent on agriculture directly or indirectly (Zargar, 2008). But 97 per cent of the farmers are small or marginal farmers with an average land holding of 0.7 hectares (Alam, 2008). The per capita income of the state at Rs.17,174, is only two thirds of the national average of Rs 25,907 in India taken as a whole (Dar, 2009). The road length per 100 sq km area in the state is 35.71 kms as against 104.64 kms in India (Kashmir Newz Board, 2007). There has been a worrying deceleration of agricultural production in the state. The valley suffers from a 44 per cent deficit in food grain production, 33 per cent in vegetables and 69 per cent in oilseeds, all of which are imported into the state from the rest of India" (Dar, 2012, pp.2-3).

As a consequence of this unfavourable socio-political situation that has emerged in Kashmir, one important concern has been its huge impact on the psychological well being of the people. There is a direct relation between exposure to trauma and worsening conditions of livelihoods, shelter, health, education, etc. with mental health. Although mental wellbeing has been an underresearched area in the context of Kashmir, the data from some of the rare studies and Out-patient department (OPD) observations in state's major hospitals in Srinagar showed a trend in the mental illness emerging in the valley. The major mental disorders that became common among Kashmiri people included major depressive disorders, dysthymia, schizophrenia, Post-Traumatic Stress Disorder, bipolar disorders, and anxiety disorders- phobias, OCD, agoraphobia and generalized anxiety disorder. In addition, certain conditions associated with mental health issues like increasing substance abuse and active suicidality also pointed towards increasing mental health problems in Kashmir.

The signs of deteriorating mental health in Kashmir also came from MSF's (Medecins Sans Frontieres) study in 2005. The study pointed out that the levels of despair, unhappiness and hopelessness had increased tremendously to the level that almost 34 percent of the people interviewed in the study reported that they were unhappy to the extent to having thoughts about ending their life. Further, 73.3% interviewees reported witnessing and 44.1% reported directly experiencing themselves, physical and psychological mistreatment. At the time of interview, almost half (48.1%) of the respondents said they felt only occasionally or never safe. Further, high rates of physical complaints including headaches (23.5%), body pains such as joint and back complaints (20.5%), and abdominal complaints (16.9%) were mentioned (MSF, 2006). Though this study didn't classify these findings in terms of mental health disorders, it did point out to the increasing and alarming symptoms of deteriorating mental health.

Another study conducted by Jong et. al in two districts of Kashmir-Kupwara and Budgam- in 2005 on 510 individuals found that almost a third of them (33.3) had symptoms of psychological distress (with symptoms like nervousness, tiredness, easily frightened, regular headaches, sleep disturbances, being unhappy, crying, lost interest in things, etc.), with women experiencing such issues significantly higher than men. Alarmingly, the study found that one third of the respondents (33.3%) had considered ending their life in the past 30 days prior to survey (Jong et. al, 2008). Suicidality is known to be an associated condition with mental health disorders, and such higher levels of respondents contemplating suicide indicate the severity of the psychological distress in people. The study observed poor socio-economic conditions and self-rated poor health being associated with high levels of psychological distress (Jong et. al, 2008).

The study conducted by Margoob et. al in 2004-05 on the community prevalence of trauma (13 types) in Kashmir revealed that lifetime prevalence of traumatic experience was among 58.69% respondents. Among the traumas, the exposure to fire or explosion was highest, 81.37% among those who had experienced any trauma. As Kashmir has also been witness to many other natural disasters, the lifetime prevalence of exposure to natural disasters was also high; prevalent within 13.56% of the respondents (Margoob et. al, 2006a). The studies have also shown a close association between exposure to trauma and mental health disorders. A study conducted on 100 children diagnosed with mental health related disorders pointed out the impact of armed conflict

on mental wellbeing of children. 49% of these children had experienced traumatic events in the form of killing of a close relative, 15% witnessed arrest and torture of a close relative, 11% witnessed night raids, 14% were caught up in cross firing, and 4% had been beaten up/tortured (Khan & Margoob, 2006).

Another study conducted on 76 inmates, who were orphans and in the age-group of 5 to 12 years, of a girl's orphanage in Srinagar found that 42.10% of them suffered from different mental health disorders; Post Traumatic Stress Disorder (PTSD) being present in 13 and major depressive disorder was present in 8 of the children who were living in this orphanage. This high prevalence of mental health disorders among these children could be because of the facts that all of them had lost their father when they were very young and belonged to lower socio-economic class, which are risk factors associated with mental health disorders (Margoob, et. al, 2006b). Another study conducted on 56 children diagnosed with PTSD and seeking treatment from the State Psychiatric Diseases Hospital, Srinagar observed that 75% of them had witnessed a traumatic event (Margoob et. al, 2006c). These studies indicate a strong relationship between exposure of children to traumatic conditions and mental health issues.

These studies pointed to the different mental health issues Kashmiri population was suffering from at different points of time, but failed to present scientific evidences on estimates of these issues. In such direction, a community study by *Margoob and Ahmad* on the prevalence of PTSD was conducted in 2003-05 through all the districts of Kashmir on 2391 randomly selected respondents was an alarming one. The study revealed a much higher prevalence of PTSD in Kashmir valley than expected. The study estimated that 7.27% respondents suffered from PTSD at the time of the survey (current prevalence), and 15.19% of respondents suffered from PTSD sometime in the life (lifetime prevalence) [Margoob and Ahmad, 2006].

As mentioned earlier that Kashmir has also witnessed natural disasters which also increase vulnerability of people to mental health issues. A study conducted in a village devastated by snow storm in 2005 leading to death of 164 people, indicated a very high vulnerability of survivors to mental health issues. The study followed up 142 survivors of the village for 3 months post disaster and observed trends in symptoms of mental health illness. The study didn't,

however, classify symptoms as mental health disorders since many of these symptoms may disappear with time. Although the symptoms gradually subsided, it was observed that traumatic, depressive, and somatic and anxiety symptoms were common even after three months of disaster. After 3 months, 53% respondents reported re-experiencing same event (through nightmares/flashbacks); 87% were avoiding the place of event; 32% were sad, 87% experienced sleep disturbances; 32% felt muscular skeletal pain; 40% gastro intestinal; 50% experienced headache; 40% had generalised worry and apprehensions; and 20% with isolated phobias (Hussain and Margoob, 2006). This study other than showing that a significant proportion of survivors continued to be struggling with mental health issues even after 3 months of disaster. Those who are marginalised, less educated, poor, happen to be women and those who lack social support are more vulnerable and likely to be unable to cope up.

These studies referred above reveal that a significant proportion of the population suffers from psychological distress in Kashmir. Although studies are not available to compare pre-conflict period to post conflict state of mental health, OPD records in various hospitals indicate a tremendous surge of mental health issues in Kashmir. Margoob in his paper presented in a Seminar stated that only an average of 6 people per day would seek OPD services from the State Psychiatric Hospital in Srinagar in 1990 and this increased to an average of 250-300 a day during 2000 (Scholte, 2001). The phenomenal increase in psychological problems was also indicated by tremendous rise in the number of psychiatric patients attending the Government Psychiatric Hospital in Srinagar. The OPD records show that 775 people attended State Psychiatric Diseases Hospital, Srinagar in 1985, which was the lone hospital in Kashmir where psychiatric services were available, and this increased to 1, 30,000 in 2015 in two state hospitals including State SMHS Hospital and State Psychiatric Hospital in Srinagar (both affiliated with GMC Srinagar) [Nissa, 2015]. ActionAid's community health camps where all people who come to seek treatment are screened for mental health issues also show that a higher proportion of people in Kashmir suffer from minor to severe mental illness. This prevalence is much more among those who are directly affected by conflict in terms of any of their family member being killed or disappeared (Dar, 2015a). PTSD has been reportedly unknown in Kashmir pre-1990/pre-conflict (Margoob and Ahmad, 2006), and its surge in post-1990s period indicates that the prevalence of mental health disorders has increased in Kashmir to a large extent and PTSD in particular.

Mental health issues just do not remain limited to the persons who suffer but also leads to intergenerational trauma through a cycle of increased stress in families, declining socioeconomic conditions, health care burden, anger, breakdown of families (therefore, of support systems), and inability to take care of children, marital issues, domestic violence, and so on. In worst case scenarios, it also leads to social isolation leading to further social exclusion and stigmatization. Therefore, it perpetuates a cycle of trauma and stress further. Its economic implications are also tremendous. Annualized work loss due to major depressive disorder in education, bank and health sectors in Kashmir is 56 days (Hussain, 2008a). In lower socioeconomic classes the costs are catastrophic. This is more serious because mental-health-problems in Kashmir are afflicting productive age groups furthering the economic burden (Hussain, 2015). A study conducted by Wani and Margoob on 221 family members of 50 PTSD patients, who were on treatment from State Psychiatric Diseases Hospital, Srinagar revealed that a majority of them (62%) had developed mental illness. PTSD being common with 32.12% of family members suffering from it at the time of survey, major depressive disorder affected 19.45% and generalised anxiety disorder affected 4.5% of the family members. Importantly, this study revealed that those who were not educated (46.7%) were more vulnerable to PTSD than those who were educated (17.8%); and similarly women were 2.29 times more vulnerable to PTSD than men (Wani and Margoob, 2006). The findings of this study indicate that there is a high probability that other family members might be at risk of developing mental health issues.

Despite the fact that mental illness has increased in Kashmir drastically over the last two and half decades, the primary mental health services have seen little improvement. In fact, the Primary Health services hardly have a component of mental health care. The secondary and tertiary Government hospitals also have inadequate numbers of psychiatrists. Nor does any major community based mental health intervention exist.

Realising that there was a high treatment gap, Government of India had initiated a National Mental Health Programme (NMHP) in 1982 to ensure availability and accessibility of mental health for all, particularly to the vulnerable and underprivileged sections. Under this flagship programme, Government of India launched a District Mental Health Plan (DMHP) in 1996 with the intention to provide community based mental health services and to integrate mental health services with generalised services. The program was subsequently expanded to 123 districts across country, and was initiated in four districts of Jammu and Kashmir in 2004-2005, but all falling in Jammu region (Government of India, n.d). Within Kashmir, mental health services are localised mostly in urban areas. Lately the mental health services at state level have seen improvements with the State level Government Psychiatric Diseases Hospital, Srinagar being upgraded to an Institute of Mental Health and Neurosciences (IMHANS).

Further, due to lack of awareness, high stigmatization about mental health issues and lack of socio-economic and physical access, whatever services are available remain underutilized. ActionAid's psychosocial project which has been implemented in Kashmir since 2004 has also demonstrated that the mental health services remain majorly inaccessible to people with mental illness and belong to far off areas due to a variety of factors. The inability to seek treatment also worsens the situation, and the illnesses that were mild, preventable and/or treatable drift to severe stages, and increases disability induced by mental health disorder.

The culmination of factors ranging from direct exposure to violence to being affected by deteriorated socio-economic conditions, impact of floods as well as lack of services is expected to result into increasingly higher experiences of mental health issues among people in Kashmir, as pointed out by the research as well as indicated by OPD records.

1.2. Issues for Research:

The review of literature and data suggests that conflict and related processes have led to a multidimensional impact of people in Kashmir. The questions of access of people to essential services, livelihood and employment, and about socio-economic conditions and the ways people have lived within such situations are important to be explored but have not been researched. Health is one of the areas of neglect in Kashmir from research point of view. Even though it is now widely recognised that mental health issues have increased tremendously in Kashmir, but the linkages of political problems and mental health hasn't been explored. Access issues to mental health services also raise questions.

With some estimates of the prevalence of mental illness claiming up to 40 percent, there is a need to understand the levels of mental illness and answer the question whether such higher levels do actually exist in community and to what extent are they related to conflict situation in Kashmir. There has been only one community prevalence study so far but it focused on only PTSD disorder. The other two studies by MSF and Jong et. al in 2005 have only looked at psychological distress and didn't classify symptoms into mental health disorders. Most of the research studies focusing on the mental health issues in Kashmir have been institutional (hospital) centric or targeted on some of the vulnerable groups, therefore, not presenting a scientific estimate of the problem that exists in a wider population. Information about the untreated mental health morbidity (illness) is also not available.

Overall, the question around prevalence of mental health disorders and accessibility of mental health services have remained under-researched in the context of Kashmir, creating a knowledge gap in academic discourse, as well as in public policy thinking. Similarly, the questions on the impact of mental illnesses itself on individuals and families in relation to their socio-economic functioning, and in wider processes of development are important to understand and explore. The questions about the association of mental illness and gender, economic conditions, education and other socio-demographic variables are important to look at. Further, the linkages of trauma/conflict and mental illness are important to know.

It is in this context that the present study focused on the core issues of mental wellbeing and intends to determine the prevalence of common mental health disorders (major depressive disorder, dysthymia, manic episodes, panic disorders, agoraphobia, social phobia, obsessive compulsive disorder, post-traumatic stress disorder, psychotic disorders/schizophrenia and general anxiety disorders) in Kashmir. It also looked into the access of people to mental health services. The study also tried to analyze the impact of conflict on the prevalence of mental health disorders, as well as explore the socio-economic determinants of mental health. The study intends to contribute to fill some of the knowledge and research gaps on mental wellbeing of people in Kashmir and towards public policy.

2. Study Design

There is a wide recognition of the fact that the mental health issues have increased over the time, particularly since conflict began in Kashmir. This is obvious from one's experiences in the neighbourhood as well as highlighted by research conducted in Kashmir, and also indicated by OPD records. Mental health is one of the many debated issues in Kashmir, but what is still largely absent from the discussions is an authentic estimate of the numbers of people suffering from mental health issues at any point of time. A lot of guess work has been made; in fact much research has been quoted out of context, putting the percentage of the population suffering from mental illness extremely high – up to 50%. What is needed is to have some authentic data on levels of mental illness in Kashmir. The issue of knowing the extent and levels of mental illness is very important, even to make basic plans, and of primary significance for the government and civil society. It is with this concern that this study was conducted in two of the districts of Kashmir focusing on rural areas. The reason that Kashmir region was chosen for the study and not Ladakh and Jammu was because mental health issues have significantly been reported to have increased in Kashmir owing to the fact that armed conflict has affected it drastically. It was also not logistically feasible to spread the study to other two regions although it may have offered useful comparison. With these presumptions and limitations, the study was designed along the following lines:

2.1: Objectives:

The approach of the present study was structured to fulfil the following objectives:

- To determine the prevalence rate of common mental health disorders including major depressive disorder, dysthymia, manic episodes, panic disorders, agoraphobia, social phobia, obsessive compulsive disorder, post-traumatic stress disorder, psychotic disorders/schizophrenia and general anxiety disorders in Kashmir.
- To investigate into the relationship between prolonged conflict and the prevalence of these mental health disorders in Kashmir.
- To understand the patterns of prevalence of these mental illnesses along the lines of gender and socio-economic class and among conflict-affected and non-affected families.

- 4) To study the accessibility of mental health services available for the treatment of people suffering from common mental illnesses in Kashmir, and whether there are disparities along the lines of gender and socio-economic class.
- 5) To use the findings of the study for advocating comprehensive policies and programmes to address mental health needs in Kashmir.

2.2: Methods and Process of Data Collection:

The study was conducted in two parts. A review of literature was undertaken to analyse secondary sources of data, which is reflected in the first chapter of this report, and a micro-level household study was conducted to determine the prevalence of common mental health illnesses. The primary study also tried to understand the patterns of prevalence along different socio-economic groups and the impact of conflict on mental health.

Study Area: It was a cross sectional study in which a mixed sampling technique was used to collect data. Kashmir region is arbitrarily divided into three zones: north, south and central. Because the study's focus was on rural Kashmir, it was decided to include one district each from South and North zones, so as to have a geographical spread of the sample in the study as well as to capture diverse political and socio-economic conditions which vary from south to north zones of Kashmir. It was decided to select Pulwama from the south zone and Baramulla from the north zone on purposive basis for the fact that these two districts have seen a greater impact of conflict on mental health in the recent years as is observed in ActionAid's Psychosocial Project.

Within these two districts, the study was conducted in three blocks in each of the districts, selected based on geographical spread, distance from district head quarter –neither too far nor too close— and logistic feasibility. The chosen blocks were Singhpora, Pattan and Baramulla blocks in Baramulla district, and Shadimarg, Pampore and Tral blocks in Pulwama district. Within each block, the villages were selected randomly.

Sample and Sampling Process: Within villages, researchers would pick up any household randomly and then the team would move in clock-wise direction to interview other households in the village. Every person fulfilling certain selection criteria was interviewed. The criteria

included that the person should be above 18 years of age; should be willing to participate; should not have any severe mental retardation or any other organic brain disorder; shouldn't have any serious physical disability (e.g. Blindness, polio, amputated limbs, etc.) or any other severe medical condition (e.g. congenital heart disease, rheumatic heart disease, tuberculosis, malignancy, etc.). Those who were present in the households at the time of interview and would qualify on these parameters were screened and interviewed for the study.

Against a sample requirement of 3914 to ascertain the prevalence of some of the common mental health illnesses in Kashmir, a total of 4000 people were actually interviewed in the study. This sample was statistically significant to estimate the prevalence of mental illness in Kashmir and was calculated within 0.3% of its true value with 95% confidence level. A design effect of 1.5 and a non-response rate of 10% was considered for the study. *As this study is first of its nature with no existing cross sectional data available in Kashmir on the prevalence of these common mental health disorders, it was imperative to take a scientific sample under this study to estimate the prevalence of these disorders considering its importance for both academic research, clinical practice and policy making. The sample size was divided equally among these two districts of Baramulla and Pulwama.*

Tools of Data Collection: The study was quantitative in nature. The interview process included two parts- one collecting data related to socio-demographic and economic conditions and second was a screening process to determine whether the person was suffering from any mental health disorder. Therefore, the interview schedule composed of two sections accordingly. The first part of the schedule had questions about age, sex, marital status, occupation, caste, religion, and nature of family, type of house, drinking water source, toilet facility and land availability, as well as including a section on access to treatment. The questions related to access to treatment were asked to only those who were found to have a mental illness. These set of questions were asked after screening process was done and it was known to researchers whether the person had any mental health issue. Respondents were assured of full confidentially before the interview process began.

For the sake of screening respondents whether they suffered from any mental health disorders, all respondents were screened using a MINI Screen. A sample of those with confirmed diagnosis based on MINI Screen guidelines were assessed by Research Associates (Psychiatrists from Institute of Mental Health and Neurosciences, Srinagar) for confirmation of psychiatric disorders. Wherever felt necessary, therapeutic intervention was done.

The Mini-International Neuropsychiatric Interview (MINI) is a structured diagnostic interview compatible with Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV¹ and International Classification of Diseases (ICD)- 10^2 criteria, which was designed for making an accurate diagnosis of mental health disorders to be used in epidemiological studies and clinical settings (Sheeshan et. al, 1998).

Implementing Organization and Research Team: The Research Project was carried out by Institute of Mental Health and Neurosciences (IMHANS), Government Medical College, Srinagar with Dr. Arshad Hussain (Associate Professor) as its Principal Investigator. IMHANS, Kashmir (earlier known as Government Psychiatric Diseases Hospital) is a state level tertiary hospital and has a huge experience of teaching, research and clinical practice into the mental health issues that existed and/or emerged post conflict in Kashmir.

The field survey part of the study was carried out by a group of 12 Research Investigators under the supervision of Research Associates, who were Psychiatrists associated with IMHANS. All of Research Investigators were post graduates in Psychology. This team went through a rigorous training of 10 days and were trained on the mental health illnesses, use of MINI Screen tool for diagnosis and other aspects of interview schedule. The training also included a trial of making diagnosis in the OPD of IMHANS to ensure that the field investigators are able to use the tool with high accuracy. This practical demonstration (on-job training) helped field investigators to gain in-depth understanding of the mental health issues in Kashmir and on how to make accurate diagnosis.

 ¹ 4th Edition of American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.
² WHO's 10th version of International Classification of Diseases

Reliability of Screening process of making diagnosis: Although a rigorous training of the investigators helped them to use the tool effectively and increase reliability of the study, in order to check the reliability of the data collected in the field, the research associates (who were psychiatrists) cross-checked a sample of 15 percent of confirmed cases (70 out of 452) from the field. The process included organising medical camps in the field and a random sample of those who were diagnosed with any mental illness during the study attended the camps. All those who attended the camps were provided consultations by the psychiatrists, which also served as a process for verifying the diagnosis made by the field investigators. This process indicated that the data on diagnosis made by the research investigators using MINI screen was highly reliable and accurate. However, it was observed by the psychiatrists that the field researchers haven't been properly able to make a diagnosis of PTSD among people who were also suffering from depression at the same time. PTSD in most cases exists as co-morbidity with depression. In most such cases where PTSD and depression existed as co-morbidity, researchers have only diagnosed depression as a mental health disorders. This has become the reason for PTSD being reported at lower levels in this study than it is expected to be, and is discussed ahead in the prevalence chapter of the study.

Data Analysis and Techniques: The collected data, which was quantitative in nature, was analyzed using statistical methods and techniques (with the help of SPSS). The analysis included drawing frequencies, percentages and cross-tabs. The variables were tested using Pearson Chi Square test. A note of 'data not available' was made in respective tables wherever needed. The significance level was set at P < 0.05.

Timeframe: The field study was conducted from September to November, 2015, and thereafter the processes of data entry, cleaning and analysis were done during November and December, 2015. The first draft of the report was written in the month of December only, and the preliminary findings were shared on 31st December in a workshop with many stakeholders and peers.

2.3. Scope and Benefits of the Research Project:

This is the first community level prevalence study on mental health disorders in Kashmir based on a rigorous data collection process using scientific tools, and the first of its type which has looked into the prevalence of most of the common mental health disorders (10 disorders in total). It has also looked into the association of socio-economic variables like gender, age, economic class and education, and experiences of trauma with mental health disorders, as well as into the accessibility to treatment. In that way, it assumes significance and is likely to shape the public discourse on mental illness in Kashmir. It is assumed considering the relevance of the issue in Kashmir that the research study will have both direct and indirect benefits. Some of which are given below:

- Its direct contribution to the research on mental health in the present context is immense; but is also likely to shape further academic research. It does indicate issues that should be taken for further research.
- It provides valuable information to all the relevant stakeholders like governmental and nongovernmental health agencies functioning in the valley, and this information may be used to design their programmes to reach out to people suffering from mental illness.
- 3) Mental disorders are chronic illnesses and need sustainable and long term programmes. This report can also be used for advocacy to promote coherent policies and programming in the field of mental health in Kashmir. It will contribute towards advocating for long term and sustainable programmes on mental illness in Kashmir, and will highlight mental health as an important issue to be given priority. The quality data on the disease prevalence also provide a strong rationale for more sustainable programmes to be designed by other organisations including government.
- 4) ActionAid will also use this study for future programming aimed at long term sustainable care to people suffering from mental illness due to conflict in Kashmir.

2.4. Dissemination:

The findings of the study have already been disseminated through a workshop with ECHO partners, local CSOs, other non-governmental stakeholders, governmental health organisations and academia. In continuation, the workshop also included sharing of ActionAid's community based psychosocial healthcare model which was supported by ECHO. The workshop invoked curiosity and interest among all stakeholders who are looking forward to this report. In fact, a few good recommendations were put forward during plenary sessions, and are part of this report.

This report will also be shared with some of the key stakeholders including government and nongovernmental agencies, and will also be kept available for public. This report, we believe, will serve as a tool in the hands of many stakeholders to raise further questions on the mental health issues, availability of services and research to the next level.

2.5. Limitations of the Study:

Although this study has been able to give us an estimate about the prevalence of 10 common mental health disorders in general population as well as among different socio-economic groups, it, however, has indicated certain limitations which need further exploration and analysis. It has indicated disparities in the prevalence of mental health disorders along the lines of gender, economic class and education levels but the underlying processes and pathways of this association need rigorous analysis. The study was conducted only on adults, while children constitute a significant proportion of population and have also been highly vulnerable to mental illness in the context of prolonged conflict in the state. The mental health of children also needs to be studied at the community level. Further, this study has looked at 10 common mental health disorders but not all of them. These are also the reasons why the estimate on the prevalence of mental illness made under this study needs to be generalized to the whole population with caution. This study has indicated low levels of treatment sought by people with mental illness, but the questions on the accessibility and underutilization of mental health services needs to be studied and understood in a broader socio-economic and political context. This study has given us an understanding of the extent of active mental illness in Kashmir, what is also important to understand is the impact of mental illness itself on the socio-economic functioning of persons suffering from them and on their families in terms of education, incomes, care of children, family interactions, etc.

These all aspects are important in understanding mental health in a broader context and are a limitation of this study. But it is expected that the future academic research will be shaped by the findings of this study and on further aspects of mental health.

3. Prevalence of Mental Health Issues and Access to Treatment in Kashmir

It is widely recognised in Kashmir that the prevalence of mental health issues have significantly increased since conflict began, but relying on random observations, OPD records and very limited research conducted on some of the very vulnerable groups and/ or in health care institutions. One of the widely quoted data is based on OPD records on numbers of people who attended the State Psychiatric Diseases Hospital, Srinagar in 1985³ (taken as baseline) and the number attending now. These records show that 775 people attended State Psychiatric Diseases Hospital, Srinagar in 1985, which was the lone hospital in Kashmir where psychiatric services were available, and this increased to 1,30,000 in 2015 in two state hospitals including State SMHS Hospital and State Psychiatric Hospital in Srinagar (both affiliated with GMC Srinagar) (Nissa, 2015). In State Psychiatric Hospital alone, 75,000 had attended OPD in 2015. This certainly indicates a steep increase in numbers of patients who sought psychiatric services but suffers from many loopholes. Firstly, in 1985, the transport services were much less, affordability of treatment was a major issue, stigmatisation of mental illness was high, and general awareness about such issues was low, therefore, much of the mental illnesses would have gone unreported. On the other hand, in 2015, not only the two State Hospitals including SMHS Hospital and State Psychiatric Hospital in Srinagar are providing psychiatric services but psychiatrists are available in all major district hospitals, and most of these psychiatrists also provide services at their private clinics. Those who attend private clinics (and are very significant in numbers) also go unreported. Because of these reasons the comparison of OPD records between 1985 and 2015 suffers from major loopholes. But the sudden increase in mental illness in the valley remains a fact, which is also corroborated with research findings from other smaller studies. As the conflict has been prevalent throughout Kashmir, affecting all districts, any estimate on mental illness warrants a community based prevalence study. In this context, this present study is significant for being the first community based study in Kashmir based on scientific methods and rigorous process of data collection led by experienced people in the field. This chapter presents the findings of this community based prevalence study conducted in two districts of Kashmir - Pulwama and Baramulla.

³ Although the conflict began in 1989 and that should ideally be taken as a baseline year but the records were lost in a fire accident in the State Psychiatric Diseases Hospital, Srinagar and therefore no such data is available up to 1994.

3.1. Socio-Economic Characteristics of Sample:

The study included 4000 respondents. All of them were above 18 years and all were originally from Kashmir region. 64.5% of the respondents (2579) were women. The reason that women outnumbered men in this survey is because of the fact that women being predominantly engaged

in household work were available for the interview during daytime. A significant proportion, about 57%, was young, below 40 years of age, and 13% were old, above 60 years age. Table 3.1 shows the age and gender distribution of the sample.

Table 3.1: Age and Gender of People Covered						
Age group	Male	Female	Total			
18-40	780 (55.0%)	1486 (57.7%)	2266 (56.8%)			
40-59	419 (29.6%)	789 (30.7%)	1208 (30.3%)			
60 & above	218 (15.4%)	299 (11.6%)	517 (13.0%)			
Total 1417(100.0%) 2574(100.0%) 3991 (100.0%)						
*Data was not available for 9 respondents						

Table 3.2 shows that 51.6% respondents were illiterate/without any education. Almost one third of the sample (34.9%) had attained above high school level education. As per census 2011, literacy rate in Jammu & Kashmir was 68.74% with male literacy as 78.26% and female literacy

Table 3.2: Education Attainments of People			
Education Status	Frequency	Percent	
Illiterate/no education	2065	51.6	
Up to High School	530	13.3	
Above High School	1397	34.9	
Data not available	8	0.2	
Total	4000	100.0	

58.01% (RGI, 2011). Lower education attainments of a majority of people covered in our sample could be because of the fact that the study was conducted in rural and far off areas where

education status is relatively poor and the study largely covered women who have lower literacy rates.

A majority of respondents (64.1%) had nuclear families, followed by joint families (33.1%) and nuclear extended were only 2.6 %, as shown in

Table 3.3: Family Structures of People				
Family Structure	Frequency	Percent		
Nuclear	2562	64.1		
Joint	1324	33.1		
Nuclear-extended	103	2.6		
Data not available	11	0.3		
Total	4000	100.0		

Table 3.3. Further, a majority of 67.2 % respondents were married (2686), followed by 28.1% (1123) who reported as not married at the time of survey. The respondents' also included 4.8 % people, who were divorced, separated or widowed (190). A majority of respondents were married because of the fact that study excluded children.

One fourth of the respondents (25.8%) has reported holding no land, 23.3% of respondents reported having 1 to 3 Kanals of land (8 Kanals make an acre), and 22.4% had 4 to 8 kanals of land. Only 23.2 % respondents had more than 9 Kanals of land as shown by Table 3.4.The data about land holdings isn't available for 5.4% respondents because they were not able to give the details. This data corresponds to the macro-data on land holdings in Kashmir, which

Table 3.4: Land Ownership of People			
Land Holdings (in Kanals)	Frequency	Percent	
0	1030	25.8	
1 - 3	931	23.3	
4 - 8	897	22.4	
More than 9	928	23.2	
Data not available	214	5.4	
Total	4000	100.0	

shows that almost 94 percent farmers in J&K are small and marginal famers (holding less than 2 acres of land) [Government of J&K, 2012–13].

These characteristics of the sample indicate that the sample covered under the study corresponds to the broader socio-economic context of the state, particularly the rural areas.

3.2. Psychiatric Morbidity/Illness: Prevalence of Mental Health Issues

Mental health is one of the worst casualties of conflict. Mental illnesses not only lead to direct sufferings of the people but its economic burden is tremendous, in terms of work days lost and investments to be made into the treatment. Inability of people to access treatment further leads to a perpetual and vicious circle of socio-economic drift hampering employment, relationships, and many other severe social problems. This is more serious in Kashmir because mental health problems are affecting a younger age-group.

This study has shown that overall the psychiatric morbidity (presence of mental health disorders) was present in 11.3% (452) of the respondents, as shown by Table 3.5. Mental health disorders included major depressive disorder, dysthymia, (Hypo)

Table 3.5: Prevalence of Mental Health Disorders			
Mental Illness	Frequency	Percent	
Absent	3547	88.7	
Present	452	11.3	
Data not available	1	0.02	
Total	4000	100.0	

maniac episode, panic disorder, agoraphobia, social anxiety disorder, obsessive compulsive disorder, PTSD, psychotic and mood disorders with psychotic features and generalized anxiety disorder.

The study also showed that out of those who suffered any mental illness, 333 (12.9%) were females and 119 (8.4%) were males. Persons with traumatic/conflict exposure had a significantly higher morbidity with almost 24% of them suffering from mental health disorders.

This study only reflects current levels of mental illnesses, meaning those who suffered any mental illness at the time of survey. It doesn't reflect lifetime morbidity. *But because the study looked only into current illnesses present at the time of survey this level of illness at 11.3% is of very serious nature, as it reflects active psychiatric illnesses in the valley presently.* This prevalence is significantly higher than the Indian national average of 7.3% (Ganguli, 2000).

The psychiatric disorders are classified into groups and the widely followed classification is the one given in American Psychiatric Association's Diagnostic and Statistical Manual (DSM). We are presenting analysis of psychiatric disorders as per 4th edition of DSM, but have also indicated DSM-5 classification in respective tables for helping readers to follow both the classifications.

3.2.1. Mood Disorders:

Mood is a pervasive and sustained emotion of feeling tone that influences a person's behaviour and colours his/her perception of the world. *Mood disorders form an important class of psychiatric illnesses and include depressive disorders, dysthymia, bipolar (maniac) disorders, among others.* Patients with only major depressive episodes are said to have major depressive disorder or unipolar depression. Patients with maniac as well as depressive episodes or only maniac episode are considered having bipolar disorder.

As a group, mood disorders were present in more than 10% respondents. The World Health Organization ranks depressive disorders as the fourth leading cause of diseases worldwide, and projected that by 2020, they will be the second leading cause (WHO, 2001). Among the individual disorders, Major Depressive Disorder (commonly known as depression) was the most

common illness among the respondents, affecting 6.9% of the respondents, as shown by Table 3.6. Depression affects people greatly to function poorly at work, at school and in the family (Murray and Lopez, 1996). A complex interaction of social, psychological and biological factors leads to depression. Patients with depression usually have symptoms characterized by low mood,

loss of interest in pleasurable activities, lack of energy, change in pattern of sleep and or appetite, recurring thoughts of suicide and death, lasting for at least two weeks.

	Table 3.6: Prevalence of Mood Disorders					
DSM-4 Classification	DSM-5 Classification	Type of Mental Health Disorder	Present	Percent (out of total sample)		
Mood	Depressive disorders	Major depressive disorder	276	6.9		
Disorders		Dysthymia	61	1.5		
Districts	Bipolar disorders	(Hypo)manic episode	37	0.9		
Total sample was 4000; Data was not available for 1 person.						

Dysthymia, on the other

hand, lasts for a longer term of at least two years and has features of depression which are sufficiently serious to fit criteria of major depressive episode. In other words, if the depressive features are persistent through two years, it is diagnosed as Dysthymia. The present study indicated that 1.5% of respondents (61) suffered from Dysthymia disorder as shown by Table 3.6.

A manic episode is characterized by elevated or irritable mood lasting for at least one week or less in case of hospitalization. It is associated with inflated self esteem, decreased need for sleep, easy distractibility and excessive involvement in pleasurable behaviour. Hypomanic episode lasts at least 4 days and is similar to manic episode but is not sufficiently severe to cause impairment in daily functioning. The present study indicated that 0.9% of respondents (37) suffered from hypomanic disorder as shown by Table 3.6.

3.2.2 Anxiety Disorders:

Anxiety manifests as diffuse and unpleasant apprehension associated with palpitation, chest discomfort, restlessness and stomach discomfort. Anxiety disorders include panic disorder,

agoraphobia, specific phobia, social anxiety disorder, generalised anxiety disorder, obsessive compulsive disorder and Post traumatic stress disorder.

As a group, Anxiety Disorders were found to be present in 7% of respondents under this study, as can be seen from the Table 3.7. Individually, panic disorder was found in 1.7 % of the respondents;

while		Table 3.7: Pre	revalence of Anxiety Disorders			
Agoraphobia was	DSM-4	DSM-5	Type of Mental	Present	Percent (out of	
present in 2.3 %	Classification	Classification			total sample)	
of the			Panic Disorder	66	1.7	
respondents.		Anvioty	Agoraphobia Social Anxiety Disorder	90	2.3	
Social Anxiety		disorders		17	0.4	
Disorder was	Anxiety disorders		Generalized Anxiety Disorder	26	0.7	
present in 0.4%		OCD and	Obsessive			
of the		Related	Compulsive Disorder	41	1.02	
respondents, and		disorders	(OCD)			
Obsessive		Trauma-stress- related disorders	Post Traumatic Stress Disorder (PTSD)	40	1.0	
Compulsive	Total sample was 4000; Data was not available for 1 person.					

Disorder was present in 1% of the respondents. Post-Traumatic Stress Disorder, one of the directly linked to conflict, was reported in another 1% of the respondents. The reason why PTSD has been reported at lower levels in this study than what has been indicated by other studies conducted in Kashmir is because PTSD in most cases exists as co-morbidity with depression. During the cross-check of a sub-sample of those with confirmed diagnosis during the field study, it was observed by the psychiatrists that the field researchers haven't been able to make a separate diagnosis of PTSD among people who were also suffering from Depression, and most people with PTSD and depression were only diagnosed as having depression.

3.2.3. Psychotic Disorders:

Psychosis (from Greek "psyche", for mind/soul, and "-osis", for abnormal condition) means abnormal condition of the mind, and is a generic psychiatric term for a mental state often described as involving a "loss of contact with reality". People suffering from psychosis are

described as *psychotic*. Psychotic disorders are a group of serious illnesses that affect the mind. These illnesses alter a person's ability to think clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately. When symptoms are severe, people with psychotic disorders have difficulty staying in touch with reality and often are unable to meet the ordinary demands of daily life (McMullan, 2010). It includes schizophrenia related disorders.

This study also included screening all respondents for this set of disorder and found it very rare with 0.1%

Table 3.8: Prevalence of Psychotic Disorders						
DSM-4	DSM-5	Type of Mental	Present	Percent (out of		
Classification	Classification	Health Disorder		total sample)		
Psychotic disorders	Psychotic disorders	Psychotic disorders and mood disorders with psychotic features	5	0.1		
Total sample w	Total sample was 4000; Data was not available for 1 person.					

respondents (5) suffering from it.

3.2.4. Suicidality condition:

Suicidality is not classified as a separate disorder but is an associated condition with many other mental health disorders, and represents a serious

Table 3.9: Prevalence of Active Suicidality					
Mental Health	Present	Percent (out of			
Issue		total sample)			
Suicidality	71	1.8			
Total sample was 4000; Data was not available for 1 person.					

situation. Respondents were screened for any Active Suicidality (active suicidal wish/idea/will/gesture or a pre-contemplated attempt) and found it in 9% of the morbid people (those who had any mental disorder). In the overall sample of 4000 respondents, Active Suicidality was present in 1.8% of respondents as shown in Table 3.9.

All major psychiatric disorders carry an increased risk of suicide. 90% of suicides can be traced to *depression*, linked either to bipolar disorder, major depressive disorder, schizophrenia or personality disorders, and particularly borderline personality disorder. Co-morbidity of mental disorders (with presence of more than one mental health disorder) increases suicide risk (Reddy, 2010). That is the reason why this study has indicated that active suicidality was present in 9% of the people with mental health disorders.

Kashmir, predominantly a Muslim society had one of the lowest suicide rates in whole of India at 0.5 per one lakh population, comparable to Kuwait which has 0.1 per one lakh population and lowest in world. However, the medical records show that in past few years Kashmir has seen a spurt of suicides, para–suicides and deliberate self-harm. The increase in incidence of para-suicides and deliberate self-harm are much more alarming, and are predictors of eventual suicide. Suicide as a health problem has announced its arrival in an unlikely socio-religious scenario, where suicide is condemned, and therefore, its urge is all the more alarming (Hussain, 2008b & Hussain, 2015).

As is well known that the National Crime Records Bureau (NCRB) data and also the medical records suffer from gross underreporting, this study (being rigorous and community led) may indicate relatively more reliable levels of suicidality. The 1.8% of respondents among a sample of 4000 would mean that almost 1775 persons per lakh population would have active suicidality in Kashmir⁴ and much more among those who have any mental illness. This number was expected to be higher than NCRB data and medical records, because NCRB only records actual deaths, and medical records only show cases reported to hospitals, but this study has considered active suicidality in a broader context including active suicidal wish/idea/will/gesture or a precontemplated attempt. This rate of active suicidality itself is an indication of the seriousness of the problem.

The table 3.10 below summaries and provides the prevalence of all disorders that were looked into among respondents under this study.

⁴The rate of suicide is calculated per lakh population as a standard measure. That is why we have also presented active suicidality per lakh population (Lakh means 100,000).

Table 3.10: Prevalence of all Mental Health Disorders				
DSM-4 Classification	DSM-5 Classification	Type of Mental Health Disorder	Present	Percent (out of total sample)
Depressive		Major depressive disorder	276	6.9
Disordors	disorders	Dysthymia	61	1.5
Distincts	Bipolar disorders	(Hypo)manic episode	37	0.9
Anxiety disorders	Anxiety disorders	Panic Disorder	66	1.7
		Agoraphobia	90	2.3
		Social Anxiety Disorder	17	0.4
		Generalized Anxiety Disorder	26	0.7
	OCD and Related disorders	Obsessive Compulsive Disorder (OCD)	41	1
	Trauma-stress- related disorders	Post Traumatic Stress Disorder (PTSD)	40	1
Psychotic disorders	Psychotic disorders	Psychotic disorders and mood disorders with psychotic features	5	0.1
		Suicidality	71	1.8
Total sample was 4000; Data was not available for 1 person.				

3.3. Socio-economic determinants of Mental Health Disorders

The study also intended to look at the patterns of mental illness along the lines of gender and economic conditions. It is widely recognised in public health literature that socio-economic conditions determine the patterns of prevalence of health issues across different groups of populations. This study also found significant inequalities across gender and economic conditions among the respondents.

3.3.1. Age and Mental Illness: Although it is known that mental health disorders affect young populations more, but the results of this study show that people in middle-age group of 40-60 years had slightly higher prevalence than those younger as well as those older to them. For instance, almost 10% of the respondents (from 2265) in the age group of 18-40 years had a mental health disorder, while 13.3% respondents (from 1208) in the age group of 40-60 had a

mental illness, and 12.0% of the respondents (from 517) in the age group of '60 and above' had developed mental illness.

3.3.2. Gender and Mental Illness: The results of the study, as shown in Table 3.11, have clearly shown that the prevalence of mental health disorders was much higher among women (12.9%)

than men (8.4%). This is corroborated by findings of many research studies globally and in Kashmir, which have found women being more vulnerable to mental illness. The same results are also corroborated from ActionAid's community mental health programme which has shown that almost 60-65 percent people who suffer from mental health disorders are women.

3.3.3. Education and Mental Illness: The study has shown a clear correlation between having a mental illness with the educational attainments of the people. As shown in Table 3.12, only 8.7% of those who

Table 3.11: Mental Health Disorders by Gender				
Sex	Psychiatric Morbidity			
	Present	Percent	Total Sample	
Male	119	8.4%	1419 (100.0%)	
Female	333	12.9%	2578(100.0%)	
Total	452	11.3%	3997 (100.0%)	
			·	

Table 3.12: Mental Health Disorders by Education				
Attainment				
Education	Education Psychiatric Morbidity			
Attainment	Present	Percent	Total Sample	
Illiterate/No education	262	12.7%	2064 (100.0%)	
Up to High School	68	12.8%	530 (100.0%)	
Above High School	122	8.7%	1397 (100.0%)	
Total	452	11.3%	3991 (100.0%)	
<i>p<.001</i>				

had attained education above high school had mental illness as compared to 12.8% of those who were educated up to high school and 12.7% of those who had no education. As the educational attainment is itself determined by socio-economic factors –those with good financial status are able to achieve better levels of education than those who are poor; this indicator indirectly represents a socio-economic variable. Therefore, the mental illness is correlated with education for its characteristic as a socio-economic variable.

3.3.4. Marital Status and Mental Illness: The study has shown that those who were either divorced or separated or widowed had a significantly higher morbidity (14.7%) than those who

were married or never married, as shown in the table 3.13. This is probably because of the reason that such situation increased vulnerability to stressors, and is also related to relatively lower

socio-economic status of such people. Further, those who were not married at the time of study had significantly lower levels of mental illness.

3.3.5. Economic class and Mental Illness: As noted earlier the improvements in the health and

Table 3.13: Mental Health Disorders by Marital Status				
Marital Status	Psychiatric Morbidity			
	Present	Percent	Total Sample	
Never married	98	8.7%	1123 (100.0%)	
Married	326	12.1%	2685 (100.0%)	
Divorced/Separated/ Widow/Widower	28	14.7%	190 (100.0%)	
Total	452	11.3%	3998 (100.0%)	
<i>P</i> = .003				

wellbeing have not benefited all economic sections equally anywhere in the world as well as in the context of India. A similar finding has also been shown by this study with regard to the prevalence of mental illness among different economic classes. This study collected data on land holdings and used it as a proxy of class. Although there is diversification in the livelihoods now but still 80% of the population in J&K remains dependent on the agricultural and allied activities for their livelihoods that validates the use of landholdings as a proxy indicator of economic class. The study also collected data on the type of ration card families had. Though there are issues of inclusion and exclusion with ration cards nationally but with a universal Public Distribution

System (PDS) in J&K such issues are relatively lesser (refer to Dar, 2009 and Dar, 2015b). The government's classification of people into different ration-card-categories under PDS relies on number of economic indicators. Therefore, types of ration cards represent different economic classes.

Table 3.14: Mental Health Disorders by Land Ownership				
Land	Psychiatric Morbidity			
(in kanals)	Present	Percent	Total Sample	
0	134	13.0	1030 (100.0%)	
1 – 3	106	11.4	931 (100.0%)	
4 - 8	104	11.6	896 (100.0%)	
9 or more	84	9.1	928 (100.0%)	
Total	428	11.3	3785 (100.0%)	
<i>P</i> = .0051				

As shown in the table 3.14, people whose families had lesser landholdings had higher morbidity of mental health disorders than those with higher land holdings. For instance, among those who

reported to have no land holdings at all, 13% suffered from some mental illness, while as among those who had 1 to 8 Kanals of land (1 acre), 11.5% had mental illness. In contrast among those who had more than 8 Kanals of land, a significantly lower proportion of 9.1% had mental illness.

This differential prevalence of mental illness across land-classes is also corroborated by findings across ration-card-type categories. The table 3.15 shows that those who had the Below poverty line card (BPL) or the Above poverty line card (APL) didn't differ much in terms of having a mental illness (among the BPL it is slightly higher than the APL), but among Antyodya Anna

Yojana (AAY) ration card holders the prevalence of mental illness was significantly higher than BPL and APL ration card holders. Among AAY card holders, mental health disorders were found among 16.3% respondents, while it was 10.8% and 10.2% among BPL and APL card holders respectively.

Table 3.15: Mental Health Disorders by Ration card Type				
Ration card	Psychia	tric Morbidity	Total Sample	
type	Present	Percent	Total Sample	
APL	196	10.2	1917 (100.0%)	
BPL	169	10.8	1559 (100.0%)	
AAY	58	16.3	355 (100.0%)	
None	9	12.0	75 (100.0%)	
Total	432	11.1	3906 (100.0%)	
P=.009				

This differential in prevalence of mental illness across economic class is likely because of the protection mechanisms, social support and relatively better access to health services that higher income groups enjoy than the poorer groups.

3.4. Trauma and Mental Illness:

It is well known that vulnerability and exposure to trauma related situations have a significant impact on the mental health of people, and inability to cope with the trauma (or recurrent episodes of trauma) may result into a mental health disorder. As mentioned earlier, Kashmir has been experiencing a prolonged armed conflict from last two and half decades, which has taken a heavy toll on socio-economic and psychological wellbeing of the people. In a politically unstable situation like Kashmir, it is very difficult to segregate people along the lines of affected by conflict and not affected. The long drawn conflict has affected people widely and in number of

ways. But the exposure to conflict, level of impact, and sensitivity of the exposure vary, and impact psychological health accordingly.

For the sake of this study, respondents were divided into two groups of those who have witnessed traumatic event in their close family, and those who haven't. The events were considered traumatic if anyone in the family was killed/had disappeared/was detained/was tortured or had become disabled due to conflict related reasons or was sexually assaulted. Such events, if witnessed by any family member, were thought to leave a greater impact on all family members.

A total of 494 respondents (12.3%) had witnessed such traumatic events in their families, and among them a significantly higher proportion of about 24.3% had developed mental

Table 3.16: Mental Health Disorders by Trauma Exposure				
Trauma	Psychiat	Total Sample		
Exposure	Present	Percent	i otar Sampie	
No	330	9.4	3502 (100.0%)	
Yes	120	24.3	494 (100.0%)	
Total	450	11.3	3996 (100.0%)	

health disorders, as shown by Table 3.16. The level of illness was much lower among those who reported not having been exposed to such events in their families, and was just 9.4% among them. This is an important finding about the impact of conflict induced traumatic events on the mental health of people in Kashmir.

Similar findings about higher prevalence of psychiatric morbidity in persons with trauma exposure have been observed worldwide. WHO estimates that in the situations of armed conflicts, "10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behaviour that will hinder their ability to function effectively. The most common conditions are depression, anxiety and psychosomatic problems such as insomnia, or back and stomach aches" (WHO, 2001)

3.5: Access to Treatment:

The macro-data on the levels of access to treatment in J&K shows a better picture. For instance, the NSSO data shows that the proportion of ailing persons⁵ who were able to access medical

⁵ Those who reported an ailment during the period of 15 days preceding the survey

treatment was quite high, almost 82 percent, as high as in India as a whole (Dar, 2012). Such surveys, however, have a broader focus on physical ailments, which are clearly recognised by people and therefore get significantly reported. But in case of mental illness, the reporting levels are generally very low due to many reasons including very high stigmatisation and low awareness. In many cases, families aren't able to understand what is happening with the person suffering from mental illness because of the invisible nature of the mental illnesses. As a result, the changes in behaviour and psycho-social functioning are often explained by the families and the community as effects of supernatural powers/evil spirit/ evil spells, which also inhibit treatment seeking behaviour. At the same time, the availability of mental health services at community levels is quite dismal too, with psychiatrists being available only in some district

hospitals. In this context of very high stigmatisation, low awareness, lack of services and affordability issues, the levels of access to treatment is expected to be low. The chronic nature of the mental illnesses which need long term treatment and are therefore costly and not immediately effective also discourages people to seek treatment.

This study has indicated similar findings and showed that among those who were suffering from any mental illness (452), only 12.6% respondents reported being able to access any medical treatment for their illness, as is shown in Table 3.17. This lack of treatment in majority of cases also worsens the situation, and increases severity of illness over time.

Importantly, the study shows that the proper treatment (from a psychiatrist) is in fact much lesser. The table 3.18 shows the sources of treatment that people with mental illness have managed to access. It shows that only 6.4 % of

Table 3.17: Access to Medical Treatment			
Any Medical	Frequency	Percent	
Treatment Taken	rrequency		
No	395	87.4	
Yes	57	12.6	
Total	452	100	

Table 3.18: Sources of Medical Treatment			
Source	Frequency	Percent	
General Medical Officer at Public	18	31.6	
Psychiatrist at a Private clinic	18	31.6	
Psychiatrist at a Govt. Hospital	11	19.3	
Neurologist at Public hospital/ Private Clinics	4	7.0	
Local chemist	3	5.3	
Others	3	5.3	
Total	57	100	

those who had mental illness sought treatment from psychiatrists at public hospitals or private clinics.

Among those who received any medical treatment, a significant proportion had sought it from private services. This fact has also been earlier corroborated by macro-surveys including the NSSO reports, NFHS-3 data and a Planning Commission study that a significantly large population of up to 48 percent access private care in rural areas of J&K. There are many issues that affect the access of people to public health services and may push the people to private health care. Poor quality of health services, limited outreach of grassroots level workers, costly treatment, inability to pay, lack of nearby facility or inconvenient timings, long waiting hours, among others are some of the factors cited (Dar, 2012). The NFHS-3 survey showed that among those households, which do not access public health facilities, 55.3 percent reported poor quality of care; 33.2 percent reported lack of a nearby facility; 22.4 percent cited long waiting times; 9.3 percent reported facility timing as not convenient; 5.9 percent reported that health personnel were often absent; and 7.3 percent reported other reasons for not being able to access government services (IIPS & Macro International, 2007 cited in Dar, 2012). However, the Planning Commission's study, revealed that people who suffered from chronic diseases reported non-availability of medicines in public health facilities, public health facilities located far and emergency as major reasons (67.7 %) in J&K for availing treatment from private health facilities (Government of India, 2011a).

With lack of availability of proper medical care locally and with no provision for medicines, the actual expenditures in case of chronic illnesses like mental health disorders add to a huge sum, and majority of poor households have to borrow money to cope up. For some, the costly expenditure may have a catastrophic impact pushing them to destitution. That might be the reason why a majority of people who had mental illness did not access treatment.

4. Summary and Conclusion

The macro level data suggest that Jammu and Kashmir provides a better picture on many of the health indicators as compared to India as a whole. For instance, the Neo-Natal Mortality rate in J&K was 29.8 (39 in India), Infant Mortality rate was 44.7 (57 in India), Child Mortality rate was 6.8 (18.4 in India) and Under-five Mortality rate was 51.2 (74.3 in India). Similarly, the proportion of under-weight children less than three years was 29.4 percent, as compared to 40 percent in India ⁶(IIPS & Macro International, 2007 cited in Dar, 2012). But what the macro-data doesn't reflect is the prevalence of mental health issues in Kashmir, which has suffered armed conflict from last 25 years. This prolonged armed conflict has taken a heavy toll on human lives, psycho-social and economic wellbeing. The killing and disappearances of thousands of people have resulted into new marginalized groups of widow headed households, orphans, elderly without any support, disabled and has also accentuated the marginalization of already marginalized like labour and landless class. The macro data also indicates that J&K lags behind in many of the development indicators as compared with India as a whole including literacy rate, roads, per capita incomes, agriculture, employment opportunities, etc. The conflict has resulted into many structural constraints and has created many barriers that shape the access of people to employment, livelihood and essential services.

In this socio-economic and political context, many more have become victims of mental trauma, stress, anxiety, depression and many other mental health disorders. This has been a debate and a widely recognised fact in Kashmir that the prevalence of mental health issues have significantly increased since conflict began. By relying on observations of OPD records and limited research conducted on some of the very vulnerable groups and those in health care institutions, a steep increase in numbers of patients who sought psychiatric services is reported. But these estimates suffer from many loopholes to demonstrate anything near to actual estimates. As the conflict has been prevalent throughout Kashmir, affecting all districts, any estimate on the prevalence warranted a community based scientific study. The present study was carried out to estimate the

⁶There was a change in reference standards after the NFHS-3 data was released and the adjusted figure adds up to 46 percent for India, but the adjusted figure was not able for J&K.

prevalence of mental illness in the valley, and therefore, achieves significance for its being first community led study to determine the prevalence of mental health disorders in Kashmir.

The study surveyed 4000 people across two districts of Kashmir. It was carried using scientific methods and rigorous process of data collection led by experienced people in the field and guided by those who have decadal-long experience as practitioners and teachers in the field of mental health in Kashmir. A sample of people who were identified suffering from mental illness during the field study was cross-verified by the psychiatrists to check the reliability and validity of the data. This is the first scientific study which has looked at prevalence of active and untreated morbidity of mental health disorders and can be considered fairly representative for whole population of Kashmir but with some limitations.

Unlike many other higher-end estimates on the prevalence of mental health issues in Kashmir, this study indicates that 11.3% of adult population suffers from mental illness in the valley. This prevalence is significantly higher than the Indian national average of 7.3% (Ganguli, 2000). The study finds that the prevalence of mental health disorders was more in females (12.9%) than males (8.4%). It was also more among those who were not educated (12.7%) than those who had attained education up to high school (12.8%) or higher levels of education (8.7%). The prevalence was also significantly higher among those who were either divorced or separated or widowed (14.7%) than those who were married (12.1%) or never married (8.7%). The prevalence of mental health disorders also showed a clear class gradient, higher among those who were poor than those who were better off. 13% of those who reported to have no land holdings at all suffered from some mental illness, while as 11.5% of respondents who had 1 to 8 Kanals of land (1 acre) had mental illness. In contrast a significantly lower proportion of 9.1% of those who had more than 8 Kanals of land had any mental illness. This was corroborated by findings across ration-card-type categories with significantly higher presence of mental health disorders among AAY ration card holders (16.3%) than BPL (10.8%) and APL ration card holders (10.2%).

Importantly, the study indicated very clearly the impact of conflict on mental health, and one of the reasons for a higher prevalence of mental illness in Kashmir. A total of 494 respondents

(12.3%) had witnessed conflict induced traumatic events in their families (in terms of anyone in the family killed/disappeared/detained/tortured/disabled due to conflict related reasons), and among them a significantly higher proportion of about 24.3% had developed a mental health disorder. This was much lower among those who reported not having being exposed to such events in their families, and was just 9.4%. These findings about higher prevalence of psychiatric morbidity in persons with trauma exposure are in accordance with research from other conflict ridden areas. As per WHO estimates, 10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behaviour that will hinder their ability to function effectively, in the situations of armed conflicts (WHO, 2001).

Mental health disorders are classified into different groups. The study has looked into three groups of mental health disorders including mood disorders, anxiety disorders and psychotic disorders (which include 10 individual disorders) for being reported as common disorders in Kashmir. Mood disorders as a group formed the major chunk of those affected by mental disorders in almost 10% respondents. It included major depressive disorder (commonly called as depression) was most common in 6.9% of respondents. Dysthymia was prevalent among 1.5% respondents and bipolar affective disorder (maniac episodes) was in 0.9% of respondents. These figures are significantly higher than observed by Ganguly in Indian population and found that affective disorders (including depression, psychotic and neurotic disorders) were prevalent in 3.4% of the population (Ganguli, 2000).

Anxiety disorders were also prominent in 7% of respondents. It includes panic disorder, agoraphobia, specific phobia, social phobia, social anxiety disorder, generalized anxiety disorder, obsessive compulsive disorder and post traumatic stress disorder. Individually, panic disorder was found in 1.7 % of the respondents; while as agoraphobia was present in 2.3 % of the respondents. Social anxiety disorder was present in 0.4% of the respondents, and obsessive compulsive disorder was present in 1% of the respondents. Post traumatic stress disorder, one of the directly linked conflict disorder, was reported in another 1% of the respondents. Obsessive compulsive disorder was found in 1% of population which is higher than what has been reported

in other parts of India. The third category of psychotic disorders was found very rare with 0.1% respondents suffering from it.

The study also included screening of respondents for any Active Suicidality (active suicidal wish/idea/will/gesture or a pre-contemplated attempt). Although suicidality is not classified as a separate disorder but is an associated condition with many other mental health disorders, and represents a serious situation. The study indicates that active suicidality was found in 9% of the morbid people (those who had any mental disorder). In overall sample of 4000 respondents, active suicidality was present in 1.8% of respondents. The 1.8% of respondents among a sample of 4000 would mean that almost 1775 persons would have active suicidality per lakh population in Kashmir and much more among those who have any mental illness. This represents a serious situation, and may be one of the reasons why suicide cases are being reported in newspapers regularly in Kashmir now.

Although the prevalence of 11.3% mental health disorders in the population represents an abnormally serious situation, what was also surprising was that the treatment gap was very high? Only 12.6% of the people with mental illness sought help from health services and only 6.4% of those who had mental illness had consulted a psychiatrist. The reasons for this low treatment levels may be because of very high stigmatization of these illnesses in the society, very low awareness about illness as well as about treatment, and inaccessible treatment at the community level, as most mental health services available in Kashmir are located in urban areas.

Although the findings of this study show a more conservative picture of the scale of the problem as against many other small-scale studies which have put estimates at much higher level, but 11.3% morbidity of mental illness is also very high, almost double than the overall national picture, much of which is undetected and untreated. Depressive and anxiety related disorders constitute most of the mental illnesses in the valley.

Further, the study shows a higher prevalence among women, among lesser educated sections and among the poorer. In a way, mental illness is related with socio-economic conditions. It also shows that those who have witnessed conflict induced traumatic events are almost 3 times (24.3%) more affected than those who have not witnessed (9.4%). That means almost one in four people who experience a traumatic event would be affected by mental illness. In other words, it could also mean that more than one member in the family⁷, who experiences a traumatic event, may be affected by mental illness. The study also shows a minimal access to treatment, which is owing to the fact that mental health services are very poor in the Valley. These findings should sound the alarm to initiate processes to address mental health issues with urgency.

The exposure to trauma and mental illness also leads to intergenerational trauma through a cycle of increased stress in families, declining socio-economic conditions, health care burden, anger, breakdown of families (therefore support system), and inability to take care of children, marital issues and so on. In worst case scenarios, it also leads to social isolation, and affects the economic productivity of people suffering from illness and their care takers. *In a way, mental illness perpetuates a cycle of trauma*. Therefore, it is very important that the people affected by armed conflict are enabled to start their lives afresh, and the impact of their experiences and exposure to trauma is reduced. As the situation is complex and widespread, it calls for multi-fold intervention by involving diverse stakeholders.

What is also important to realize is that mental health interventions are now being looked at as initiatives for peace building, justice and reconstruction in ways that such interventions will help people who are victims of conflict to start their lives afresh by enabling them to cope with distress. It is important to break the cycle of violence and trauma, develop interface between community and service systems, as well as help in institutional building, and strengthening social support systems in communities and re-integrating people suffering from mental health issues into the society. In fact, it is also being argued now that for any peace building initiatives and measures for providing justice to be sustainable, psychological needs are to be addressed within it.

In that spirit, it is important that the state of J&K conceives a comprehensive community mental health programme comprising promotive, preventive and curative dimensions of treatment to address mental health issues of people in the immediate and long term in ways which will help

⁷ Average family size is 5.9 in J&K as per Census 2011 (RGI, 2011)

promote mental wellbeing, reduce stigmatization, address physical health needs, creating mass awareness, provide home based counseling, facilitate psychiatric treatment from public hospitals. Other aspects such as organizing child clubs, building vocational skills and sustainable livelihoods, linking people with government entitlements, and to create an environment where those who are affected by conflict can meet to ventilate and share experiences to focus on restarting new ways of life afresh, also need to be built in.

The approach paper to 12th Five year plan had given a clear mandate to initiate mental health services on a wider-scale and on priority in J&K. It states, "*Mental health services, including psycho-social care and counselling, should be prioritized, in settings of transition due to migration, areas of conflict and disturbances, especially in the NER and J&K and in areas of natural disasters/calamities*" (Government of India, 2011b, pp. 89). This reference to J&K comes in the purview of the state being ridden by conflict from last two and half decades resulting into abnormally high mental health problems among people as shown by this study. But the government structures to deal with this alarming situation of mental illnesses in Kashmir are minimal and mostly urban based. Due to lack of awareness, high stigmatization of mental health issues and lack of socio-economic and physical access, whatever services are available remain underutilized. There is a high gap between the extent of problem and the resources government has made available to.

4.1. Recommendations:

The findings of the study show a strong need for mental health interventions to address such higher levels of mental illness in Kashmir. Building on the existing local structures and strengths, the state of J&K must start a community based mental health care programme integrated into the primary health care. The national mental health programme also lays a stress on expanding mental health services. Some of the key initiatives that could be part of the larger community based mental health programme are:

 Promoting Mental Health and Building Resilience: It is important that initiatives are taken that help promote mental well-being at large and building resilience of communities to be able to cope with stressors. Initiatives like child recreational clubs, youth clubs, revival of socio-cultural activities aimed at providing recreation as well as helping the vulnerable and the poor through panchayat based work will help in many ways to promote mental health in communities. Initiatives on mass awareness on mental health issues and building capacities of community leaders and gross roots level workers will help building resilience of communities to deal with mental health issues with much preparation and on timely basis.

2) Primary Health Care approach: It is important that the mental health services are expanded and improved to deal with this alarming situation in the state. In doing so, *the state should adopt primary health care approach in the mental health services based on principles of comprehensibility, universality, equity, effectiveness, decentralisation and sustainability to bring health care as close as possible to people.* It should ensure active community participation, training of gross roots level workers, inter-sectoral coordination, develop required specialised services and improve delivery of health care system, should be made more effective. The chain of referral system from community up to tertiary hospitals needs to be strengthened. There is a need to decentralize the mental health service system to make quality services available down to the district and block level, which also helps in reducing the stigma attached to mental illness.

A graphical representation of how mental health services can be delivered through a threetier service delivery system in Kashmir is shown in Fig 4.1. The mental health service system could build from the primary level with involvement of community and grass roots level workers – teachers, Accredited Social Health Activists (ASHA) and anganwadi workers- as well as by strengthening Primary Health Centres (PHC) and Community Health Centres (CHC)/Sub-district hospitals. With the high level of mental illness in the valley compounded with very low awareness and high stigmatization, it is important that screening processes (for mental health issues) are put in place in all PHCs and CHCs. That would require having psychosocial counselors in hospitals, who could help in screening process as well as in providing counseling. In all CHCs the government should make psychiatrists available. NGOs working in this field could also help in strengthening and training community leaders and grass root level workers, as well as in public mobilisation around the issues of mental health.

The second level of health care will be provided at district hospitals through specialized doctors in psychiatry. All the district hospitals should have available trained psychosocial counselors. The District Mental Health Programme Unit (mentioned ahead) could function as secondary level of care in mental health service system.

At the tertiary level, the State Psychiatric Hospital of Srinagar (now called Institute of Mental Health & Neurosciences, Kashmir) could take a lead in making the advanced and specialized psychiatric services available at state level, as well in



developing capacity, teaching and research, rather than being the first referral point. These tertiary services could also be complemented by SMHS Hospital in Srinagar, and a similar-type hospital in Jammu.

- 3) **Availability of Psychiatrists**: Psychiatrists should be posted on full time basis in all the district and CHC (sub-district) hospitals. As of now, although most of the district hospitals have psychiatrists but most CHCs don't have.
- 4) **Provisioning of Medicines**: The availability of psychiatrists at the district and CHC hospitals will be one important milestone towards ensuring that people with mental illness receive treatment. However, one of the important reasons for people not being able to seek or receive

psychiatric treatment is their inability to afford medicines and diagnostic tests. It would be a significant step to make the psychotropic medicines available free of cost at district and CHC (sub-district) hospitals where psychiatrists are available. These medicines should be made available for all the people who seek treatment for mental illness to ensure that they are able to continue their treatment on long term basis.

- 5) District Mental Health Programme: The treatment for mental health issues needs a comprehensive approach comprising of promotive, preventive, curative and rehabilitative dimensions of treatment to address mental health issues of people. As an initiation towards developing this kind of comprehensive programme, *State Government may consider expanding District Mental Health Programme (DMHP) to all the districts in Kashmir.* The DMHP is the flagship mental health intervention programme of Government of India. The programme is presently being implemented in only 4 districts of Jammu region including Jammu, Kathua, Rajouri and Udhampur with effect from 2004-05. Under this programme a separate DMHP unit is placed with a 7-member team including a psychiatrist, psychiatric social worker, psychologist, psychiatric nurse, and admin staff. The programme envisages a community based approach. In fact the approach paper to 12th five year plan mentions that mental health services be expanded and prioritized in regions like J&K and North-east for these areas being ridden by conflict.
- 6) Specialized Services: Other than advanced medical services, which will be provided by institutions such as IMHANS and SMHS (Shri Maharaja Hari Singh) hospital in Kashmir (and by similar-type hospitals in Jammu), state government will also be required to create residential institutions for people with mental illness who are abandoned by their families. With such number of people being low, two such institutions can be created one each for men and women. Such centers should serve as a rehabilitative process; therefore, need to be equipped with providing medical as well as other services like vocational training, etc. Further, the state government must facilitate setting up of other types of rehabilitative and specialised institutions for persons with mental disabilities like children with autism, mental retardation, etc.

- 7) Community sensitization and involvement: In order to touch more lives and spread mental health work in far off areas and to excluded sections, it is important to build the capacity of community leaders and youth to facilitate psycho-social services to people especially those who are affected by traumatic events. Week long training for panchayats and ASHA workers on mental health issues will be very helpful to provide psychological first aid as well as facilitate referrals to psychiatric treatment from their respective areas.
- 8) Integrating Mental Health Services with Education and ICDS: There is very high stigmatisation and a very low awareness among people about the mental health issues. To reach to larger masses, it is important to train and build a cadre to make the intervention sustainable and widespread. As teachers and anganwadi workers come in contact with children who are almost 40 percent of the population, their sensitization about mental health issues to be able to help children who are experiencing mental trauma may be very helpful. They could also facilitate delivery of psycho-social services of the health department to the children, and help parents to find appropriate referral services if needed by children. In fact, schools and ICDS centres with sensitive and trained teachers/anganwadi workers can work as natural processes of recovery for children experiencing mental health issues.

To do so, the education and social welfare departments may consider developing a training module on psychosocial issues as part of the refresher and training courses provided by these departments to teachers and ICDS workers. Further, the education department may also consider the option of visiting courselors for schools. Such courselors could also be trained in career courseling and personality development, which will help reducing stigmatization of counseling for mental illness in schools.

On a similar pattern, police departments also need to train and sensitize police on mental health issues. With police being sensitized about the issue, they may help many of those who are arrested for offending behaviors but actually need psychiatric help.

9) Linkages with entitlements and other services: As this study as well as studies conducted in many other parts of world has shown a strong association of socio-economic conditions

and mental illness, it is important that government also initiates action to reduce poverty and improve socio-economic conditions of people especially those who are vulnerable to mental illness. An initial step could be giving a priority to families with any member suffering from mental illness under food, housing and livelihood programmes and to people with mental illness under social security schemes and pensions.

- 10) **Policy Research:** There is dearth of data and research related to mental health issues in Kashmir. It is important to carry further studies on different issues that are related to mental illness to provide empirical research data for policy formulations. Some of the issues that would need further research are given below. These aspects are important in understanding mental health in a broader context. We hope that this study would be of some use to such academic and policy research on mental health issues that will be undertaken in the future.
 - The findings of this study have cleared many doubts and indicated prevalence of 10 common mental health disorders in general population as well as among different socioeconomic groups in Kashmir. But it is important such a survey is also carried out in some other parts of Kashmir, as well as in Jammu and Ladakh regions. That could also help validate the findings of this study.
 - Although this study has indicated disparities in the prevalence of mental health disorders along the lines of gender, economic class and education levels but the underlying processes and pathways of this association need rigorous analysis.
 - 3. The study was conducted only on adults, while children constitute a significant proportion of population and have also been highly vulnerable to mental illness in the context of prolonged conflict in the state. Mental health of children also needs to be studied at the community level.
 - 4. This study has indicated low levels of treatment sought by people with mental illness, but the questions on the accessibility and underutilization of mental health services needs to be studied and understood in a broader socio-economic and political context.
 - 5. This study has given us an understanding of the extent of active mental illness in Kashmir, what is also important to understand is the impact of mental illness itself on the socio-economic conditions of persons suffering from it and on their families.

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