Final Technical Report

for

Research Project

Feasibility Testing and Validation of the Flexible Interview for ICD-11 (FLII-11) Adult Epi version for the Mental Health Survey in Sri Lanka

Principal Investigator: Yasara Manori SAMARAKOON, (WCO Sri Lanka)
Co-Investigator(s): Sumal Nandasena (Provincial Directorate of Health Services, Western Province, Sri Lanka)

2024.22.MP

November 2025

Final Technical Report

Disclaimer

The final technical report is submitted by the research on completion of a research project funded and sponsored by WHO regional office for South-East Asia and the WHO country offices in the South-East Asia Region. The final technical report publishes preliminary and unpolished results and aim to provide a vehicle for early access to research finding to maximize their use for informing policies and programs. The reports have not been edited, proof-read or peer reviewed, and have been published as presented. The findings, interpretations, and conclusions expressed in the final technical report are entirely those of the author(s) and should not be attributed in any manner to the World Health Organization, or to its affiliated organizations. Citation and the use of material presented in the final technical report should take into account this provisional character. The sponsoring technical team and author(s) bear full responsibility for the quality of the technical contents and presentation of material in the series.

Feasibility Testing and validation of the Flexible Interview for ICD-11 (FLII-11) Adult Epi version for the Mental Health Survey in Sri Lanka

Final Technical Report

WHO Reference 2024/1528257-0
Purchase Order 203582735
Unit Reference SRL-MH-APWs (GD)

Institution
FIRST RATE STRATEGIES PVT LTD
BATTARAMULLA
Battaramulla
Sri Lanka

Table of Contents

Local Technical Team

Team Lead
Dr Sumal Nandasena (Specialist in Community Medicine)

Co-Team Lead
Prof. Thilini Rajapaksha (psychiatrist)

Other Investigators
Prof. Chathurie Suraweera (psychiatrist)
Prof. S. Sivayokan (psychiatrist)
Dr Buddika Dayarathna (Health-Informatician)

Coordinator
Mr. Danuka Panangala

Executive Summary

This technical report presents the findings of the project titled "Feasibility Testing and validation of the Flexible Interview for ICD-11 (FLII-11) Adult Epi version for the Mental Health Survey in Sri Lanka". This project comprised three major components, which were organised as two projects. Three major components are as follows.

(1) Translation and Feasibility testing using the translated FLII-11 Adult Epi version and the Interview Experience Questionnaire (IEQ) in Sinhala and Tamil languages.
(2) Validation of the flii-11 adult epi version to adapt culturally and to identify measures of diagnostic accuracy (sensitivity, specificity, predictive values) and reliability.
(3) Qualitative needs assessment for assessing the perceived needs, unmet needs, continuum of care, community-based care, gaps at the facility level, community level and gaps in the continuum of care.

The feasibility phase assessed the FLII-11 – Adult Epidemiological Version in Sinhala and Tamil to determine its practicality, clarity, and cultural appropriateness in Sri Lankan settings. The study was conducted at the National Hospital of Sri Lanka, Teaching Hospital Peradeniya, and Teaching Hospital Jaffna, involving 263 Sinhala-speaking adults (140 patients known to have a mental disorder, 123 individuals did not report having a mental health disorder) and 200 Tamil-speaking adults (102 patients known to have a mental disorder, 98 individuals did not report having a mental health disorder). The FLII-11 and the IEQ were translated using forward- and back-translation, reviewed by psychiatrists and linguists, and administered electronically through the QUALTRICS platform. Both participants and interviewers rated the instrument very positively: in Sinhala, over 90 % found the questions clear, culturally relevant, and appropriately sequenced; in Tamil, more than 85 % rated language, structure, and flow favourably. Across both groups, participants felt respected, comfortable, and reported that the interview enhanced their understanding of mental health. Minor issues such as limited insight or mild cognitive difficulty affected only a small subset of patients. Overall, findings confirmed that the Sinhala and Tamil versions of the FLII-11 are linguistically accurate, culturally sensitive, and operationally feasible for wider field application and subsequent validation studies.

Subsequently, a cross-sectional study validated the FLII-11 in Sinhala and Tamil, assessing diagnostic accuracy and inter-rater reliability against psychiatrist diagnoses as the gold standard. Data were collected electronically through Qualtrics using Samsung A9 devices, and anonymized datasets were managed by Columbia University.

A total of 456 adults participated—259 Sinhala-speaking and 197 Tamil-speaking. Each participant was interviewed independently by a trained research assistant and a consultant psychiatrist. Subsamples of 59 (Sinhala) and 53 (Tamil) participants were re-assessed by a second research assistant for reliability testing.

The Sinhala Version FLII-11 correctly identified 77.2% of true mental-disorder cases and 76.4% of true healthy cases, with an overall diagnostic accuracy of 76.9% (95% CI 71.4–81.7). Predictive values were balanced (PPV 78.4 %, NPV 75.2 %). Reliability was strong (Cronbach $\alpha = 0.844$; ICC = 0.844, 95 % CI 0.74–0.91), indicating excellent inter-rater agreement.

Diagnostic performance was even higher in the Tamil Version, with sensitivity 76.1 %,

specificity 96.6 %, and overall accuracy 85.3 % (95 % CI 79.6–89.7). The PPV (96.5 %) demonstrated very low false-positive rates, while the NPV (76.6 %) confirmed sound exclusion of non-cases. Reliability was excellent (Cronbach α = 0.896; ICC = 0.896, 95 % CI 0.82–0.94).

The qualitative needs assessment explored gaps in mental-health care in Kalutara District through service mapping, key-informant interviews, and focus-group discussions with 28 professionals, patients, and community representatives. Using QGIS, existing resources were mapped—three consultant psychiatrists, 17 medical officers in mental health, and a limited number of counsellors, social workers, and community psychiatric nurses provided services across 15 outpatient clinics and one inpatient unit, with no NGO-run counselling or rehabilitation centres. Thematic analysis revealed a rapidly increasing burden of depression, anxiety, substance use, and dementia that far exceeds service capacity. Barriers included stigma, distance, transport costs, and culturally rooted misconceptions, while weak referral systems and poor record-keeping disrupted continuity of care. Human-resource shortages, overcrowded clinics, and inadequate infrastructure further constrained service quality, and community-level outreach remained minimal. Vulnerable groups—adolescents, elderly persons, women (especially those facing gender-based violence or perinatal issues), and individuals without caregivers—were the most underserved. The study concluded that although Kalutara possesses the structural base for a functional mental-health system, coordination between the hospital, community, and social sectors remains weak.

Based on the findings of this consultancy, it is recommended that the validated Sinhala and Tamil versions of the FLII-11 – Adult Epidemiological Version be adopted as the standard diagnostic and screening tools for national and regional mental-health surveys in Sri Lanka. Their integration into primary health-care and mental-health service delivery would enable standardized, ICD-11–aligned diagnosis and facilitate early detection at community and outpatient levels. In line with the findings from the qualitative assessment, strengthening district mental-health systems is essential—particularly through the establishment of short-stay wards, rehabilitative day-care centres, and community outreach services coordinated by intersectoral committees. Expanding multidisciplinary human resources, including counsellors, community psychiatric nurses or public health nurses, occupational therapists, and psychologists, is vital to improve service coverage and quality. Furthermore, enhanced community engagement through schools, workplaces, and NGOs is recommended to improve mental-health literacy and reduce stigma, especially among vulnerable groups such as adolescents, women, and the elderly.

Brief Introduction

Mental health stands as a cornerstone of individual and societal well-being, influencing everything from economic productivity and social cohesion to the fundamental quality of life. Globally, the burden of mental health conditions is substantial, demanding urgent attention and comprehensive interventions (1). Sri Lanka, a nation marked by its resilience and cultural diversity, faces a series of mental health challenges. The prolonged civil conflict over decades has left deep psychological impacts across Sri Lankan society. Although the war was confined to the Northern and Eastern provinces, the entire Sri Lanka faced the impacts of violence, displacement, and the loss of loved ones which contributed to widespread post-traumatic stress disorder (PTSD), anxiety, and depression (2) (3).

The 2004, Tsunami, further impacted these challenges, triggering acute stress reactions and exacerbating pre-existing mental health conditions (4,5). The psychological impact of these events continues highlighting the critical need for long-term mental health support and disaster preparedness.

More recently, Sri Lanka had economic instability, marked by inflation, unemployment, and resource scarcity. The economic stressors have significantly impacted mental well-being, contributing to increased anxiety, depression, and feelings of hopelessness (6) (7). The COVID-19 pandemic has further amplified these challenges, disrupting social support networks, increasing social isolation, and creating a climate of fear and uncertainty (8).

While the Sri Lankan government has made commendable efforts to address mental health through national policies and strategic plans, the effective implementation of these initiatives remains a significant challenge. The existing mental health infrastructure is often strained, characterized by a shortage of trained mental health professionals (e.g., psychiatrists), limited availability of specialised facilities, and inadequate access to community-based services. This disparity is particularly pronounced in rural and underserved areas, where access to mental health care is often severely limited. Furthermore, the cultural stigma surrounding mental illness continues to act as a formidable barrier to help-seeking behaviour, discouraging individuals from seeking professional support. Traditional beliefs and practices may also influence how mental health conditions are perceived and managed, highlighting the need for culturally sensitive interventions.

Existing data on mental health needs and service utilization in Sri Lanka are often fragmented, outdated, or lack the granularity necessary to inform targeted interventions. There is a critical need for a comprehensive and up-to-date assessment of mental health needs, particularly among vulnerable populations such as youth, the elderly, conflict-affected individuals, marginalised communities, and those residing in rural and underserved areas. This warrants conducting a rapid qualitative evaluation of the current state of mental health services.

Additionally, the consultancy introduces the FLII-11 as a means to bridge this gap by providing a culturally sensitive and scientifically robust tool for mental health evaluation. It emphasizes the critical need for tools that are adapted to local languages—Sinhala and Tamil—to ensure effective communication and accurate diagnosis. The Flexible Interview for ICD-11 (FLII-11) is a sophisticated diagnostic tool tailored to support the evaluation of mental health disorders

in alignment with the World Health Organization's 11th Revision of the International Classification of Diseases (ICD-11).
FLII-11 was developed by the World Health Organization's (WHO) Department of Mental Health, Brain Health, and Substance Abuse (MSD). The FLII-11 is a structured diagnostic interview designed to support both clinical and epidemiological studies, providing a comprehensive evaluation of a wide range of mental health conditions that contribute to the global burden of mental disorders and substance use. The WHO MSD's vision centres on making open-access diagnostic tools based on the ICD-11 widely available, in line with the "Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural, and Neurodevelopmental Disorders" published in March 2024. As part of this vision, the FLII-11 aims to meet the need for accessible instruments for use in national mental health surveys, clinical studies, and population-based research. WHO has recognized the significant interest from several member states in accessing such tools to enhance their mental health data collection and analysis efforts.

In brief, the consultancy includes the flexibility assessment of the FLII-11 questionnaire, validation of the flexibility assessment questionnaire for Sinhala and Tamil languages, and rapid assessment of the state of mental health services in the District of Kalutara.

Summary of Activities Conducted based on Terms of Reference (ToR)

The feasibility testing of the Flexible Interview for ICD-11 (FLII-11) and rapid assessment of the state of mental health services were conducted through two sequentially coordinated projects under WHO collaboration. Work performed and the status are given in Table 1.

Table 1: Work performed under each project and subcomponents

Project	Time frame	Activity	Status
Project 1	26-JUN-2024 to 31-OCT-2024	**Feasibility testing exercise)**	
		To conduct the feasibility testing (testing of FLII-11's feasibility, clinical utility and acceptability) component using the translated FLII 11 Adult Epi version and the Interview Experience Questionnaire (IEQ)	Completed. Provided a report at the end of the Project 1.
		To provide a comprehensive report of the feasibility testing.	Feasibility testintg report is provided as **Annexure A** of this report.
Project 2	18-NOV-2024 to 31st -Aug-2025		
Component 1		To validate the FLII-11 adult epi Version to adapt culturally and to identify the measures of diagnostic accuracy (Sensitivity, Specificity, Predictive values) and reliability.	Completed
		To provide the validation study report.	Completed. Will be provided as the **Annexure B** of this report.
Component 2		To conduct a qualitative needs assessment for assessing the perceived needs, unmet needs, continuum of care, community-based care, gaps at facility level, community level and gaps in the continuum of care based on an appropriate methodology developed.	Completed.
		To provide a comprehensive report of the needs assessment exercise.	Completed. Will be provided as the **Annexure C** of this report.

Ethical and Administrative Clearance

Prior to commencing the study, ethical and administrative approvals were obtained to ensure compliance with both national and international standards. The Local Ethical Review Committee (National Institute of Health Sciences, Ministry of Health) granted clearance in two components: first for the *Feasibility Testing and Validation of the Flexible Interview for ICD-11 (FLII-11)* (Annexure 1)and second for the *Needs Assessment Study* (Annexure 2). In addition, the WHO Ethical Review Committee reviewed and approved the protocol (Annexure 3), and administrative clearance was secured from the Director General of Health Services, Ministry of Health, Sri Lanka (Annexure 4).

Methods, Results, Conclusions and Recommendations

As per the scope outlined in the ToRs and in collaboration with the World Health Organisation (WHO), the Ministry of Health, and Columbia University, the consultancy carried out a structured set of activities aligned with the activities described in Table 1. A brief methodology, results, conclusions, and recommendations are provided for each component in the Sub-Sections A to C. A few photos of field activities are given in Figures 1 to 5. Training plans used for training data collectors are provided in Annexures 5 and 6. Relevant questionnaires received in the English language are given in Annexure 7 and 8.

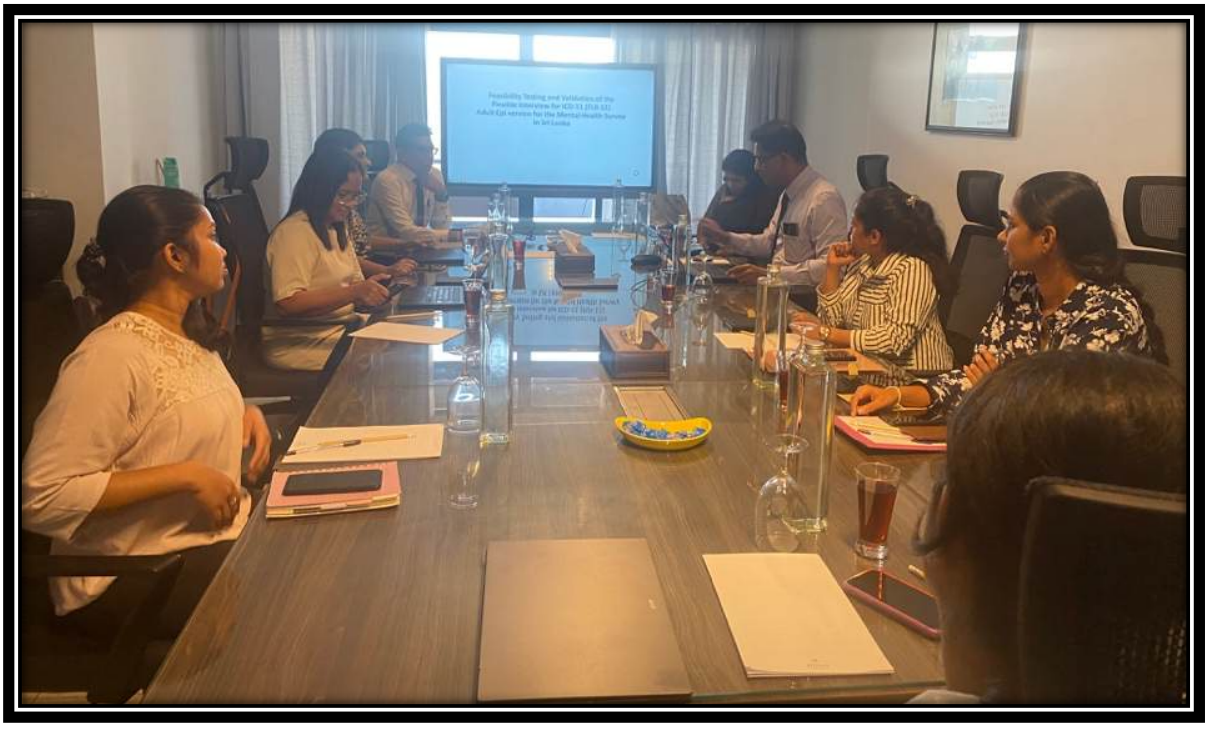

Figure 1: Physical Training Conducted by the investigators for Sinhala-speaking data collectors

Figure 2: Experience sharing session of Sinhala data collectors for the Tamil data collectors

Figure 3: Questionnaire administration by a research assistant. (Sinhala Medium)

Figure 4: Questionnaire administration by a research assistant. (Sinhala Medium)

Figure 5: Key Informant Interview with a Public Health Midwife

Annexures

Annexure 1:
Ethical Clearance for Feasibility Testing and Validation of the Flexible Interview for ICD-11
Annexure 2:
Ethical Clearance for Needs Assessment Study
Annexure 3:
WHO Ethical Review Committee approval
Annexure 4:
Administrative approval from the Director General of Health Services, Ministry of Health, Sri Lanka
Annexure 5:
Training Plan for Data Collectors (Sinhala)
Annexure 6:
Training Plan for Data Collectors (Tamil)
Annexure 7:
FLII -11 Questionnaire (English version)
Annexure 8:
Interviewer Experience Questionnaire – Participant/ Interviewer components (English)

Downloadable Link of the original databases, translated questionnaires and recordings - https://drive.google.com/drive/folders/1JScsUe72cKnK88agwGXRBmwLsjshWOOB?usp=sharing

Sub Sections

SUB SECTION A - PROJECT 1: FEASIBILITY TESTING OF THE FLEXIBLE INTERVIEW FOR ICD-11 (FLII-11) ADULT EPI VERSION (AND RESULTS OF FEASIBILITY TESTING)

SUB SECTION B - PROJECT 2 - COMPONENT 1: TO VALIDATE THE FLII-11 ADULT EPI VERSION TO ADAPT CULTURALLY AND TO IDENTIFY THE MEASURES OF DIAGNOSTIC ACCURACY (SENSITIVITY, SPECIFICITY, PREDICTIVE VALUES) AND RELIABILITY.

SUB SECTION C - PROJECT 2 - COMPONENT 2: QUALITATIVE NEEDS ASSESSMENT FOR ASSESSING THE PERCEIVED NEEDS, UNMET NEEDS, CONTINUUM OF CARE, COMMUNITY-BASED CARE, GAPS AT THE FACILITY LEVEL, COMMUNITY LEVEL AND GAPS IN THE CONTINUUM OF CARE.

Ethics Review Committee

National Institute of Health Sciences
P.O.Box 28, Matugama Rd, Nagoda, Kalutara, Sri Lanka.
Telephone: +94-34-2222264 ext 219
Email: nihs.erc@gmail.com

03rd September 2024
Reference No: **NIHS/ERC/24/58**

Dear Dr.Sumal Nandasena

Title : Feasibility Testing and Validation of the Flexible Interview for ICD-11(FLII-11) Adult Epi version for the Mental Health Survey in Sri Lanka

.Co-investigator -Dr.Thilini Rajapakse
Dr. Chathurie Suraweera
Other investigators - Dr. Buddika Dayarathne
Mr. Danuka Panangala

Thank you for submitting the above research proposal. I am pleased to inform you that you have been granted the ethical clearance for the above study by the Ethics Review committee, National Institute of health Sciences, which met on 03/09/2024

This approval is valid for one year from the date of issue of this letter, and the committee requires that you furnish a final report once the study is concluded.

If the study is continued for a period beyond one year, you are required to furnish a progress report for the year and an application for the extension of approval by a further year. The ERC will issue such extension after consideration of the progress report and any other information it may require from you for this purpose.

This approval relates to the ethical content of the study only, and you are responsible for the following:
Negotiating individual arrangements with the Heads of Service Departments in those situations where the use of their resources is involved.

If appropriate, inform the study sponsor that the membership and procedures of the National Institute of Health Sciences, Ethics Review Committee complies with appropriate guidelines of the Forum of Ethics Review Committees in Sri Lanka.

With best wishes,

.....
Dr. Nadeeka Perera

Chairperson
Ethics Review Committee
National Institute of Health Sciences,
Kalutara.

Chairperson
Ethics Review Committee
National Institute of Health Sciences,
Kalutara, Sri Lanka.

Ethics Review Committee

National Institute of Health Sciences
P.O.Box 28, Matugama Rd, Nagoda, Kalutara, Sri Lanka.
Telephone: +94-34-2222264 ext 219
Email: nihs.erc@gmail.com

08th May 2025
Reference No: **NIHS/ERC/25/11**

Dear Dr. Sumal Nandasena

Title : Needs Assessment of Mental Health Services in Western Province, Sri Lanka: A qualitative study

Co-investigator - Dr. Thilini Rajapakse
Dr. Chathurie Suraweera

Other investigators - Dr.Champika Wickramasinghe
Dr. Buddika Dayarathne
Mr. Danuka Panangala

Thank you for submitting the above research proposal. I am pleased to inform you that you have been granted the ethical clearance for the above study by the Ethics Review committee, National Institute of health Sciences, which met on 08/05/2025

This approval is valid for one year from the date of issue of this letter, and the committee requires that you furnish a final report once the study is concluded.

If the study is continued for a period beyond one year, you are required to furnish a progress report for the year and an application for the extension of approval by a further year. The ERC will issue such extension after consideration of the progress report and any other information it may require from you for this purpose.

This approval relates to the ethical content of the study only, and you are responsible for the following:
Negotiating individual arrangements with the Heads of Service Departments in those situations where the use of their resources is involved.

If appropriate, inform the study sponsor that the membership and procedures of the National Institute of Health Sciences, Ethics Review Committee complies with appropriate guidelines of the Forum of Ethics Review Committees in Sri Lanka.

With best wishes,

.....
Dr. K.P.S.D.S.Chandrasekara
Chairperson
Ethics Review Committee
National Institute of Health Sciences,
Kalutara.

Chairperson
Ethics Review Committee
National Institute of Health Sciences,
Kalutara, Sri Lanka.

World Health Organization
REGIONAL OFFICE FOR South-East Asia

SEARO Research Ethics Review Committee
(SEARO-ERC)
World Health House, Indraprastha Estate,
Mahatma Gandhi Marg, New Delhi-11001, India

SEARO ERC Approval

Unique Proposal ID: 2024.22.MP

Protocol Title: Feasibility Testing and Validation of the Flexible Interview for ICD-11 (FLII-11) Adult Epi version for the Mental Health Survey in Sri Lanka

Version: 23 September 2024

WHO responsible office: World Health Organization, Country Office Sri Lanka

WHO responsible unit/department: Department of Non-Communicable Diseases

Principal investigators: Dr Sumal Nandasena, Provincial Directorate of Health Services, Western Province, Sri Lanka

WHO responsible technical officer: Dr Yasara Manori Samarakoon, National Consultant Mental Health

SEARO role in Research: Technical assistance & collaboration and funding (26 794 USD)

Dear Dr Yasara Manori Samarakoon

Thank you for submitting the above-referenced protocol to SEARO-ERC. The proposal went through an expedited review process.

Decision on expedited review: The proposal is **approved** on expedited review by SEARO-ERC[1] This approval is valid for the entire duration of the study.

The responsible technical officer for the research project shall submit the following documents to the Secretariat of SEARO-ERC on health research portal (https://researchportal.searo.who.int):

- Annual progress report (if the duration of the research is more than 1 year)
- Final scientific Report
- Any adverse reports
- Patient/participant feedback (if any).

Chairperson: _____
Name: Dr Suman Rijal
Date: 27.09.2024

[1] Please note that SEARO-ERC approval does not constitute budget approval or approval for procurement matters which should be approved as per Delegation of Authority.

දුරකථන) 0112669192 , 0112675011
தொலைபேசி) 0112694033, 0112675280
Telephone) 0112675449

ෆැක්ස්) 0112693866
பெக்ஸ்) 0112693869
Fax)0112692913

විද්‍යුත් තැපෑල) postmaster@health.gov.lk
மின்னஞ்சல் முகவரி)
e-mail)

වෙබ් අඩවිය) www.health.gov.lk
இணையத்தளம்)
website)

සුවසිරිපාය
சுவசிரிபாய
SUWASIRIPAYA

මගේ අංකය)
எனது இல)
My No.) DMH/B/WHO/01/2025

ඔබේ අංකය)
உமது இல)
Your No.)

දිනය)
திகதி)
Date 03 .01.2025

සෞඛ්‍ය හා ජනමාධ්‍ය අමාත්‍යාංශය

சுகாதார மற்றும் வெகுஜன ஊடக அமைச்சு

Ministry of Health & Mass Media

Deputy Director General/ National Hospital Sri Lanka
Director/ Teaching Hospital Peradeniya
Director/ National Hospital Kandy
Director/ Teaching Hospital Jaffna
Director/ Teaching Hospital Batticaloa
Director/ Colombo South Teaching Hospital, Kalubowila

Feasibility Testing and Validation of the Flexible Interview for ICD-11 (FLII-11) Adult Epi version for the Mental Health Survey in Sri Lanka

A request was made to the World Health Organization by the Ministry of Health to support conducting a National Mental Health Survey to assess the prevalence of mental disorders in Sri Lanka. The Flexible Interview for ICD-11 (FLII-11) will be used to assess the prevalence of mental health disorders in alignment with the World Health Organization's 11th Revision of the International Classification of Diseases (ICD-11). Hence the first phase of this project is to culturally adapt the FLII-11 for Sinhala and Tamil languages, assess the tool's feasibility in local contexts, and validate its accuracy and reliability against established diagnostic standards. By achieving these objectives, the project aims to enhance the effectiveness of mental health services in Sri Lanka and contribute to the global understanding of mental health assessments across diverse cultural settings.

Accordingly, an independent team of experts led by Consultant Psychiatrists and Consultant Community Physicians have been appointed for conducting the above study and will be initiating data collection in your institutions.

Please provide all the necessary support for the identified team of investigators to conduct the above study in your institutions, considering its national importance in assessing the prevalence of mental disorders in Sri Lanka.

Thank you.

Dr. Asela Gunawardena
Director General of Health Services

Dr. ASELA GUNAWARDENA
Director General of Health Services
Ministry of Health
"Suwasiripaya"
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10.

Cc: DDG/NCD
D/MH

Annexure 5

Training Plan of the Data Collectors - Sinhala Language

Training Team
SN: Dr. Sumal Nandasena (Epidemiologist))
TH: Prof. Thilini Rajapaksha (psychiatrist)
CS: Prof. Chathurie Suraweera (psychiatrist)
BD: Dr. Buddika Dayarathna (Health-Informatician)
DP: Mr. Danuka Panangala (Project Manager)

Date	Time	Content	Teaching Learning Method	Responsibility
10th February	Start: 8.30 am	Introduction to the research project, including its objectives and significance.	Presentation	SN
		Ethical aspects of the research and the confidentiality of participants	Lecture Discussion	CS
	End 4.15 pm	Introduction to the information sheet and the consent form	Lecture Discussion	CS
11th February	Start: 8.30 am	Introduction to the data collection tool -FLII-11	Demonstration	BD
		Introduction to the QUALITRICS data collection platform	Lecture Discussion, Demonstration	BD
	End 4.15 pm	Practical session to familiarize with the data collection TAB and the QUALITRICS data collection platform	Demonstration and practical session	BD,SN,DP
12th February		Public Holiday		

13th February	Start: 8.30 am	Demonstration of video developed by the NMHS, India (first Video)	Display of video	SN
		Step by step Guidance to the FLII-11 tool through hard copies and QUALITRICS	Discussions and role play	TR, CS
	End 4.15 pm	Role play – inside classroom	Discussions and role play	TR, CS
14th February	Start: 8.30 am	Step by step Guidance to the FLII-11 tool through hard copies and QUALITRICS	Discussions and role play	TR, CS, BD
		Practical session with tentative participants at the data collection site	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion	BD, SN
15th February		Public Holiday		
16th February		Public Holiday		
17th February	Start: 8.30 am	Step by step Guidance to the FLII-11 tool through hard copies and QUALITRICS	Lecture Discussion,	TR, CS
		Practical session with tentative participants at the data collection site	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion	BD, SN
18th February	Start: 8.30 am	Step by Step Guidance to the FLII-11 tool through hard copies and QUALITRICS	Lecture Discussion,	TR, CS
		Practical session with tentative participants at the data collection site	Practical sessions, supervisions	TR, CS

	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion	BD, SN
19th February	Start: 8.30 am	Step by Step Guidance to the FLII-11 tool through hard copies and QUALITRICS	Lecture Discussion,	TR, CS
		Practical session with tentative participants at the data collection site	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
20th February	Start: 8.30 am	Step by Step Guidance to the FLII-11 and IEQ tool through hard copies and QUALITRICS	Lecture Discussion,	TR, CS
		Practical session with tentative participants at the data collection site (FLII -11 and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion	BD, SN
21st February	Start: 8.30 am	Video -Demonstration of role Play Scenario 1 – Depression https://drive.google.com/file/d/1-OALpMUAca2OZT7Rz_c03LVo0EZyEVmj/view Scenario 2 - Depression https://drive.google.com/file/d/1-U6OBKp4hmq0qP3Z_iDFvq92Wy01CBIT/view	Demonstration	SN
		Practical session with tentative participants at the data collection site (FLII -11 and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
22nd February		Public Holiday		

23rd February		Public Holiday		
24th February	Start: 8.30 am	Video -Demonstration of role Play Senario 3 – Depression https://drive.google.com/file/d/1-YGu9fQUryKROkvg6zxyuEMAVxA5tAed/view	Demonstration	SN
		Introduction to the service utilization component	Discussion	SN
		Practical session with tentative participants at the data collection site (FLII -11, IEQ and service utilization questionnaire)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
25th February	Start: 8.30 am	Video -Demonstration of role Play Senario 3 – Depression https://drive.google.com/file/d/1-YGu9fQUryKROkvg6zxyuEMAVxA5tAed/view	Demonstration	SN
		Practical session with tentative participants at the data collection site (FLII -11 and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
26th February		Public Holiday		
27th February	Start: 8.30 am	Mania – Scenario 1 https://drive.google.com/file/d/1bdoPmZ3PId4U3WQXdsVDQaQk5IhbsQPq/view Mania – Scenario 2 https://drive.google.com/file/d/1PbMPFl4J4uGO9Z2Brhp6KVYiD87Kn7-1/view	Demonstration	SN

		Practical session with tentative participants at the data collection site (FLII -11 and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
28th February	Start: 8.30 am	Mixed Episode – Scenario 1 https://drive.google.com/file/d/1RDxi1X3LT9oerfGc1IPoxqiOwLteFjMP/view Mixed Episode – Scenario 2 https://drive.google.com/file/d/1PC-wlFjCxVz2q67mh8VSQSUo4aqMZIne/view	Demonstration	SN
		Practical session with tentative participants at the data collection site (FLII -11 , service utilization and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
1st March		Public Holiday		
2nd March		Public Holiday		
3rd March	Start: 8.30 am	Psychosis https://drive.google.com/file/d/1HUfUi3D12HDTFC-0qI6elmCPU21959u3/view	Demonstration	SN
		Practical session with tentative participants at the data collection site (FLII -11 , service utilization and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN

4th March	Start: 8.30 am	Agoraphobia – Scenario 1 https://drive.google.com/file/d/1AZv62vaXb-uZabexaUbiif24BW8vCCbY/view Agoraphobia – Scenario 2 https://drive.google.com/file/d/1py--V5rWGCy4OChwu4htbVj3TPkR8JyG/view	Demonstration	SN
		Practical session with tentative participants at the data collection site (FLII -11 , service utilization and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
5th March	Start: 8.30 am	GAD – Scenario 1 https://drive.google.com/file/d/1rQgN8iKWVqhDRGhfYcXuzG76cQv_wudB/view GAD - Scenario 2 https://drive.google.com/file/d/1ZAPNhcVL774ehvWnP09l7h73p6o09uZx/view Panic – Scenario 1 https://drive.google.com/file/d/14IewwisEDihlqKowcZKjSIldEn-fWy8D/view Panic – Scenario 2 https://drive.google.com/file/d/1hB0wsnMBoEWHMFI-Ypte8CZgvubegwkY/view	Demonstration	SN
		Practical session with tentative participants at the data collection site (FLII -11, service utilization and IEQ)	Practical sessions, supervisions	TR, CS

	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
6th March	Start: 8.30 am	Social Anxiety Disorder (SAD) – Scenario 1 https://drive.google.com/file/d/1GTA1PM6B1wMJaI5pzVFyzM-JbDp_NQrD/view Social Anxiety Disorder (SAD) – Scenario 2 https://drive.google.com/file/d/1j_yfJTxJDfOwM8zaZKoEgBLxF_rHmtXR/view OCD – Scenario 1 https://drive.google.com/file/d/1X3Snus0qnEFfQs4XZs3ApSoO_-U9ySmK/view OCD – Scenario 2 https://drive.google.com/file/d/1X3Snus0qnEFfQs4XZs3ApSoO_-U9ySmK/view	Demonstration	SN
		Practical session with tentative participants at the data collection site (FLII -11, service utilization and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
7th March	Start: 8.30 am	Hypochondrasis – Scenario 1 https://drive.google.com/file/d/1OHYaTaWByEIvGDpUnj3nLrEajESZRulg/view Hypochondriasis – Scenario 2 https://drive.google.com/file/d/1Dn8piuqBmVzxjs3lJTrhcxCSFBqpyHj7/view Hypochondriasis – Scenario 3	Demonstration	SN

		https://drive.google.com/file/d/1Lm4SNj7wRcUrevUW1Oy1ROI0klJpOPhB/view Anorexia – Scenario 1 https://drive.google.com/file/d/1qkINWDN5V2Fq5sdCrxNCpV7yGJyPLuxe/view Anorexia – Scenario 2 https://drive.google.com/file/d/1qkINWDN5V2Fq5sdCrxNCpV7yGJyPLuxe/view		
		Practical session with tentative participants at the data collection site (FLII -11, service utilization and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
8th March		Public Holiday		
9th March		Public Holiday		
10th March	Start: 8.30 am	Bulimia https://drive.google.com/file/d/13DDJwjF2b8X-3spYSvEAEPGLBED1GPqV/view Bulimia – Scenario 2 https://drive.google.com/file/d/13DDJwjF2b8X-3spYSvEAEPGLBED1GPqV/view PTSD – Scenario 1 https://drive.google.com/file/d/1KU8aSvGfzxTADZyGQeWQfW2Ye1SRapZw/view	Demonstration	SN

		PTSD – Scenario 2 https://drive.google.com/file/d/1Dpabl1PRtSP44vxn2Yf6Xh0RH6XnqblO/view Gambling Disorder – Scenario 1 https://drive.google.com/file/d/18uo2zewBB-Zmqw6NOzIsI8cxZuHiziNe/view Gambling Disorder – Scenario 2 https://drive.google.com/file/d/160x3MoP51bah3W_uuhQRQ7MlKAKNsAM0/view Gambling Disorder – Scenario 3 https://drive.google.com/file/d/1Eaw-EmRBitMSU70CFKyg3J_VNHhH0QkP/view		
		Practical session with tentative participants at the data collection site (FLII -11, service utilization and IEQ)	Practical sessions, supervisions	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussion and addressing the comments	BD, SN
11th March	Start: 8.30 am	SUD -Scenario 1 https://drive.google.com/file/d/1CN7BNBSZhPwCCS1fgpKS_Fkb_lTgtBaQ/view SUD – Scenario 2 https://drive.google.com/file/d/1H4tXfIny16fsmYAUQ1AqTKYVMNUQAxM3/view ADHD – Scenario 1		SN

		https://drive.google.com/file/d/1yi3beYO4aTJPNT6gR3l_5TQ6IbbiUjE_/view SD scenario https://drive.google.com/file/d/13dsyohBT6rGzyYazbVwMWscw0vHPDnbp/view		
		Practical session with tentative participants at the data collection site (FLII -11, service utilization and IEQ)	Demonstration	TR, CS
	End 4.15 pm	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Practical sessions, supervisions	BD, SN
12th March	Start: 8.30 am	Final Discussion of the questionnaire	Discussion and addressing the comments	SN, TR, CS, BD
		Study administration and administrative and financial issues relevant to the data collection process	Discussion	SN, DP
	End 4.15 pm	END of TRAINING		

Annexure 6

Training Plan of the Data Collectors – Tamil

Training Team
TR: Prof. Thilini Rajapaksha (psychiatrist)
CS: Prof. Chathurie Suraweera (psychiatrist)
SY: Prof. Sivayokan (psychiatrist)
SN: Dr. Sumal Nandasena (Epidemiologist))
BD: Dr. Buddika Dayarathna (Health-Informatician)
KM: Karen Mare (recorded lectures)
NIMH & NS: recorded role plays

Date	Time	Content	Teaching Learning Method	Responsibility
14th May	Start: 8.30 am End 4.15 pm	8.30 am to 9.30 – Introduction and opening remarks - Introduction to the research project, including its objectives and significance. – (SN) 9.30am to 12.30pm –Introduction to the questionnaire (TR and CS) Discussion of ethical aspects, including informed consent and Confidentiality (with a break for tea) 12.30pm – 1.30 pm – Lunch 1.30 pm to 3.30 pm – Continue introduction to questionnaire, and discussion of challenges/ questions (TR, SY, CS, SN, RAs). Prof Sivayokan may join in during this time, via zoom 3.30 pm to 4.30 pm – Orientation on electonic devices and data entry interface of QUALITRICS (BD)	Presentations, Discussions, role play, demonstrations	SN, TR, CS, SY, BD

		4.30 pm to 5.30 pm – Logistics and operational procedures – (SN, presentation fromRAs – Colombo)		
15th May		Travelling day to Jaffna		
16th May	Virtual Training	Interviewer Training Session 1: (Colimbia – WHO Centre for Global Mental Health) (KM) **Session 1** -: https://vimeo.com/1067427344/0d3db95a2a Interviewer Training Session 2: (Colimbia – WHO Centre for Global Mental Health) **Session 2** -: https://vimeo.com/1069606837/0ca1c5ac13 Interviewer Training Session 3: (Colimbia – WHO Centre for Global Mental Health) **Session 3** -: https://vimeo.com/1071818096/ea5a0840db **Clinical orientation presentation** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/ADgnpBo2JRF-bEpaLNZqrFM/Interviewer%20Training%20Materials/Clinical%20Orientation%20(CO)?rlkey=0ulnij86xbrxu59efano2uhlz&subfolder_nav_tracking=1&st=bcpeztq0&dl=0 **Interviewer training presentations** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/AGDP8ZHzipM1vgr7T9D2hGU?rlkey=0ulnij86xbrxu59efano2uhlz&e=1&st=hlzmrt9a&dl=0	Presentation	Colimbia – WHO Centre for Global Mental Health
17th May	Self-Study Virtual Training	Introduction to Demograpphic Questionnaire and Service Utilization Questionnaire Introduction to Interviewer Experiencing Questionnaire Questionnaires can be downloded	Lecture Discussion,	SN

		https://drive.google.com/drive/folders/1c3CbsgLmdot8sBuCEPa2v9FqA_V_k6g2?usp=sharing **MOOD EPISODES** **DEPRESSIVE EPISODE** **MANIC EPISODE AND HYPOMANIC EPISODE (MAN)** **MIXED EPISODE** **Clinical orientation presentation** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/ADgnpBo2JRF-bEpaLNZqrFM/Interviewer%20Training%20Materials/Clinical%20Orientation%20(CO)?rlkey=0ulnij86xbrxu59efano2uhlz&subfolder_nav_tracking=1&st=bcpeztq0&dl=0 **Interviewer training presentations** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/AGDP8ZHzipM1vgr7T9D2hGU?rlkey=0ulnij86xbrxu59efano2uhlz&e=1&st=hlzmrt9a&dl=0 Video -Demonstration of role Play Scenario 1 – Depression https://drive.google.com/file/d/1-OALpMUAca2OZT7Rz_c03LVo0EZyEVmj/view Scenario 2 - Depression https://drive.google.com/file/d/1-U6OBKp4hmq0qP3Z_iDFvq92Wy01CBIT/view Video -Demonstration of role Play Senario 3 – Depression https://drive.google.com/file/d/1-YGu9fQUryKROkvg6zxyuEMAVxA5tAed/view Mania – Scenario 1 https://drive.google.com/file/d/1bdoPmZ3PId4U3WQXdsVDQaQk5IhbsQPq/view Mania – Scenario 2	Demonstration	

		https://drive.google.com/file/d/1PbMPFl4J4uGO9Z2Brhp6KVYiD87Kn7-1/view Mixed Episode – Scenario 1 https://drive.google.com/file/d/1RDxi1X3LT9oerfGc1IPoxqiOwLteFjMP/view Mixed Episode – Scenario 2 https://drive.google.com/file/d/1PC-wlFjCxVz2q67mh8VSQSUo4aqMZIne/view		
18th May		Public Holiday		
19th May	Start: 8.30 am	**PSYCHOTIC SYMPTOMS** **DELUSIONS** **EXPERIENCES OF PASSIVITY, INFLUENCE AND CONTROL** **HALLUCINATIONS** **(PROBABLE) PRIMARY PSYCHOTIC DISORDER (PPD)** **Clinical orientation presentation** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/ADgnpBo2JRF-bEpaLNZqrFM/Interviewer%20Training%20Materials/Clinical%20Orientation%20(CO)?rlkey=0ulnij86xbrxu59efano2uhlz&subfolder_nav_tracking=1&st=bcpeztq0&dl=0 **Interviewer training presentations** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/AGDP8ZHzipM1vgr7T9D2hGU?rlkey=0ulnij86xbrxu59efano2uhlz&e=1&st=hlzmrt9a&dl=0 Psychosis https://drive.google.com/file/d/1HUfUi3D12HDTFC-0qI6elmCPU21959u3/view **Practical session with tentative participants**	Display of video	SN

	Virtual Meeting at evening/night (time to be identified)	Meeting with RAs to identify the language issues they come across during the questionnaire administration	Discussions and role play	TR, CS
20th May	Jaffna TH Start: 8.30 am	**ANXIETY AND FEAR-RELATED DISORDERS** **PANIC DISORDER (PD)** **AGORAPHOBIA (AGO)** **GENERALIZED ANXIETY DISORDER (GAD)** **SOCIAL ANXIETY DISORDER (SAD)** **Clinical orientation presentation** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/ADgnpBo2JRF-bEpaLNZqrFM/Interviewer%20Training%20Materials/Clinical%20Orientation%20(CO)?rlkey=0ulnij86xbrxu59efano2uhlz&subfolder_nav_tracking=1&st=bcpeztq0&dl=0 **Interviewer training presentations** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/AGDP8ZHzipM1vgr7T9D2hGU?rlkey=0ulnij86xbrxu59efano2uhlz&e=1&st=hlzmrt9a&dl=0 Agoraphobia – Scenario 1 https://drive.google.com/file/d/1AZv62vaXb-uZabexaUbiif24BW8vCCbY/view Agoraphobia – Scenario 2 https://drive.google.com/file/d/1py--V5rWGCy4OChwu4htbVj3TPkR8JyG/view GAD – Scenario 1 https://drive.google.com/file/d/1rQgN8iKWVqhDRGhfYcXuzG76cQv_wudB/view GAD - Scenario 2 https://drive.google.com/file/d/1ZAPNhcVL774ehvWnP09l7h73p6o09uZx/view	Discussions and role play	TR, CS

		Panic – Scenario 1 https://drive.google.com/file/d/14IewwisEDihlqKowcZKjSIldEn-fWy8D/view Social Anxiety Disorder (SAD) – Scenario 1 https://drive.google.com/file/d/1GTA1PM6B1wMJaI5pzVFyzM-JbDp_NQrD/view Social Anxiety Disorder (SAD) – Scenario 2 https://drive.google.com/file/d/1j_yfJTxJDfOwM8zaZKoEgBLxF_rHmtXR/view		
		Practical session with tentative participants		
	Virtual Meeting at evening/night (time to be identified)	Meeting with RAs to identify the language issues they come across during the questionnaire administration		
22nd May	Jaffna TH Start: 8.30 am	**OBSESSIVE COMPULSIVE AND RELATED DISORDERS** OBSESSIVE COMPULSIVE DISORDER (OCD) **HYPOCHONDRIASIS (HEALTH ANXIETY DISORDER) (HYP)** **POST TRAUMATIC STRESS DISORDER (PTSD) AND COMPLEX PTSD** **Clinical orientation presentation** https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/ADgnpBo2JRF-bEpaLNZqrFM/Interviewer%20Training%20Materials/Clinical%20Orientation%20(CO)?rlkey=0ulnij86xbrxu59efano2uhlz&subfolder_nav_tracking=1&st=bcpeztq0&dl=0 **Interviewer training presentations**	Discussions and role play	TR, CS, BD

		https://www.dropbox.com/scl/fo/4tqvdai4x0abv9uq8648g/AGDP8ZHzipM1vgr7T9D2hGU?rlkey=0ulnij86xbrxu59efano2uhlz&e=1&st=hlzmrt9a&dl=0 Hypochondrasis – Scenario 1 https://drive.google.com/file/d/1OHYaTaWByEIvGDpUnj3nLrEajESZRulg/view Hypochondriasis – Scenario 2 https://drive.google.com/file/d/1Dn8piuqBmVzxjs3lJTrhcxCSFBqpyHj7/view Hypochondriasis – Scenario 3 https://drive.google.com/file/d/1Lm4SNj7wRcUrevUW1Oy1ROI0klJpOPhB/view **EATING DISORDERS** **ANOREXIA NERVOSA (AN** **BULIMIA NERVOSA (BN)** **BINGE-EATING DISORDER (BED)** **DISORDERS DUE TO SUBSTANCE USE (SUS)** **DISORDERS DUE TO ADDICTIVE BEHAVIOURS** **GAMBLING DISORDER (GD)** **GAMING DISORDER (GAME)** **ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)** **POSSIBLE SECONDARY MENTAL OR BEHAVIOURAL SYNDROME (SD)** **POSSIBLE SUBSTANCE-INDUCED MENTAL DISORDER** **SUICIDAL IDEATION AND BEHAVIOUR SCREENING (SOS)**		

		Anorexia – Scenario 1 https://drive.google.com/file/d/1qkINWDN5V2Fq5sdCrxNCpV7yGJyPLuxe/view Anorexia – Scenario 2 https://drive.google.com/file/d/1qkINWDN5V2Fq5sdCrxNCpV7yGJyPLuxe/view Bulimia https://drive.google.com/file/d/13DDJwjF2b8X-3spYSvEAEPGLBED1GPqV/view Bulimia – Scenario 2 https://drive.google.com/file/d/13DDJwjF2b8X-3spYSvEAEPGLBED1GPqV/view PTSD – Scenario 1 https://drive.google.com/file/d/1KU8aSvGfzxTADZyGQeWQfW2Ye1SRapZw/view PTSD – Scenario 2 https://drive.google.com/file/d/1Dpabl1PRtSP44vxn2Yf6Xh0RH6XnqblO/view Gambling Disorder – Scenario 1 https://drive.google.com/file/d/18uo2zewBB-Zmqw6NOzIsI8cxZuHiziNe/view Gambling Disorder – Scenario 2 https://drive.google.com/file/d/160x3MoP51bah3W_uuhQRQ7MlKAKNsAM0/view Gambling Disorder – Scenario 3		

		https://drive.google.com/file/d/1Eaw-EmRBitMSU70CFKyg3J_VNHhH0QkP/view SUD -Scenario 1 https://drive.google.com/file/d/1CN7BNBSZhPwCCS1fgpKS_Fkb_lTgtBaQ/view SUD – Scenario 2 https://drive.google.com/file/d/1H4tXfIny16fsmYAUQ1AqTKYVMNUQAxM3/view ADHD – Scenario 1 https://drive.google.com/file/d/1yi3beYO4aTJPNT6gR3l_5TQ6IbbiUjE_/view SUD -Scenario 1 https://drive.google.com/file/d/1CN7BNBSZhPwCCS1fgpKS_Fkb_lTgtBaQ/view SUD – Scenario 2 https://drive.google.com/file/d/1H4tXfIny16fsmYAUQ1AqTKYVMNUQAxM3/view ADHD – Scenario 1 https://drive.google.com/file/d/1yi3beYO4aTJPNT6gR3l_5TQ6IbbiUjE_/view SD scenario https://drive.google.com/file/d/13dsyohBT6rGzyYazbVwMWscw0vHPDnbp/view SD scenario https://drive.google.com/file/d/13dsyohBT6rGzyYazbVwMWscw0vHPDnbp/view		
		Practical session with tentative participants		

	Virtual Meeting at evening/night (time to be identified)	Meeting with RAs to identify the language issues they come across during the questionnaire administration		
23rd May	Jaffna TH Start: 8.30 am	Remain video demonsatration for previous days		
		Practical session with tentative participants		
	Virtual Meeting at evening/night (time to be identified)	Meeting with RAs to identify the language issues they come across during the questionnaire administration		
24th May				
25th May				
26th May	Jaffna TH Start: 8.30 am	Remain video demonsatration for previous days		
	Virtual Meeting at evening/night (time to be identified)	**Practical session with tentative participants** Meeting with RAs to identify the language issues they come across during the questionnaire administration **END of Training**		

Annexure 7

Flexible Interview for ICD-11 (FLII-11)
Epidemiology Version for Adults
with 1-Year Prevalence for Mood and Psychotic Disorders
June 2, 2024

The full interview or individual modules may be used.

The following modules are included:

A Mood Episodes
B Psychotic Symptoms
C (Probable) Primary Psychotic Disorder
D Mood Disorders
E Anxiety and Fear-Related Disorders
F Obsessive-Compulsive and Related Disorders (OCD and Hypochondriasis)
G Post-Traumatic Stress Disorder (PTSD) and Complex PTSD
H Eating Disorders
I Disorders Due to Substance Use
J Disorders Due to Addictive Behaviours
K Attention Deficit Hyperactivity Disorder
L Possible Secondary Mental or Behavioural Syndrome
M Possible Substance-Induced Mental Disorder
N Suicidal Ideation and Behaviour Screening

Note that in order to use Module C: (PROBABLE) PRIMARY PSYCHOTIC DISORDER or Module D: MOOD DISORDERS, Modules A and B must also be used.

Target users

Trained lay interviewers

Lifetime and current diagnoses

FLII-11 modules assess both lifetime and current diagnoses for included disorders with a few exceptions in which lifetime symptoms were considered too difficult to assess. For the following conditions, only current diagnoses or symptoms are assessed: Mixed Mood Episode, Complex PTSD (although lifetime PTSD is assessed), Attention Deficit Hyperactivity Disorder, and Suicidal Ideation and Behaviour.

For all other disorders, current diagnoses take precedence over lifetime diagnoses, but lifetime screening items are administered first to minimize the number of questions. The interview flow for each disorder (other than those specifically noted above) is as follows:

1. Lifetime screening items are assessed;
2. If lifetime screening is positive, current screening items are assessed;
3. If lifetime screening is positive and current screening is negative, complete lifetime diagnostic symptoms are assessed;
4. If lifetime screening is positive and current screening is positive, complete current diagnostic symptoms are assessed;
5. If complete current diagnostic assessment is negative, complete lifetime diagnostic symptoms are assessed.

Instructions for interviewers

- **Questions are provided in bold font**; these are to be asked verbatim.
- Each item requires a rating of “NO” or “YES”, or a timeframe (Month, Year). Select “NO” if the person being interviewed cannot recall, and ask participant to make the best estimate if they are unsure about dates.
- Some items comprise multiple questions; rating rules are provided.

Instructions for programmers:

- Some Instructions and comments for programmers are included in the text (e.g., for skip logic and scoring of variables). This is not a part of what the interviewer will read and will not appear in an electronic version or other version designed to be actually administered. These instructions and comments are included here to clarity the flow of the interview.
- DISPLAY LOGIC, PIPED TEXT AND SCORING INSTRUCTIONS ARE INDICATED IN CAPITAL LETTERS.
- For any programming of the FLII-11, it is critical to retain the variable naming (numbering) system.

Read this message at the beginning of the survey or module being administered:

I am going to ask you some questions about how you have been feeling mentally and emotionally. Some questions relate to experiences you may have had at some point during your lifetime, while others are about your experiences during the past few months. Please answer each question as honestly and accurately as possible. Your responses will remain confidential and will only be used for the purposes of this research.

A	**MOOD EPISODES**
	DEPRESSIVE EPISODE (DE)
DE.1a	**Have you ever, for a period of at least 2 weeks, felt depressed, "down", sad, or "empty" for most of the day, nearly every day?**
DE.1b	**Have you ever, for a period of at least 2 weeks, been a lot less interested in, or experienced a lot less pleasure from doing things you normally enjoy?**
	IF DE.1a AND DE.1b RATED "NO" – DEPRESSIVE EPISODE SCREEN NEGATIVE SKIP TO MAN.1a - MANIC EPISODE SCREENING
DE.1c	DISPLAY IF DE.1a IS YES **During the past month, have you, for a period of at least 2 weeks, felt depressed, "down", sad, or "empty" for most of the day, nearly every day?**
DE.1d	DISPLAY IF DE.1b IS YES **During the past month, have you, for a period of at least 2 weeks, been a lot less interested in, or experienced a lot less pleasure from doing things you normally enjoy?**
DE.1e	IF EITHER DE.1a OR DE.1b OR BOTH RATED "YES" AND DE.1c AND DE.1d BOTH RATED "NO" **Please tell me when you experienced the worst period of** [LOW MOOD AND/OR LOSS OF INTEREST**] that lasted for at least 2 weeks?** Month____ Year _____
	CURRENT DE: ASK "During the past month"; CHANGE GRAMMAR TO "**Have you (had, felt, thought, etc,)**" RATHER THAN "**Did you**". LIFETIME DE: ASK "During that same period"; USE THE ANSWER FROM DE.1e AS **PIPED TEXT** IN THE QUESTIONS DE.2a – DE.3d CURRENT DE: **The next questions I am going to ask you will all refer specifically to this time, that is the two weeks during the past month when you felt at your worst. Try to remember as best you can what you were experiencing during that time, rather than what you might have experienced at other times.** LIFETIME DE: **The next questions I am going to ask you will all refer specifically to this time, that is [**INSERT ANSWER TO DE.1e**]. Try to remember as best you can what you were experiencing during that time, rather than what you might have experienced at other times.** DISPLAY LOGIC for DE.2a – DE.3d:

	WHEN THERE IS MORE THAN ONE QUESTION PER ITEM - EACH ITEM REQUIRES AT LEAST ONE QUESTION TO BE ANSWERED YES IN ORDER TO BE RATED AS "YES" – HENCE THE SECOND QUESTION IN AN ITEM NEED NOT BE DISPLAYED IF THE FIRST IS ANSWERED YES / NEED ONLY BE DISPLAYED IF THE FIRST QUESTION IS ANSWERED NO.
DE.2a	CURRENT VERSION: **During that same 2-week period in the past month, have you had more trouble concentrating and staying focused on things than usual most of the day, nearly every day?** IF NO: **During that same 2-week period in the past month, did you struggle more than usual to make decisions most of the day, nearly every day?** LIFETIME VERSION: **During that same 2-week period,** DE.1e**, did you have more trouble concentrating and staying focused on things than usual most of the day, nearly every day?** IF NO: **During that same time period,** DE.1e**, did you struggle more than usual to make decisions most of the day, nearly every day?**
DE.2b	CURRENT VERSION: **During that same 2-week period in the past month, have you felt less valuable as a person or even worthless most of the day, nearly every day?** IF NO: **During that same 2-week period in the past month, have you felt overly guilty about things you did or neglected to do most of the day, nearly every day?** LIFETIME VERSION: **During that same 2-week period,** DE.1e**, did you feel less valuable as a person or even worthless most of the day, nearly every day?** IF NO: **During that same 2-week period,** DE.1e**, did you feel overly guilty about things you did or neglected to do most of the day, nearly every day?**
DE.2c	CURRENT VERSION: **During that same 2-week period in the past month, have you felt more hopeless about the future, like things would never get better or turn out well for you most of the day, nearly every day?** LIFETIME VERSION: **During that same 2-week period,** DE.1e**, did you feel more hopeless about the future, like things would never get better or turn out well for you most of the day, nearly every day?**
DE.2d	CURRENT VERSION: **During that same 2-week period in the past month, have you thought about death or suicide on most days, or have you tried to end your life?** LIFETIME VERSION: **During that same 2-week period,** DE.1e**, did you think about death or suicide on most days, or did you try to end your life?**
DE.3a	CURRENT VERSION: **On most days during that same 2-week period in the past month, have you had more trouble falling or staying asleep than usual, or did you wake up too early?** LIFETIME VERSION: **On most days during that same 2-week period,** DE.1e**, did you have more trouble falling or staying asleep than usual, or did you wake up too early?** IF NO:

	CURRENT VERSION: **On most days during that same 2-week period in the past month, have you been sleeping a lot more than you usually do?** LIFETIME VERSION: **On most days during that same 2-week period, DE.1e, were you sleeping a lot more than you usually do?**
DE.3b	CURRENT VERSION: **On most days during that same 2-week period in the past month, has your appetite increased or decreased compared to before you started experiencing low mood and/or loss of interest?** LIFETIME VERSION: **On most days during that same 2-week period, DE.1e, did your appetite increase or decrease compared to before you started experiencing low mood and/or loss of interest?** IF NO: CURRENT VERSION: **On most days during that same 2-week period in the past month, have you lost or gained a noticeable amount of weight without trying to?** LIFETIME VERSION: **On most days during that same 2-week period, DE.1e, did you lose or gain a noticeable amount of weight without trying to?**
DE.3c	CURRENT VERSION: **On most days during that same 2-week period in the past month, have you had less energy than before the low mood and/or loss of interest started?** LIFETIME VERSION: **On most days during that same 2-week period, DE.1e, did you have less energy than before the low mood and/or loss of interest started?** IF NO: CURRENT VERSION: **On most days during that same 2-week period in the past month, have you been much more tired than usual even when doing some small task?** LIFETIME VERSION: **On most days during that same 2-week period, were you much more tired than usual even when doing some small task?**
DE.3d	CURRENT VERSION: **On most days during that same 2-week period in the past month, have you felt more restless, or were you pacing around a lot more than is usual for you?** LIFETIME VERSION: **On most days during that same 2-week period, DE.1e, did you feel more restless, or were you pacing around a lot more than is usual for you?** IF NO:

	CURRENT VERSION: **Or have you been moving or speaking more slowly than is usual for you on most days?** LIFETIME VERSION: **Or were you moving or speaking more slowly than is usual for you on most days?** IF YES TO EITHER OF THE ABOVE: CURRENT VERSION: **Has your** [RESTLESSNESS OR SLOWNESS**] been bad enough to be noticeable to others?** LIFETIME VERSION: **Was your** [RESTLESSNESS OR SLOWNESS**] bad enough to be noticeable to others?** (THIS LAST QUESTION HAS TO BE RATED YES FOR THE ITEM RATING TO BE "YES")
	SYMPTOM COUNT SCORING INSTRUCTION: FOR LIFETIME EPISODE – COUNT EACH ITEM FROM DE.1a-b and DE.2a – 3d RATED AS "YES" AS 1 (MAXIMUM SCORE = 10) FOR CURRENT EPISODE – COUNT EACH ITEM FROM DE.1c-d AND DE.2a – 3d RATED AS "YES" AS 1 (MAXIMUM SCORE = 10) SCORE = 5 OR MORE – DEPRESSION SYMPTOM COUNT AT OR ABOVE THRESHOLD – CONTINUE WITH DE.4 SCORE = 4 OR LESS: IF ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO DE.1E IF ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO MAN.1A (MANIC EPISODE SCREENING QUESTION)
DE.4	DISPLAY LOGIC: ONLY ASK SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) SKIP LOGIC: AS SOON AS ONE QUESTION IS ANSWERED YES – SKIP TO DE.5 **Did the changes in mood or interest, and the other experiences we've just talked about affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** YES TO EITHER OF THE TWO ABOVE QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT AND DEPRESSIVE EPISODE CDDR MET SKIP TO DE.5 IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO DE.1e IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO MAN.1a (MANIC EPISODE SCREENING QUESTION)
DE.5	**In the 6 months before you started having these changes in mood or loss of interest and the other experiences we just talked about, had someone very close to you died, like a spouse, parent or child?** If NO: DEPRESSIVE EPISODE – SKIP to DE.6 IF YES: BEREAVEMENT PRESENT IF YES, DISPLAY: **Do you believe that the changes in mood or interest, and the other experiences we just talked about, were a part of your reaction to that loss?** If NO: DE.1c OR d OR BOTH RATED YES – DX CURRENT DEPRESSIVE EPISODE, NO BEREAVEMENT

	DE.1a OR b OR BOTH RATED YES – DX LIFETIME DEPRESSIVE EPISODE, NO BEREAVEMENT IF NO DEPRESSIVE EPISODE, SKIP TO MAN.1a (MANIC EPISODE SCREENING QUESTION) IF YES: NORMAL GRIEF – SKIP TO MAN.1a (MANIC EPISODE SCREENING QUESTION)
DE.6	IF CURRENT DEPRESSIVE EPISODE IS PRESENT= 1 YEAR PREVALENCE = YES IF NO CURRENT DEPRESSIVE EPISODE BUT LIFETIME DEPRESSIVE EPISODE PRESENT AND IT DID NOT OCCUR IN THE LAST YEAR (Calculated by online platform) ASK: **Did you have another episode like the one we just discussed within the last year?** IF NO: 1 YEAR PREVALENCE = NO
DE.6.1a **DE.6.1b**	IF YES: **Please tell me when you experienced the worst period of [LOW MOOD AND/OR LOSS OF INTEREST] that lasted for at least 2 weeks during the last year?** TIME: _____, _____month, year [Qualtrics should only allow date within the last year – thus if currently e.g., August 2024, Sept 2023 should be earliest date allowed)
DE.6.2a **DE.6.2b**	ONE-YEAR VERSION OF LIFETIME QUESTIONS: **During that same 2-week period, DE.6.1b, did you feel depressed, "down", sad, or "empty" for most of the day, nearly every day?** **During that same 2-week period, DE.6.1b, were you a lot less interested in, or experienced a lot less pleasure from doing things you normally enjoy?**
DE.6.3a	**During that same 2-week period, DE.6.1b, did you have more trouble concentrating and staying focused on things than usual most of the day, nearly every day?** IF NO**: During that same 2-week period, DE.6.1b, did you struggle more than usual to make decisions most of the day, nearly every day?**
	During that same 2-week period, DE.6.1b, did you feel less valuable as a person or even worthless most of the day, nearly every day? IF NO: **During that same 2-week period, DE.6.1b, did you feel overly guilty about things you did or neglected to do most of the day, nearly every day?**
DE.6.3b	**During that same 2-week period, DE.6.1b, did you feel more hopeless about the future, like things would never get better or turn out well for you most of the day, nearly every day?**
	During that same 2-week period, DE.6.1b, did you think about death or suicide on most days, or did you try to end your life?
DE.6.3c	**On most days during that same 2-week period, DE.6.1b, did you have more trouble falling or staying asleep than usual, or did you wake up too early?** IF NO**: On most days during that same 2-week period, DE.6.1b, were you sleeping a lot more than you usually do?**
DE.6.3d	**On most days during that same 2-week period, DE.6.1b, did your appetite increase or decrease compared to before you started experiencing low mood and/or loss of interest?**
DE.6.4a	IF NO**: On most days during that same 2-week period, DE.6.1b, did you lose or gain a noticeable amount of weight without trying to?**
	On most days during that same 2-week period, DE.6.1b, did you have less energy than before the low mood and/or loss of interest started?

DE.6.4b	IF NO: **On most days during that same 2-week period, DE.6.1b, were you much more tired than usual even when doing some small task?**
DE.6.4c	**On most days during that same 2-week period, DE.6.1b, did you feel more restless, or were you pacing around a lot more than is usual for you?** IF NO: **Or were you moving or speaking more slowly than is usual for you on most days?** IF YES TO EITHER OF THE ABOVE: **Was your** [RESTLESSNESS OR SLOWNESS**] bad enough to be noticeable to others?** (This last question has to be rated YES for the item rating to be "YES")
DE.6.4d	IF 5 OR MORE SYMPTOMS (out of maximum 10) ARE ENDORSED, INCLUDING AT LEAST ONE OF DE.6.2a or DE.6.2b [Either low mood or anhedonia is required] - 1 YEAR PREVALENCE = YES IF IN TOTAL 4 OR FEWER SYMPTOMS ARE ENDORSED- or neither OF DE.6.2a or DE.6.2b [Either low mood or anhedonia is required] 1 YEAR PREVALENCE = NO
DE.7	IF DX CURRENT DEPRESSIVE EPISODE OR DX LIFETIME DEPRESSIVE EPISODE PRESENT **Was there another time in your life when you had similar experiences such as** [ENDORSED DEPRESSIVE SYMPTOMS] **that lasted for 2 weeks or longer?** IF NO: SINGLE DEPRESSIVE EPISODE = YES; IF MALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION, SKIP to MAN.1a (MANIC EPISODE SCREENING QUESTION) IF FEMALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION, GO TO DE.8a IF YES**: Was there a period of at least 3 months between these episodes when you did not have any symptoms or very minimal symptoms?** IF NO: SINGLE DEPRESSIVE EPISODE = YES IF MALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION, SKIP to MAN.1a (MANIC EPISODE SCREENING QUESTION) IF FEMALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION, GO TO DE.8a IF YES: RECURRENT DEPRESSIVE EPISODES = YES IF MALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION, SKIP to MAN.1a (MANIC EPISODE SCREENING QUESTION) IF FEMALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION, GO TO DE.8b (FINAL MOOD DIAGNOSES DETERMINED IN MODULE D BELOW)
DE.8a	IF SINGLE DEPRESSIVE EPISODE = YES AND FEMALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION: IF CURRENT EPISODE: **Are you pregnant or have you given birth within the last year?**

	IF LIFETIME EPISODE: **When you had the experiences we have been talking about** [ENDORSED DEPRESSIVE SYMPTOMS] **that lasted for 2 weeks or longer, were you pregnant or had you given birth within the previous one year?**
DE.8b	IF RECURRENT DEPRESSIVE EPISODES = YES: **The FIRST TIME you ever had the experiences we have been talking about** [ENDORSED DEPRESSIVE SYMPTOMS] **that lasted for 2 weeks or longer, were you pregnant or have you given birth within the previous one year?**

	MANIC EPISODE AND HYPOMANIC EPISODE (MAN)
MAN.1a	**Have you ever had a period when you felt unusually happy for at least 3 days, which other people thought was not like your usual self?** IF YES: **Did you feel like this for most of the day, nearly every day?** BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1a.TO BE SCORED AS YES
MAN.1b	DISPLAY IF MAN.1a = NO **Have you ever had a period when you felt unusually irritable or short-tempered for at least 3 days, which other people thought was not like your usual self?** IF YES: **Did you feel like this for most of the day, nearly every day?** BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1b.TO BE SCORED AS YES
	IF MAN.1a AND MAN.1b = NO: MANIC AND HYPOMANIC EPISODE SCREEN NEGATIVE SKIP TO MIX.1 - MIXED EPISODE SCREENING
MAN.1c	IF MAN.1a or MAN.1b = YES **When you were experiencing [**ELEVATED MOOD AND/OR IRRITABILITY**], were you also doing a lot more things than is usual for you, or did you have much more energy?** IF MAN.1c = NO, SKIP TO MIX.1 - MIXED EPISODE SCREENING
MAN.1d	DISPLAY IF MAN.1a AND MAN.1c = YES **During the past month, have you had a period when you felt unusually happy for at least 3 days, which other people thought was not like your usual self?** IF YES: **Did you feel like this for most of the day, nearly every day?** BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1d.TO BE SCORED AS YES
MAN.1e	DISPLAY IF MAN.1b AND MAN.1c = YES **During the past month, have you had a period when you felt unusually irritable or short-tempered for at least 3 days, which other people thought was not your usual self?**

	IF YES: **Did you feel like this for most of the day, nearly every day?** BOTH QUESTIONS MUST BE ANSWERED YES FOR MAN.1e.TO BE SCORED AS YES
MAN.1f	IF MAN.1d OR MAN.1e = YES **During this period within the past month**, **when you were experiencing [**ELEVATED MOOD AND/OR IRRITABILITY**], were you also doing a lot more things than is usual for you, or did you have much more energy?** IF YES: CONTINUE WITH MAN.3a ASSESSING CURRENT
MAN.2	DISPLAY IF (MAN.1a OR MAN.1b) AND MAN.1c IS RATED YES; AND (MAN.1d AND MAN.1e) OR MAN.1f ARE RATED NO **When did you experience your most extreme period of [**ELEVATED MOOD AND/OR IRRITABILITY**] that lasted for at least 3 days? _____** (month, year)
	IF ASSESSING CURRENT: USE "**During that same period, within the last month**" AS PIPED TEXT IN QUESTIONS MAN.3a TO MAN.3g IF ASSESSING LIFETIME: USE THE ANSWER FROM MAN.2 AS PIPED TEXT IN QUESTIONS MAN.3a TO MAN.3g
MAN.3a	**During that same period (within the past month OR MAN.2), were you talking much more and faster than usual?**
MAN.3b	**During that same period (within the past month OR MAN.2), did you have many thoughts racing through your head, or did many different ideas come to your mind one after another, flowing quickly from one to the other?**
MAN.3c	**During that same period (within the past month OR MAN.2), did you sense that you could do almost anything, or that you were very special in some way?** IF YES: **Were you convinced that you had special powers or that you were extremely important?** IF ANSWER TO FIRST QUESTION IS YES, MAN.3c = YES IF ANSWER TO SECOND QUESTION IS YES, IT IS SCORED AS A DELUSION AND PRECUDES THE POSSIBILITY OF A HYPOMANIC EPISODE.
MAN.3d	**During that same period (within the past month OR MAN.2), did you need less sleep than usual or feel well-rested after only a few hours of sleep?**
MAN.3e	**During that same period (within the past month OR MAN.2), did you have more difficulty keeping your attention on a task because things around you were very distracting?**
MAN.3f	DISPLAY SECOND QUESTION ONLY IF ANSWER TO FIRST QUESTION IS NO **During that same period (within the past month OR MAN.2), did you act on the spur of the moment, without thinking about the end results? For example, spending more money or choosing pleasurable activities instead of taking care of responsibilities, in ways that are not usual for you?**

	IF NO: **During that same period (within the past month OR** MAN.2**), did you behave recklessly without regard for your safety—for example, driving recklessly, participating in dangerous sports, having impulsive unprotected sex, or taking other physical risks like climbing on things or crossing a busy highway—in ways that are not usual for you?** IF ANSWER TO EITHER QUESTION IS YES, MAN.3f = YES
MAN.3g	DISPLAY SUBSEQUENT QUESTION ONLY IF ANSWER TO PRECEDING QUESTON IS NO; SKIP TO SYMPTOM COUNT AT FIRST YES **During that same period (within the past month OR** MAN.2**), were you more social and friendly than usual?** IF NO, DISPLAY: **During that same period (within the past month OR** MAN.2**), were you much better at planning things and getting things done?** IF NO, DISPLAY: **During that same period (within the past month OR** MAN.2**), did you have an increased sex drive?** IF ANSWER TO ANY OF THE 3 ABOVE QUESTIONS IS YES, MAN.3g = YES
	SYMPTOM COUNT SCORING INSTRUCTIONS: COUNT EACH ITEM from MAN.3a TO MAN.3g RATED AS "YES" AS 1 (MAXIMUM SCORE = 7) SCORE = 3 OR MORE – MANIA OR HYPOMANIA SYMPTOM COUNT AT OR ABOVE THRESHOLD - CONTINUE WITH MAN.4 SCORE = 2 OR LESS – IF ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO MAN.2 IF ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO MIX.1 (MIXED EPISODE SCREENING QUESTION)
MAN.4	**How long did the** [MANIC AFFECT] **and other experiences you have just told me about last?** **_____ 3 to 6 days _____ 1 week or more**
MAN.5	**Were these symptoms so severe that you had to be admitted to hospital or some other supervised care setting?**
MAN.6	**Did the mood changes and other experiences we've just talked about affect your ability to function in daily life, for example, your work or school, your social life, or your relationships?** IF YES - FUNCTIONAL IMPAIRMENT PRESENT
	• DIAGNOSE MANIC EPISODE IF MAN.6 = YES (FUNCTIONAL IMPAIRMENT) AND MAN.4 = "1 WEEK OR MORE" • OR DIAGNOSE MANIC EPISODE IF MAN.5 = YES (HOSPITAL OR SUPERVISED CARE WAS REQUIRED) AND/OR PSYCHOSIS WAS PRESENT DURING THE EPISODE (SEE MAN.3c).

	• AND DIAGNOSE MANIC EPISODE CURRENT (IF MAN.1d OR MAN.1e IS YES OR DX MANIC EPISODE LIFETIME (IF MAN.1a OR MAN.1b IS YES) THEN, SKIP TO MODULE B (OMIT MIXED EPISODE SCREENING AND ASSESSMENT) • DX HYPOMANIC EPISODE IF MAN.4 = 3 TO 6 DAYS AND MAN.5 = NO (HOSPITAL OR SUPERVISED CARE NOT REQUIRED) AND MAN.6 = NO (NO FUNCTIONAL IMPAIRMENT) AND NO PSYCHOSIS PRESENT (SEE MAN.3c). • OR DIAGNOSE HYPOMANIC EPISODE IF: MAN.5 = NO (NO HOSPITALIZATION) AND MAN.3C = NO (NO PSYCHOSIS) AND: MAN.6 = YES (FUNCTIONAL IMPAIRMENT) AND MAN.4 = "3 TO 6 DAYS" OR: MAN.6 = NO (NO FUNCTIONAL IMPAIRMENT) AND MAN.4 = "1 WEEK OR MORE" • DX HYPOMANIC EPISODE **CURRENT** IF MAN.1d OR MAN.1e = YES AND MAN.1f = YES THEN, GO BACK TO MAN.2. • OR DX HYPOMANIC EPISODE **LIFETIME** IF (MAN.1a OR MAN.1b = YES AND MAN.1c = YES
MAN.7	IF CURRENT MANIC/HYPOMANIC EPISODE IS PRESENT= 1 YEAR PREVALENCE = YES IF NO CURRENT MANIC/HYPOMANIC EPISODE BUT LIFETIME MANIC/HYPOMANIC EPISODE PRESENT AND IT DID NOT OCCUR IN THE LAST YEAR (Calculated by online platform) ASK:
MAN.7.1a	**Did you have another episode like the one we just discussed during the last year?** IF NO: 1 YEAR PREVALENCE = NO IF YES: **Please tell me when you experienced the worst period of** [ELEVASTED/ IRRITABLE MOOD AND INCREASED ENERGY] **that lasted for at least 3 days during the last year?**
MAN.7.1b	TIME: _____, _____month, year [Qualtrics should only allow date within the last year – thus if currently e.g., August 2024, Sept 2023 should be earliest date allowed)
MAN.7.2a	ONE YEAR VERSION OF QUESTIONS **During that same period, MAN.7.1b, did you feel unusually happy for at least 3 days, which other people thought was not like your usual self?**
MAN.7.2b	IF YES**: Did you feel like this for most of the day, nearly every day?** IF NO**: During that same period, MAN.7.1b, did you feel unusually irritable or short-tempered for at least 3 days, which other people thought was not your usual self?** IF YES**: Did you feel like this for most of the day, nearly every day?**

	EITHER QUESTION MAN 7.2a or MAN.7.2b MUST BE ANSWERED YES IN ORDER TO CONTINUE
MAN.7.2c	**During that same period, MAN.7.1b, when you were experiencing [**ELEVATED MOOD AND/OR IRRITABILITY]**, were you also doing a lot more things than is usual for you, or did you have much more energy?** IF YES: CONTINUE WITH ASSESSING 1-year PREVALENCE OF MANIC/HYPOMANIC EPISODE BELOW
MAN.7.3a	**During that same period, MAN.7.1b, were you talking much more and faster than usual?**
MAN.7.3b	**During that same period, MAN.7.1b, did you have many thoughts racing through your head, or did many different ideas come to your mind one after another, flowing quickly from one to the other?**
MAN.7.3c	**During that same period, MAN.7.1b, did you sense that you could do almost anything, or that you were very special in some way?** IF YES: **Were you convinced that you had special powers or that you were extremely important?** IF ANSWER TO FIRST QUESTION IS YES, MAN.7.3c = YES IF ANSWER TO SECOND QUESTION IS YES, IT IS SCORED AS A DELUSION AND PRECLUDES THE POSSIBILITY OF A HYPOMANIC EPISODE.
MAN.7.3d	**During that same period, MAN.7.1b, did you need less sleep than usual or feel well-rested after only a few hours of sleep?**
MAN.7.3e	**During that same period, MAN.7.1b, did you have more difficulty keeping your attention on a task because things around you were very distracting?**
MAN.7.3f	DISPLAY SECOND QUESTION ONLY IF ANSWER TO FIRST QUESTION IS NO **During that same period, MAN.7.1b, did you act on the spur of the moment, without thinking about the end results? For example, spending more money or choosing pleasurable activities instead of taking care of responsibilities, in ways that are not usual for you?** IF NO: **During that same period, MAN.7.1b, did you behave recklessly without regard for your safety—for example, driving recklessly, participating in dangerous sports, having impulsive unprotected sex, or taking other physical risks like climbing on things or crossing a busy highway—in ways that are not usual for you?** IF ANSWER TO EITHER QUESTION IS YES, MAN.7.3f = YES

MAN.7.3g	DISPLAY SUBSEQUENT QUESTION ONLY IF ANSWER TO PRECEDING QUESTON IS NO; SKIP TO SYMPTOM COUNT AT FIRST YES **During that same period, MAN.7.1b, were you more social and friendly than usual?** IF NO, DISPLAY: **During that same period, MAN.7.1b, were you much better at planning things and getting things done?** IF NO, DISPLAY: **During that same period, MAN.7.1b, did you have an increased sex drive?** IF ANSWER TO ANY OF THE 3 ABOVE QUESTIONS IS YES, MAN.3g = YES
	COUNT EACH ITEM from MAN.7.3a to MAN.7.3g RATED AS "YES" as 1 (Maximum score = 7) SCORE = 3 or more – MANIA OR HYPOMANIA SYMPTOM COUNT AT OR ABOVE THRESHOLD - continue with MAN.7.4
MAN.7.4	**How long did the** [MANIC AFFECT] **and other experiences you have just told me about last?** **_____ 3 to 6 days _____ 1 week or more**
MAN.7.5	**Were these symptoms so severe that you had to be admitted to hospital or some other supervised care setting?**
MAN.7.6	**Did the mood changes and other experiences we've just talked about affect your ability to function in daily life, for example, your work or school, your social life, or your relationships?** IF YES - FUNCTIONAL IMPAIRMENT PRESENT
	FOLLOW DIAGNOSTIC ALGORITHM AS OUTLINED ABOVE (p13) • DX HYPOMANIC EPISODE IN THE LAST YEAR YES/NO • DX MANIC EPISODE IN THE LAST YEAR YES/NO (BECAUSE ONLY ONE EPISODE IS ASSESSED, BOTH CANNOT BE PRESENT SIMULTANEOUSLY)
MAN.8	IF FEMALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION AND MANIC OF HYPOMANIC EPISODE CURRENT OR LIFETIME = YES **The FIRST TIME you ever had the symptoms that we have been talking about** [ENDORSED MANIC SYMPTOMS], **were you pregnant or had you given birth within the previous one year?**

	MIXED EPISODE (MIX) (ASSESSED FOR CURRENT PRESENCE ONLY)
MIX.1a	SQ : **In the past month, have you experienced a period of changing moods such as switching between feeling very happy, "on top of the world", or like you could do**

	anything alternating with feeling sad, down, unhappy, or just feeling miserable changing from day-to-day or even within the same day? IF NO: **In the past month, have you experienced a period of having these different types of feelings at the same time, like feeling very happy but at the same time feeling hopeless or worthless, or feeling sad but also very talkative and energetic?** IF YES TO EITHER**: Did you feel like this most of the day, nearly every day for at least 2 weeks?** (REQUIRED) IF NO: MIXED EPISODE SCREEN NEGATIVE, SKIP TO PSY.1a - PSYCHOSIS SCREENING QUESTION IF YES, MIX.1a = YES, PROCEED TO MIX.1b
MIX.1b	DISPLAY IF MIX.1a = YES **Please tell me during which 2-week period these mood changes were at their worst over the past month:** _____ the past 2 weeks _____ 2 – 3 weeks ago _____3 – 4 weeks ago
MIX.2a	**Did you, during that 2-week period, feel depressed, "down", sad, or "empty" for most of the day, nearly every day?**
MIX.2b	**During that 2-week period, were you a lot less interested in, or experienced a lot less pleasure from doing the things you normally enjoy?**
MIX.2c	**During that same period, MIX.1b, did you have more trouble concentrating and staying focused on things than usual?** IF NO: **During that same time period, MIX.1b, did you struggle more than usual to make decisions?**
MIX.2d	**During that same period, MIX.1b, did you feel less valuable as a person or even worthless?** IF NO: **During that same time period, MIX.1b, did you feel overly guilty about things you did or neglected to do?**
MIX.2e	**During that same period, MIX.1b, did you feel more hopeless about the future, like things would never get better or turn out well for you?**
MIX.2f	**During that same period, MIX.1b, did you think often about death or suicide, or did you try to end your life?**
MIX.2g	**During that same period, MIX.1b, did you have more trouble falling or staying asleep than usual?** IF NO: **During that same period, MIX.1b, were you sleeping a lot more than you usually do?**
MIX.2h	**During that same period, MIX.1b, did your appetite increase or decrease compared to before you started experiencing mood changes?** IF NO: **During that same period, MIX.1b, did you lose or gain a noticeable amount of weight without trying to?**

MIX.2i	**During that same period,** MIX.1b**, did you have less energy than before the** [LOW MOOD AND/OR LOSS OF INTEREST] **started?** IF NO: **Were you much more tired than usual even when doing some small task?**
MIX.2j	**During that same period,** MIX.1b**, did you feel more restless, or were you pacing around a lot more than is usual for you?** IF NO: **Or were you moving or speaking more slowly than is normal for you?** DISPLAY THIS QUESTION IF YES TO EITHER: **Was your** [RESTLESSNESS OR SLOWNESS] **bad enough to be noticeable to others?** (THIS LAST QUESTION HAS TO BE RATED YES FOR THE ITEM RATING TO BE "YES")
	SCORING INSTRUCTIONS: ONLY CONTINUE WITH MIX.3 IF: AT LEAST 3 ITEMS OF MIX.2a-j = YES MIXED DEPRESSIVE SYMPTOM SCORE = YES - IF MIXED DEPRESSIVE SYMPTOM SCORE = NO, SKIP TO PSY.1
MIX.3a	**During that 2-week period,** MIX.1b**, did you feel unusually happy, to the extent that other people thought it was not like your usual self?** **IF NO: During that 2-week period,** MIX.1b**, did you feel unusually irritable or short-tempered, to the extent that other people thought it was not like your usual self?** IF YES TO EITHER: **Did you feel like this for most of the day, nearly every day?** (REQUIRED)
MIX.3b	**During that same period,** MIX.1b**, were you doing a lot more things than is usual for you, or did you have much more energy?**
MIX.3c	**During that same period,** MIX.1b**, were you talking much more and faster than usual?**
MIX.3d	**During that same period,** MIX.1b**, did you have many thoughts racing through your head, or did many different ideas come to your mind one after another, flowing quickly from one to the other?**
MIX.3e	**During that same period,** MIX.1b**, did you sense that you could do almost anything or that you were very special in some way?**
MIX.3f	**During that same period,** MIX.1b**, did you need less sleep than usual or feel well-rested after only a few hours of sleep?**
MIX.3g	**During that same period,** MIX.1b**,did you have more difficulty keeping your attention on a task because things around you were distracting you?**
MIX.3h	DISPLAY LOGIC – ONLY DISPLAY THE SECOND QUESTION IF THE FIRST IS ANSWERED NO (EITHER QUESTION ANSWERED AS YES IS SUFFICIENT FOR A "YES" RATING)

	During that same period, MIX.1b **did you act on the spur of the moment, without thinking about the end results,—for example, spending more money, or choosing pleasurable activities instead of taking care of responsibilities—in ways that are not usual for you?** IF NO: **During that same period,** MIX.1b **did you behave recklessly without regard for your safety—for example, driving recklessly, participating in dangerous sports, having impulsive unprotected sex, or taking other physical risks like climbing on things or crossing a busy highway—in ways that are not usual for you?**
MIX.3i	FOR THE FOLLOWING 3 QUESTIONS, DISPLAY SUBSEQUENT QUESTION ONLY IF ANSWER TO PRECEDING QUESTON IS NO; SKIP TO MIX.4 AT FIRST YES **During that same period,** MIX.1b **were you more social and friendly than usual?** IF NO: **During that same period,** MIX.1b **were you much better at planning things and getting things done?** IF NO: **During that same period,** MIX.1b **did you have an increased sex drive?** IF ANSWER TO ANY OF THE 3 ABOVE QUESTIONS IS YES, MIX.3i = YES

MIX.4	SCORING INSTRUCTIONS: ONLY CONTINUE WITH MIX.5 IF: AT LEAST 3 ITEMS OF MIX.3a-i = YES MIXED MANIC SYMPTOM SCORE = YES IF MIXED MANIC SYMPTOM SCORE = NO, SKIP TO PSY.1
MIX.5	DISPLAY IF MIX.4 IS RATED YES **Did the changes in mood, thoughts, and/or behaviour we've just talked about affect your ability to function in daily life, for example, your work or school, your social life, or your relationships?** YES: FUNCTIONAL IMPAIRMENT PRESENT AND MIXED EPISODE CDDR MET) AND DX MIXED EPISODE CURRENT IF NO – SKIP TO PSY.1a (PSYCHOSIS SCREENING QUESTION)
MIX.6	IF FEMALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION AND MIXED EPISODE CURRENT = YES: **The FIRST TIME you ever had the symptoms that we have been talking about** [ENDORSED MANIC AND DEPRESSIVE SYMPTOMS], **were you pregnant or had you given birth within the previous one year?**

B	**PSYCHOTIC SYMPTOMS (PSY)** (All SQs)
PSY.1	1. DELUSIONS FOR ALL ITEMS IN THE DELUSIONS SECTION, THE LOGIC OF THE QUESTIONS IS AS FOLLOWS: • **Have you ever believed that [**SPECIFIC DELUSION**]?** IF YES: • **Were you convinced that this experience was real?** *IF NO, IT IS NOT A DELUSION (SKIP TO NEXT ITEM)* IF YES: • **Did other people around you also believe this?** ___ YES ____ NO ____ UNKNOWN (NO ONE AROUND OR DOESN'T KNOW.) *IF YES, IT IS NOT A DELUSION (SKIP TO NEXT ITEM)* IF NO: • **Would someone from your same religion or culture think this is a reasonable thing to believe?** *IF YES, IT IS NOT A DELUSION (SKIP TO NEXT ITEM)* IF NO OR UNKNOWN: SCORE YES FOR LIFETIME **[**SPECIFIC DELUSION**]** THEN: • **Have you experienced this during the past month?** IF YES: SCORE YES FOR CURRENT **[**SPECIFIC DELUSION**]**
PSY.1a Persecutory	**Have you ever believed that you were being watched or followed?** IF NO: **Have you ever believed that someone was planning to harm you?** IF YES TO EITHER: **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN: **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.1a = YES **Have you believed this during the past month?** IF YES: CURRENT PSY.1a = YES (and 1 year prevalence PSY.1f = YES) IF NO: **Have you believed this in the last year?** IF YES: 1 year prevalence PSY 1a = YES

PSY.1b Grandiose	**Have you ever believed that you were especially important or powerful, or that you had special powers?** IF NO: **How about being famous or related to very powerful people?** IF YES TO EITHER: **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN : **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.1b = YES **Have you believed this during the past month?** IF YES: CURRENT PSY.1b = YES (and 1 year prevalence PSY.1f = YES) IF NO: **Have you believed this in the last year?** IF YES: 1 year prevalence PSY 1b = YES
PSY. 1c Guilt	**Have you ever believed that you had done something terribly wrong or committed a horrible crime for which you deserved punishment, or that you were responsible for a natural disaster such as a storm or earthquake?** IF YES: **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN: **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.1c = YES **Have you believed this during the past month?** IF YES: CURRENT PSY.1c = YES (and 1 year prevalence PSY.1f = YES) IF NO: **Have you believed this in the last year?** IF YES: 1 year prevalence PSY 1c = YES
PSY.1d Somatic	**Have you ever believed that there was something wrong with your organs or other parts of your body?** If YES: **Was this limited to worries about the way your body looks?** IF YES: SKIP TO PSY.1e – DELUSIONS OF JEALOUSY IF NO: **Was this due to a medical condition that a doctor confirmed you had?** IF YES: SKIP TO PSY.1e – DELUSIONS OF JEALOUSY IF NO (I.E. NOT LIMITED TO BODY DYSMORPHIA OR DUE TO A DIAGNOSED MEDICAL CONDITION): **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN: **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.1d = YES **Have you believed this during the past month?** IF YES: CURRENT PSY.1d = YES (and 1 year prevalence PSY.1f = YES) IF NO: **Have you believed this in the last year?** IF YES: 1 year prevalence PSY 1d = YES
PSY.1e Jealousy	

	Have you ever been convinced that your partner or spouse has been unfaithful, despite other people not believing it, or despite your partner never admitting it? IF YES: **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN: **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.1e = YES **Have you believed this during the past month?** IF YES: CURRENT PSY.1e = YES (and 1 year prevalence PSY.1f = YES) IF NO: **Have you believed this in the last year?** IF YES: 1 year prevalence PSY 1e = YES
PSY.1f Reference	**Have you ever felt like something on TV, the movies, radio, social media, or the internet was meant specifically for you or was trying to send you a special message?** IF NO: **Have objects or people that you encounter in your daily life ever communicated particular special messages to you but not to most other people?** IF YES: **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN: **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.1f = YES **Have you believed this during the past month?** IF YES: CURRENT PSY.1f = YES (and 1 year prevalence PSY.1f = YES) IF NO: **Have you believed this in the last year?** IF YES: 1 year prevalence PSY 1f = YES
PSY.2	2. EXPERIENCES OF PASSIVITY, INFLUENCE AND CONTROL
PSY.2a	**Have you ever felt like someone or something was controlling how you think, feel, or behave?** IF YES: **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN: **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.2a = YES **Has this happened during the past month?** IF YES: CURRENT PSY.2a = YES (and 1 year prevalence PSY.3e = YES) IF NO: **Has this happened during the last year?** IF YES: 1 year prevalence PSY.2a = YES
PSY.2b	**Have you ever had the experience that thoughts that were not your own were being put into your head?** IF NO: **Have you ever had the experience that your thoughts were being taken out of your head?**

	IF NO: **Or that your thoughts were being broadcast so that other people could know what you are thinking?** (NOTE: IF THE PERSON INDICATES ONLY THAT GOD CAN KNOW THEIR THOUGHTS, THIS SHOULD BE CODED NO.) (ONLY ONE YES ANSWER FOR THE THREE QUESTIONS ABOVE IS SUFFICIENT TO PROCEED) IF YES TO ANY OF THE ABOVE: **Were you convinced that this experience was real?** IF YES: **Did other people around you also believe this? Or was there no one else around?** IF NO OR UNKNOWN: **Would someone from your same religion or culture think this is a reasonable thing to believe?** IF NO OR UNKNOWN: LIFETIME PSY.2b = YES **Has this happened during the past month?** IF YES: CURRENT PSY.2b = YES (and 1 year prevalence PSY.3e = YES) IF NO: **Has this happened during the last year?** IF YES: 1 year prevalence PSY.2b = YES
PSY.3 **PSY. 3a** Auditory	3. HALLUCINATIONS **Have you heard voices talking to you or to each other when there was no one else around?** IF YES**: Did this last for longer than a few seconds?** IF YES**: Did this happen at least several times?** [CLARIFY IF NECESSARY: **3 or more times?**] **If YES: Could other people hear these voices?** **If NO: Was it as clear as how you hear me talking?** **If YES: Is it under your control?** [CLARIFY IF NECESSARY: **Can you stop hearing these voices if you wish to?**] **If NO: Has this occurred when you were awake?** (ONLY WHEN FALLING ASLEEP OR WAKING UP SHOULD BE CODED AS NO) IF YES: LIFETIME PSY.3a = YES **Has this happened during the past month?** IF YES: CURRENT PSY.3a = YES (and 1 year prevalence PSY.3e = YES) IF NO: **Has this happened during the last year?** IF YES: 1 year prevalence PSY.3a = YES
PSY.3b Visual	**Have you ever seen things that other people couldn't see, that were not caused by a substance or medication?** IF YES**: Did this last for longer than a few seconds?** IF YES**: Did this happen at least several times?** [CLARIFY IF NECESSARY: **3 or more times?**] **If YES: Could other people see these things?** **If NO: Was it as clear as how you see this** (OBJECT)**?** (HOLD UP PEN OR SIMILAR) **If YES: Is it under your control? [**CLARIFY IF NECESSARY: **Can you stop seeing these things if you wish to?**] **If NO: Has this occurred when you were awake?** (ONLY WHEN FALLING ASLEEP OR WAKING UP SHOULD BE CODED AS NO) IF YES: LIFETIME PSY.3b = YES **Has this happened during the past month?** IF YES: CURRENT PSY.3b = YES (and 1 year prevalence PSY.3e = YES)

	IF NO: **Has this happened during the last year?** IF YES: 1 year prevalence PSY.3b = YES
PSY.3c Tactile	**Have you ever felt unusual sensations on or under your skin that you could not explain, for example feeling like bugs were crawling on your skin?** IF YES**: At that time, were you taking a substance or withdrawing from a substance?** (IF YES – SKIP to PSY.3d) IF NO**: Did this last for longer than a few seconds?** IF YES**: Did this happen at least several times?** [CLARIFY IF NECESSARY: **3 or more times?**] **If YES: Was the sensation just as strong as it would be if an object were actually touching you?** **If YES: Is it under your control? [**CLARIFY IF NECESSARY: **Can you stop this sensation if you wish to?**] **If NO: Has this occurred when you were awake?** (ONLY WHEN FALLING ASLEEP OR WAKING UP SHOULD BE CODED AS NO) IF YES: LIFETIME PSY.3c = YES **Has this happened during the past month?** IF YES: CURRENT PSY.3c = YES (and 1 year prevalence PSY.3e = YES) IF NO: **Has this happened during the last year?** IF YES: 1 year prevalence PSY.3c = YES
PSY.3d Gustatory	**Have you ever experienced a strange or bad taste that could not be explained by something you ate or drank, or caused by a substance or medication?** IF YES**: Did this last for longer than a few minutes?** IF YES**: Did this happen at least several times?** [CLARIFY IF NECESSARY: **3 or more times?**] **If YES: Is it under your control? [**CLARIFY IF NECESSARY: **Can you stop this sensation if you wish to?**] **If NO: Has this occurred when you were awake?** (ONLY WHEN FALLING ASLEEP OR WAKING UP SHOULD BE CODED AS NO) IF YES: LIFETIME PSY.3d = YES IF YES: **Has this happened during the past month?** IF YES: CURRENT PSY.3d = YES (and 1 year prevalence PSY.3e = YES) IF NO: **Has this happened during the last year?** IF YES: 1 year prevalence PSY.3d = YES
PSY.3e Olfactory	**Have you ever smelled something strange or bad that other people couldn't smell that could not be explained by something you inhaled, or caused by a substance or medication?** IF YES**: Did this last for longer than a few minutes?** IF YES**: Did this happen at least several times?** [CLARIFY IF NECESSARY: **3 or more times?**] **If YES: Is it under your control? [**CLARIFY IF NECESSARY: **Can you stop this sensation if you wish to?**] **If NO: Has this occurred when you were awake?** (ONLY WHEN FALLING ASLEEP OR WAKING UP SHOULD BE CODED AS NO) IF YES: LIFETIME PSY.3ef = YES IF YES: **Has this happened during the past month?** IF YES: CURRENT PSY.3e = YES (and 1 year prevalence PSY.3e = YES)

	IF NO: **Has this happened during the last year?** IF YES: 1 year prevalence PSY.3e = YES

C	(PROBABLE) PRIMARY PSYCHOTIC DISORDER (PPD)	1.Lifetime	2.One year (includes current disorder)	2.Current (in the last month)
PPD.1	IF: 1. PSYCHOTIC SYMPTOMS CURRENT OR LIFETIME AND 2. NO SECONDARY CAUSE AT THE TIME OF SYMPTOMS (SEE P43-44) AND 3. IF MOOD SYMPTOMS PRESENT - PSYCHOTIC SYMPTOMS PRESENT MAJORITY OF THE TIME, MOOD SYMPTOMS DO NOT OCCUR OUTSIDE OF PSYCHOTIC SYMPTOMS/EPISODES. IF MOOD EPISODE ALSO PRESENT: **Was there a time when you had the things we just talked about, the** [PSYCHOTIC SYMPTOMS], **but you did not have the** [MOOD SYMPTOMS]? (EXAMPLE OF QUESTION WITH PIPED TEXT / INFORMATION SUPPLIED BY INTERVIEWER: ***"Was there a time when you were hearing voices and thinking your life was in danger, but you did not have the irritability and sleeplessness?*** THE AIM IS TO SEPARATE A PRIMARY PSYCHOTIC DISORDER FROM A MOOD DISORDER WITH PSYCHOTIC FEATURES) NO: Likely Mood disorder YES: Likely Psychotic disorder	NO / YES	NO / YES	NO / YES
PPD.2	IF LIKELY PSYCHOTIC DISORDER = YES AND FEMALE BASED ON GENDER REPORTED IN DEMOGRAPHIC SECTION: **The FIRST TIME you ever had any of the experiences that we have been talking about** [ENDORSED PYCHOTIC SYMPTOMS]**, were you pregnant or had you given birth within the previous one year?** IF YES – ADD SPECIFIER VARIABLE TO (PROBABLE) PRIMARY PSYCHOTIC DISORDER (BELOW) "WITH FIRST ONSET IN THE PERINATAL PERIOD"			

D	**MOOD DISORDERS** IF ANY MOOD EPISODE RATED AS YES (CURRENT OR PAST): (DE.5, MAN.6, OR MIX.5) THE FIRST 4 ARE MUTUALLY EXCLUSIVE DISORDERS (E-VERSION AUTOMATICALLY SCORED)	
SEDD.1	**Single Episode Depressive Disorder (6A70)** PRESENCE OR HISTORY OF A SINGLE DEPRESSIVE EPISODE (NO HISTORY OF MANIC, MIXED, OR HYPOMANIC EPISODES) IF A DEPRESSIVE EPISODE PRESENT – CURRENT OR LIFETIME AND NO MANIC / HYPOMANIC / MIXED EPISODES IF DE.6 RATED NO: DX SINGLE EPISODE DEPRESSIVE DISORDER (6A70) IF DE.6 RATED YES: DX RECURRENT DEPRESSIVE DISORDER (6A71) IF YES DE.7a AND SINGLE EPISODE DEPRESSIVE DISORDER IS ASSIGNED – ADD SPECIFIER VARIABLE TO SINGLE EPISODE DEPRESSIVE DISORDER "WITH ONSET DURING PERINATAL PERIOD"	
RDD.1	**Recurrent Depressive Disorder (6A71)** AT LEAST TWO DEPRESSIVE EPISODES, WHICH MAY INCLUDE A CURRENT EPISODE, SEPARATED BY SEVERAL MONTHS (3) WITHOUT SIGNIFICANT MOOD DISTURBANCE. (NO HISTORY OF MANIC, MIXED, OR HYPOMANIC EPISODES) REFER TO DE.6 FOR THIS INFORMATION IF YES DE.7b AND RECURRENT DEPRESSIVE DISORDER IS ASSIGNED – ADD SPECIFIER VARIABLE TO RECURRENT DEPRESSIVE DISORDER "WITH FIRST DEPRESSIVE EPISODE DURING PERINATAL PERIOD"	
BDI.1	**Bipolar Disorder type I (6A60)** PRESENCE OR HISTORY OF AT LEAST ONE MANIC OR MIXED EPISODE PRESENT IF ONE MANIC OR MIXED EPISODE CURRENT OR PAST (THE FOLLOWING SPECIFIERS ARE MUTUALLY EXCLUSIVE) IF YES DE.7a AND BIPOLAR TYPE I DISORDER IS ASSIGNED, ADD SPECIFIER "WITH FIRST DEPRESSIVE EPISODE DURING PERINATAL PERIOD" IF YES DE.7b AND BIPOLAR TYPE I DISORDER IS ASSIGNED – ADD SPECIFIER VARIABLE TO BIPOLAR TYPE I DISORDER "WITH FIRST DEPRESSIVE EPISODE DURING PERINATAL PERIOD". IF YES MAN.7 AND BIPOLAR TYPE I DISORDER IS ASSIGNED – ADD SPECIFIER VARIABLE TO BIPOLAR TYPE I DISORDER "WITH FIRST MANIC/HYPOMANIC EPISIDE DURING PERINATAL PERIOD".	

	IF YES MIX.6 AND BIPOLAR TYPE I DISORDER IS ASSIGNED – ADD SPECIFIER VARIABLE TO BIPOLAR TYPE I "WITH FIRST MIXED EPISODE DURING PERINATAL PERIOD"	
BDII.1	**Bipolar Disorder type II (6A61)** A HISTORY OF AT LEAST ONE HYPOMANIC EPISODE *AND* AT LEAST ONE DEPRESSIVE EPISODE (NO HISTORY OF MANIC OR MIXED EPISODES.) PRESENT IF ONE DEPRESSIVE AND ONE HYPOMANIC EPISODE (THE FOLLOWING SPECIFIERS ARE MUTUALLY EXCLUSIVE) IF YES DE.7a AND BIPOLAR TYPE II DISORDER IS ASSIGNED, ADD SPECIFIER "WITH FIRST DEPRESSIVE EPISODE DURING PERINATAL PERIOD" IF YES DE.7b AND BIPOLAR TYPE II DISORDER IS ASSIGNED – ADD SPECIFIER VARIABLE TO BIPOLAR TYPE II DISORDER "WITH FIRST DEPRESSIVE EPISODE DURING PERINATAL PERIOD". IF YES MAN.7 AND BIPOLAR TYPE II DISORDER IS ASSIGNED – ADD SPECIFIER VARIABLE TO BIPOLAR TYPE II DISORDER "WITH FIRST MANIC/HYPOMANIC EPISIDE DURING PERINATAL PERIOD".	
DET.1	SPECIFIERS to any of the 4 Mood Disorders above: - If Depressive Episode = Current "WITH CURRENT DEPRESSIVE EPISODE" OR - If Depressive Episode occurred within the last year (see DE.7) "WITH DEPRESSIVE EPISODE OCCURRING IN THE LAST YEAR"	NO/ YES NO/ YES
MHET.1	SPECIFIERS to Bipolar Disorder type 1 - If Manic, Hypomanic or Mixed Episode = Current "WITH CURRENT MANIC EPISODE" "WITH CURRENT HYPOMANIC EPISODE" "WITH CURRENT MIXED EPISODE" - If Manic or Hypomanic Episode occurred within the last year (Mixed not assessed) "WITH MANIC EPISODE OCCURRING IN THE LAST YEAR" "WITH HYPOMANIC EPISODE OCCURRING IN THE LAST YEAR" SPECIFIERS to Bipolar Disorder Type 2 - If Hypomanic Episode = Current "WITH CURRENT HYPOMANIC EPISODE" OR	NO/ YES NO/ YES NO/ YES NO/ YES NO/ YES NO/ YES

	- If Hypomanic Episode occurred within the last year "WITH HYPOMANIC EPISODE OCCURRING IN THE LAST YEAR"	NO/ YES
MEPS.1	**Mood Episode with Psychotic Symptoms** IF MOOD EPISODE PRESENT AND DELUSION OR HALLUCINATION PRESENT OVER THE LIEFTIME: **Did you ever experience [**DELUSION AND/OR HALLUCINATION**] when you were not having [**ABNORMAL MOOD – Low / elevated / irritable / loss of interest**]?** YES: Mood disorder and probable primary psychotic disorder NO: Mood episode / disorder with psychotic features	NO / YES

E	**ANXIETY AND FEAR-RELATED DISORDERS**
	MB23.H PANIC ATTACK (PA)
PA.1	SQ **: Have you ever experienced an episode of intense fear or anxiety that started suddenly and got worse within minutes that was not a response to immediate danger?** IF NO: SKIP to AGO.1 - SCREENING QUESTION FOR AGORAPHOBIA
PA.2	DISPLAY IF PA.1 RATED AS YES. ONCE 3 SYMPTOMS ENDORSED = DX LIFETIME PANIC ATTACK GO TO PD.1 SCREENING FOR PANIC DISORDER IF THE END IS REACHED AND < 3 SYMPTOMS ENDORSED – SKIP TO AGO.1 SCREENING QUESTION FOR AGORAPHOBIA **Along with the anxiety ("panic"), did you also experience:** *(✔CHECK ALL THAT APPLY)* **A racing / fast beating heart?** **Sweating?** **Trembling or feeling shaky?** **Feeling short of breath?** **Feeling like your throat was closing up or that you were choking?** **Having chest pain or pressure?** **Feeling nauseous, having stomach cramps?** **Feeling dizzy or lightheaded?** **Chills or hot flushes?** **Tingling sensations or numbing in your hands or feet?** **Feeling like you were unreal and detached from your body, or that things around you were unreal?**

	Fearing that you were losing control? **Fearing that you were going crazy** **Fearing that you were going to die?**

	6B01 - PANIC DISORDER (PD)
PD.1a	IF DX LIFETIME PANIC ATTACK IS PRESENT: **Was there ever a time when you had two or more of these panic attacks during a single month?** IF YES**: Did some or all of these panic attacks happen unexpectedly ("out of the blue"), for no apparent reason?** BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"
	IF PD.1a RATED "NO" - PANIC DISORDER SCREEN NEGATIVE SKIP TO AGO.1 – AGORAPHOBIA SCREENING
PD.1b	DISPLAY IF PD.1a RATED AS YES SQ **: In the past month, have you had more than one of these "panic attacks"?** IF YES**: Do some (or all) happen unexpectedly ("out of the blue"), for no apparent reason?** BOTH QUESTIONS NEED TO BE ANSWERED AS YES FOR THIS ITEM TO BE RATED "YES"
PD.1c	DISPLAY IF PD.1a IS RATED AS YES AND PD.1b IS RATED AS NO **Thinking about the panic attacks that you have experienced during your lifetime, when was the month that they occurred most frequently?** Year _____Month____ **Did you have at least 2 panic attacks during that month?**
PD.2	LIFETIME: USE THE ANSWER FROM PD.1c AS PIPED TEXT IN THE QUESTIONS PD.2-3 CURRENT: CHANGE GRAMMAR – "**Are you having / Do you …"** AND **"During the past month"** DISPLAY IF PD.1a OR PD.1b IS RATED AS YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) ONE QUESTION ANSWERED YES IS SUFFICIENT FOR A YES RATING OF THIS ITEM **During that month, did you worry that the panic attacks would happen again?** IF NO: **Did you worry that something was physically wrong with you?**

	IF NO: **Did you do things differently to try and prevent them from happening again?** IF NO AND PD.1b WAS RATED YES: LOOP BACK TO PD.1c OTHERWISE SKIP TO AGO.1a
PD.3	DISPLAY IF PD.2 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) **Did the panic attacks and your worry about having another panic attack affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** YES TO EITHER OF THE TWO QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT (PANIC DISORDER CDDR MET) AND DX PANIC DISORDER CURRENT (IF PD.1b IS YES) Or DX PANIC DISORDER LIFETIME (IF PD.1a IS YES AND PD.1b IS NO) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AGO.1a (AGORAPHOBIA SCREENING QUESTION)

	6B02 - AGORAPHOBIA (AGO)
AGO.1a	SQ **: Was there ever a time when, for three or more months, you were very anxious in public situations because you felt like you would be stuck without an easy way to leave or without access to help in case you needed it? Examples of these types of situations include: using public transport, being in crowds, being outside the home alone, being in the shops, going to the theatre, or standing in line.** IF YES: **Did you have this anxiety in more than one type of situation?** BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"
	IF AGO.1a RATED "NO" - AGORAPHOBIA SCREEN NEGATIVE SKIP TO GAD.1a – GENERALIZED ANXIETY DISORDER SCREENING
AGO.1b	DISPLAY IF AGO.1a RATED AS YES SQ **: Over the last three or more months, have you been very anxious in public situations because you felt like you would be stuck without an easy way to leave or without access to help in case you needed it? Examples of these types of situations include: using public transport, being in crowds, being outside the home alone, being in the shops, going to the theatre, or standing in line.** IF YES: **Did you have this anxiety in more than one type of situation?**

	BOTH QUESTIONS NEED TO BE ANSWERED YES FOR THIS ITEM TO BE RATED "YES"
AGO.1c	DISPLAY IF AGO.1a RATED AS YES AND AGO.1b RATED AS NO **When did you experience your <u>worst</u> period of anxiety about being in these types of situations that lasted for 3 months or more?** Year _____ 3 Month period____
AGO.2	DISPLAY IF AGO.1a or AGO.1b RATED AS YES LIFETIME: USE THE ANSWER FROM AGO.1c AS PIPED TEXT IN THE QUESTIONS AGO.2-3 CURRENT: CHANGE GRAMMAR – "**Are you having / Do you …"** AND **"During the last 3 months"** **During [the last / those] 3 months, were you afraid in these situations because you thought something bad might happen to you? For example, having a panic attack, fainting, falling, losing control of your bowels or bladder, or anything else disabling or embarrassing?** IF NO AND AGO.1b WAS RATED YES: LOOP BACK TO AGO.1c OTHERWISE SKIP TO GAD.1a
AGO.3	DISPLAY IF AGO.2 RATED AS YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) **During [the last / those] 3 months, did you always avoid these places or situations?** IF NO: **Or when you had no choice but to be there, suffer through being in these places or situations with intense fear?** IF NO: **Or were you only able to tolerate these places or situations under certain circumstances, like being with a trusted person or taking medication to calm you down?** IF NO AND AGO.1b WAS RATED YES: LOOP BACK TO AGO.1c OTHERWISE SKIP TO GAD.1a
AGO.4	DISPLAY IF AGO.3 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) **Did the fear of being in these places or situations and your reactions to this fear affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did your fear of being in these places or situations and your reactions to this fear bother you a lot?**

	YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT (AGORAPHOBIA CDDR MET) AND DX AGORAPHOBIA CURRENT (IF AGO.1b IS YES) Or DX AGORAPHOBIA LIFETIME (IF AGO.1a IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO AGO.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAD.1a (GENERALISED ANXIETY DISORDER SCREENING QUESTION)

	6B00 - GENERALIZED ANXIETY DISORDER (GAD)
GAD.1a	SQ **: Was there ever a time when, for a period of 3 months or more, you experienced anxiety or worry on most days?** IF YES: **At that time, were you very worried about many different aspects of your life, for example, relationships, work, health, money, etc.?** IF NO: **At that time, did you feel very anxious in general, without it being connected to a particular worry, or did you have a general feeling that something very bad was about to happen?** (REQUIRED – 1ST QUESTION = "YES" AND 2ND OR 3RD QUESTION = "YES")
	IF GAD.1a RATED "NO" - GENERALIZED ANXIETY DISORDER SCREENING IS NEGATIVE SKIP TO SAD.1 - SOCIAL ANXIETY DISORDER SCREENING QUESTION
GAD.1b	DISPLAY IF GAD.1a IS RATED YES SQ **: Over the last 3 months, have you experienced anxiety or worry on most days?** IF YES: **Have you been very worried about many different aspects of your life, for example, relationships, work, health, money, etc.?** IF NO: **Have you felt very anxious in general, without it being connected to a particular worry, or did you have a general feeling that something very bad was about to happen?** (REQUIRED – 1ST QUESTION = "YES" AND 2ND OR 3RD QUESTION = "YES")
GAD.1c	DISPLAY IF GAD.1a IS RATED YES AND GAD.1b IS RATED NO **Please tell me during which 3-month period your feelings of anxiety or worry were at their worst:** _____, _____ (3-Month Period, Year)
GAD.2	DISPLAY IF GAD.1a OR GAD.1b IS RATED YES **When you were anxious or worried, did you also have, on most days:** *(✔CHECK ALL THAT APPLY, AT LEAST 2 REQUIRED)* (PROGRAM SKIP TO GAD.3 AS SOON AS 2 SYMPTOMS ENDORSED)

	Your muscles feeling tight or tense? **Being unable to sit still or feeling physically restless?** **Feeling nauseous, or having abdominal cramps?** **A racing or pounding heart?** **Sweating a lot?** **Hands trembling or body shaking?** **Dry mouth?** **Feeling nervous or on edge?** **Struggling to concentrate?** **Feeling irritable?** **Having difficulty falling asleep or staying asleep?** **Not feeling rested when you wake up?**
GAD.3	DISPLAY IF GAD.1 - 2 ARE RATED YES **Did the feelings of anxiety or worry we've just talked about affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did feelings of anxiety or worry bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND GENERALISED ANXIETY DISORDER CDDR MET) AND DX GENERALISED ANXIETY DISORDER CURRENT (if GAD.1b IS YES) Or DX GENERALISED ANXIETY DISORDER LIFETIME (if GAD.1a is YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SAD.1a (SOCIAL ANXIETY DISORDER SCREENING QUESTION)

	6B04 - SOCIAL ANXIETY DISORDER (SAD)
SAD.1a	SQ**: Have you ever, during a period of 3 months or more, consistently felt very anxious about interacting with other people in social situations? For example, at parties or other social functions, meeting people you don't know, or social contacts at work?**
SAD.1a.1	IF NO: **Have you ever, during a period of 3 months or more, consistently felt very anxious in situations where you needed to perform or might be judged by people watching you? For example, giving a speech, playing an instrument in public, eating in a restaurant, or using a public restroom?** (EITHER QUESTION RATED YES IS SUFFICIENT FOR AN ITEM RATING OF YES)
	IF BOTH SAD.1a AND SAD.1a.1 ARE RATED "NO" - SCREENING FOR SAD IS NEGATIVE SKIP TO OCD.1a - OCD SCREENING QUESTION

SAD.1b	DISPLAY IF SAD.1a IS RATED "YES" SQ**: Over the last 3 months, have you consistently felt very anxious about interacting with other people in social situations? For example, at parties or other social functions, meeting people you don't know, or social contacts at work?** DISPLAY IF SAD.1a.1 IS RATED "YES"
SAD.1b.1	**Over the last 3 months, have you consistently felt very anxious in situations where you need to perform or might be judged by people watching you? For example, giving a speech, playing an instrument in public, eating in a restaurant, or using a public restroom?** (EITHER QUESTION RATED YES IS SUFFICIENT FOR AN ITEM RATING OF YES)
SAD.1c	DISPLAY IF SAD.1a OR SAD.1a.1 IS RATED YES AND SAD.1b AND SAD.1b.1 IS RATED "NO" **Please tell me during which 3-month period your anxiety about social situations or situations where you might be judged was at its worst.** _____, _____ (3-Month Period, Year)
SAD.2	DISPLAY IF SAD.1a OR SAD.1a1 OR SAD.1b OR SAD.1b1 IS RATED YES LIFETIME: USE THE ANSWER FROM SAD.1c AS PIPED TEXT IN THE QUESTIONS SAD.2-3 CURRENT: CHANGE GRAMMAR – "**Are you having / Do you …"** AND **"During the last 3 months"** **When you were in these situations, were you concerned that others would form negative opinions of you?** IF NO: **Were you worried that you might say or do something embarrassing or offensive?** (A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO SAD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD SCREENING QUESTION)
SAD.3	**Did you mostly avoid these kinds of social situations or situations where you might be judged?** IF NO**: When you could not avoid them, did you barely tolerate them and feel very anxious while they were going on?** (A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO SAD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD SCREENING QUESTION)
SAD.4	DISPLAY IF SAD.1 - 3 ARE RATED YES

	Did the anxiety about social situations or situations where you might be judged affect your ability to function in daily life, for example, your work or school, your social life or your relationships? IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did the anxiety about social situations or situations where you might be judged bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND SOCIAL ANXIETY DISORDER CDDR MET) AND DX SOCIAL ANXIETY DISORDER CURRENT (IF SAD.1b IS YES) Or DX SOCIAL ANXIETY DISORDER LIFETIME (IF SAD.1a IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO SAD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO OCD.1a (OCD SCREENING QUESTION)

F	**OBSESSIVE COMPULSIVE AND RELATED DISORDERS**
	6B20 - OBSESSIVE COMPULSIVE DISORDER (OCD)
OCD.1a	
OCD.1a1	SQ **: Was there ever a time when for a month or more you had repetitive, unpleasant, and unwanted thoughts? For example, thoughts about germs or contamination, having to organize things perfectly, disrespectful thoughts about God or thoughts of harming yourself or others.**
OCD.1a2	IF NO**: Was there ever a time when for a month or more you had unwanted images appear in your mind over and over that caused you distress? For example, unwanted violent or sexual images?**
OCD.1a3	IF NO**: Was there ever a time when for a month or more you had repeated urges to do things over and over that didn't really need to be done, even if you did not act on these urges? For example, the urge to ask about instructions multiple times, the urge to confess something, the urge to check a switch or a lock many times, the urge to arrange things until they are "just right," or the urge to clean something more than once, even if you did not do it?** SKIP TO OCD.1a4 AT THE FIRST YES, ONLY ONE YES ANSWER IS SUFFICIENT FOR A RATING OF "YES" IF OCD.1a1 AND OCD.1a2 AND OCD.1a3 = NO, OCD 1.a = NO, SKIP TO OCD.1b2
OCD.1a4	IF OCD.1a1 OR OCD.1a2 OR OCD.1a3 = YES: **The kinds of** [THOUGHTS/IMAGES/URGES] **you were talking about, were they simply excessive worries about real life problems such as finance, family, or the future**? IF OCD.1a4 = NO, OCD.1a = YES, GO TO OCD.1b1 IF OCD.1a4 = YES, OCD.1a = NO, GO TO OCD.1b2

OCD.1b	
OCD.1b1	ASK IF OCD.1a = YES SQ **: Did you attempt to neutralize or decrease these** [THOUGHTS/IMAGES/URGES] **with some other behaviour or mental act? For example, washing your hands or objects many times, checking switches or locks multiple times, lining up objects in a specific way, mentally reviewing everything you said or touched or have to do, counting objects or counting the number of times you're doing something.** IF NO, GO TO OCD.1b3
OCD.1b2	ASK IF OCD.1a = NO **Was there ever a time when for a month or more you felt driven to do something over and over, in a very specific way or according to a set of rules in your mind, or until it felt "just right" to you, and it was hard not to do this? For example, washing your hands or objects many times, checking switches or locks multiple times, lining up objects in a specific way, mentally reviewing everything you said or touched or have to do, counting objects or counting the number of times you're doing something.**
OCD.1b3	ASK IF OCD.1b1 = NO **Was there ever a time when for a month or more you did the kinds of things I just mentioned over and over and it was hard not to do this, even if it wasn't in response to specific thought, images, or urges?** IF OCD.1b1, OCD.1b2, OR OCD.1b3 = YES, THEN OCD.1b = YES
	IF BOTH OCD.1a AND OCD.1b ARE RATED "NO" - SCREENING FOR OCD IS NEGATIVE SKIP TO HYP.1a - HYPCHONDRIASIS SCREENING QUESTION
OCD.1c	
OCD.1c1	IF OCD.1a1 = YES: **Over the past month, have you had repetitive, unpleasant, and unwanted thoughts? For example, thoughts about germs or contamination, having to organize things perfectly, disrespectful thoughts about God or thoughts of harming yourself or others?**
OCD.1c2	IF OCD.1a2 = YES OR OCD.1c1 = NO: **Over the past month, have you had unwanted images appear in your mind over and over that caused you distress? For example, unwanted violent or sexual images?**
OCD.1c3	IF OCD.1a3 = YES OR OCD.1c2 = NO: **Over the past month, have you had repeated urges to do things over and over that didn't really need to be done, even if you did not act on these urges? For example, the urge to ask about instructions multiple times, the urge to confess something, the urge to check a switch or a lock many times, the urge to arrange things until they are "just right," or the urge to clean something more than once, even if you did not do it?** SKIP TO OCD.1c4 AT THE FIRST YES, ONLY ONE YES ANSWER IS SUFFICIENT FOR A RATING OF "YES")

OCD.1c4	IF OCD.1c1 AND OCD.1c2 AND OCD.1c3 = NO, OCD.1c = NO, SKIP TO OCD.1d2 IF OCD.1c1 OR OCD.1c2 OR OCD.1c3 = YES: **The kinds of** [THOUGHTS/IMAGES/URGES] **you are talking about, are they simply excessive worries about real life problems such as finance, family, or the future?** IF OCD.1c4 = NO, OCD.1c = YES, GO TO OCD.1d1 IF OCD.1c4 = YES, OCD.1c = NO, GO TO OCD.1d2
OCD.1d **OCD.1d1** **OCD.1d2** **OCD.1d3**	 ASK IF OCD.1c = YES **Over the past month, have you attempted to neutralize or decrease these** [THOUGHTS/IMAGES/URGES] **with some other behaviour or mental act? For example, washing your hands or objects many times, checking switches or locks multiple times, lining up objects in a specific way, mentally reviewing everything you said or touched or have to do, counting objects or counting the number of times you're doing something?** IF NO, GO TO OCD.1d3 ASK IF OCD.1c = NO **Over the past month, have you felt driven to do something over and over, in a very specific way or according to a set of rules in your mind, or until it felt "just right" to you, and it was hard not to do this? For example, washing your hands or objects many times, checking switches or locks multiple times, lining up objects in a specific way, mentally reviewing everything you said or touched or have to do, counting objects or counting the number of times you're doing something** ASK IF OCD.1d1 = NO **Over the past month, have you done the kinds of things I just mentioned over and over and it was hard not to do this, even if it wasn't in response to specific thought, images, or urges?** IF OCD.1d1, OCD.1d2, OR OCD.1d3 = YES, THEN OCD.1d = YES
OCD.1e	DISPLAY IF OCD.1a AND/OR OCD.1b ARE RATED YES AND OCD.1c AND OCD.1d ARE RATED "NO" **Please tell me during what month these experiences were at their worst, that is, the experiences of unwanted thoughts, images, or urges, or feeling driven to do something over and over, in a very specific way.** _____, _____ (Month, Year)
OCD.2	IF OCD.1c OR OCD.1d ARE RATED YES, ASSESS FOR CURRENT IMPAIRMENT (PAST) MONTH: **During the past month…** IF OCD.1e WAS PRESENTED, ASSESS FOR PAST IMPAIRMENT: **During that month [**MONTH, YEAR FROM OCD.1e**] …**

	Did you spend more than an hour a day having these thoughts, images or impulses and performing these repetitive actions? IF NO: **Did having these thoughts, images or impulses and having to perform these repetitive actions affect your ability to function in daily life, for example, your work or school, your social life, or your relationships?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did having these thoughts, images or impulses and having to perform these repetitive actions bother you a lot?** ONE YES OF THE ABOVE FOUR QUESTIONS IS SUFFICIENT TO RATE THE FUNCTIONAL IMPAIRMENT / DISTRESS ITEM AS "YES". IF YES: AND OCD.1c OR OCD.1d IS YES: DX CURRENT OCD AND OCD.1a OR OCD.1b IS YES AND OCD.1c AND OCD.1d IS NO: DX LIFETIME OCD IF NO AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO OCD.1e IF NO AND ENQUIRING ABOUT LIFETIME SYMPTOMS – PROCEED TO HYP.1a (HYPOCHONDRIASIS SCREENING QUESTION)

	6B23 - HYPOCHONDRIASIS (HEALTH ANXIETY DISORDER) (HYP)
HYP.1a	SQ **: Was there ever a period when, for 3 months or longer, you were very worried that you had or would develop one or more serious, progressive, or life-threatening illnesses?** IF YES: **Was this because you had been diagnosed with or were getting tested for a serious disease, like cancer, HIV or heart disease, or a similar disease that would likely cause disability or early death?** IF NO: HYP1a = YES; GO TO HYP.1b IF YES: **Did you have this type of worry at other times, for 3 months or longer?** IF YES: HYP1a = YES; GO TO HYP.1b IF NO OR IF WORRY SOLELY RELATED TO DIAGNOSED ILLNESS: HYP.1a = NO: SCREENING FOR HYPOCHONDRIASIS IS NEGATIVE SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)
HYP.1b	DISPLAY IF HYP.1a = YES **During the past 3 months, were very worried that you had or would develop one or more serious, progressive, or life-threatening illnesses?**

	IF YES: **Was this because you had been diagnosed with or were getting tested for a serious disease, like cancer, HIV or heart disease, or a similar disease that would likely cause disability or early death?** IF YES: HYP1b = NO; GO TO HYP.1c IF NO: **Did you talk to a doctor or other health professional about your concerns?** **I**F YES: **Did the health professional confirm that something was seriously wrong, or did they try to reassure you that you were healthy or only had a minor ailment?** **_____ Something was seriously wrong _____ Said I was healthy or a minor ailment** IF UNKNOWN OR UNDETERMINED (UNDIAGNOSED), CODE AS "Something serious was wrong". IF SOMETHING WAS SERIOUSLY WRONG: HYP1b = NO; GO TO HYP.1c IF HEALTHY OR MINOR AILMENT: **Did you continue to worry even after the health professional said that nothing was seriously wrong with you?** IF NO: HYP.1b = NO; GO TO HYP.1c IF YES: HYP.1b = YES; GO TO HYP.2 **OR - IF DID NOT TALK TO A DOCTOR OR OTHER HEALTH PROFESSIONAL:** **Did you have physical symptoms that were getting worse and affecting your daily life?** IF YES: HYP.1b = NO; GO TO HYP.1c IF NO: **Did you continue to worry even though your health was not getting worse?** IF YES: HYP.1b = YES; GO TO HYP.2 IF NO: HYP.1b = NO; GO TO HYP.1c
HYP.1c	DISPLAY IF HYP.1a = YES AND HYP.1b = NO: **When did you experience your <u>worst</u> period of 3 months or longer of being very worried that you had or would develop one or more serious, progressive, or life-threatening illnesses?** **Year _____ 3 Month period _____**
HYP.1d	DISPLAY IF HYP.1c IS DISPLAYED **During that 3-month period:** **Did you talk to a doctor or other health professional about your concerns?** IF YES: **Did the health professional confirm that something was seriously wrong, or did they try to reassure you that you were healthy or only had a minor ailment?**

	_____ Something was seriously wrong _____ Said I was healthy or a minor ailment IF UNKNOWN OR UNDETERMINED (UNDIAGNOSED), CODE AS "Something serious was wrong". IF SOMETHING WAS SERIOUSLY WRONG: HYP1d = NO; SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION) IF HEALTHY OR MINOR AILMENT: **Did you continue to worry even after the health professional said that nothing was seriously wrong with you?** IF NO: HYP.1d = NO; SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION) IF YES: HYP.1d = YES; GO TO HYP.2 **OR - IF DID NOT TALK TO A DOCTOR OR OTHER HEALTH PROFESSIONAL:** **Did you have physical symptoms that were getting worse and affecting your daily life?** IF YES: HYP.1d = NO; SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION) IF NO: **Did you continue to worry even though your health was not getting worse?** IF YES: HYP.1d = YES; GO TO HYP.2 IF NO: SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)
HYP.2	DISPLAY IF HYP.1b OR HYP.1d IS RATED YES IF HYP.1b = YES: **During the past three months …** IF HYP.1c WAS PRESENTED: **During the time we just identified [**MONTH, YEAR**]** … **Did you repeatedly check your body for evidence that you have this illness?** IF NO: **Did you spend many hours seeking information about the illness?** IF NO: **Did you make many visits to doctors, nurses, or other healers to have your health checked out?** IF NO: **Did you avoid visits to health clinics (because you feared bad news) or avoid tests or hospitals, or even talking or thinking about this illness?** ANY YES ANSWER YES IS SUFFICIENT FOR A "YES" RATING – GO TO HYP.3 IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO HYP.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)
HYP.3	DISPLAY IF HYP.2 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) **Did the worry about having a serious illness affect your ability to function in daily life, for example, your work or school, your social life or your relationships?**

	IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** IF NO**: Did the worry about having a serious illness bother you a lot?** YES TO ANY OF THE 3 QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND HYPCHONDRIASIS CDDR ARE MET AND DX HYPCHONDRIASIS CURRENT (IF HYP.1b = YES) OR DX HYPCHONDRIASIS LIFETIME (IF HYP.1a = YES AND HYP.1b = NO) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO HYP.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO PTSD.1 (PTSD TRAUMA SCREENING QUESTION)

G	6B40 - POST TRAUMATIC STRESS DISORDER (PTSD) AND COMPLEX PTSD
PTSD.1	**I am now going to ask you some questions about difficult experiences that people encounter over the course of their lives. I will ask whether you have ever experienced certain types of events that people often find threatening or horrifying. I am not going to ask you to tell me anything specific about what happened to you other than what type of event it was. Then, I will ask you about your reactions to those events.** (ALL QUESTIONS ARE SQ)
PTSD.1a	SQ **: Have you ever been involved in war – either as a soldier or as a civilian in an area where armed conflict was ongoing?**
PTSD.1b	**Have you ever been the victim of physical violence, whether by a stranger or a family member or partner?**
PTSD.1c	**Have you ever been forced to participate in sexual activity against your will, as a child or an adult, by someone known or unknown to you?**
PTSD.1d	**Have you ever been in a serious accident, for example in a car, bus or train?**
PTSD.1e	**Have you ever been in a disaster such as a tsunami or flood, a major earthquake, a fire or a building collapse?**
PTSD.1f	**Have you ever lost a loved person very suddenly and unexpectedly, or in a very horrific way?**
PTSD.1g	**Have you ever witnessed extremely horrific events happening to other people, such as seeing a pedestrian getting hit by a car, someone jumping from a bridge, or someone being badly beaten?**
PTSD.1h	**Have you experienced a medical event, like a heart attack or an injury that almost caused you to die?**

PTSD.1i	**Have you ever been exposed to an event or a series of events (either short- or long-lasting) that wasn't covered by the types of events I just asked you about and that you experienced as extremely threatening or horrific?**
PTSD.1j	If NO TO ALL: **Did you actually experience any of the things I just asked you about, but you didn't want to say what it was?** IF NO: SCREEN FOR TRAUMA NEGATIVE; SKIP TO AN.1a – SCREENING FOR ANOREXIA NERVOSA IF YES: CONTINUE BELOW **When did that occur or start?** Trauma date/period: _____ (Year(s)) TICK HERE IF SINGLE EVENT BASED ON DESCRIPTION: _____ IF UNKNOWN, ASK: **Was that a single event?** IF NOT A SINGLE EVENT AND IF NOT CLEAR FROM ABOVE: **How long did it last? _____ (Years) _____ (Months)** IF MULTIPLE EVENTS REPORTED: **Which of these events affected you the most in terms of your feelings, other reactions and your ability to function in your everyday life over time?** **When did that occur or start?** Trauma date/period: _____ (Year(s)) TICK HERE IF SINGLE EVENT BASED ON DESCRIPTION: _____ IF UNKNOWN, ASK: **Was that a single event?** IF NOT A SINGLE EVENT AND IF NOT CLEAR FROM ABOVE: **How long did it last? _____ (Years) _____ (Months)**
PTSD.2a	DISPLAY IF PTSD.1 RATED "YES" **The next questions have to do with your reaction to that event.** **During a period of a month or more, did you ever have episodes when you suddenly felt as if the event was happening again in the here and now, like you were reliving it, for example, as a "flashback"?**

	If NO: **During a period of a month or more, did you have very vivid memories of what happened, so real that you had the same strong emotions or physical sensations again?** IF NO: **During a period of a month or more, did something that reminded you of the event make you feel overwhelmed with a rush of the same emotions or physical sensations you had when it happened?** IF NO: **During a period of a month or more, did upsetting images of the event intrude on your thoughts?** IF NO: **During a period of a month or more, did you have vivid and frightening dreams or nightmares related to the event?** ONLY ONE QUESTION RATED "YES" IS SUFFICIENT FOR A "YES" RATING FOR THIS ITEM
PTSD.2b	DISPLAY IF PTSD.2a RATED "YES" **During the past month, have you had episodes when you suddenly felt as if the event was happening again in the here and now, like you were reliving it, for example, as a "flashback"?** If NO: **During the past month, have you had very vivid memories of the event, so real that you had the same strong emotions or physical sensations again?** IF NO: **During the past month, has something that reminded you of the event made you feel overwhelmed with a rush of the same emotions or physical sensations you had when it happened?** IF NO: **During the past month, have upsetting images of the event intruded on your thoughts?** IF NO: **During the past month, have you had vivid and frightening dreams or nightmares related to the event?** SKIP TO PTSD.3 AS SOON AS ONE QUESTION ANSWERED YES
	IF PTSD.2A AND PTSD 2B RATED "NO" - SCREENING FOR PTSD IS NEGATIVE SKIP TO AN.1A - ANOREXIA NERVOSA SCREENING QUESTION
PTSD.2c	DISPLAY IF PTSD.2a RATED "YES" AND PTSD.2B RATED "NO" **Please tell me during which month these reactions were at their worst:** _____, _____ (Month, Year)
PTSD.3	DISPLAY IF EITHER PTSD.2a OR PTSD.2b RATED "YES" **During that time, (**PTSD.2c**), did you try very hard to avoid anything that reminded you of what happened? For example, did you try to avoid thoughts or memories of what happened, or try to avoid reminders such as specific people, conversations, places or situations?** If NO: **Did you change anything in your social, work or everyday routine to stay away from reminders of what happened? Were there things you didn't do, or places you didn't go to because it might cause you to think about what happened?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING

	IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PTSD.2c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)
PTSD.4	DISPLAY IF PTSD.3 IS RATED YES **During that time (**PTSD.2c**), were you constantly expecting danger, or were you more watchful of potential danger than before? Were you easily startled, for example, jumping at sudden noises? Were you constantly watching for signs of danger in regular situations, more so than before the event?** (NOTE: IF NO MEMORY OF VIGILANCE LEVEL PRIOR TO TRAUMA BUT HYPERVIGILANCE IS PRESENT – SCORE AS "YES") IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PTSD.2c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)
PTSD.5	DISPLAY IF PTSD.4 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) **Did the experiences that you had after the event that we've just talked about affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT AND PTSD CDDR MET) AND DX PTSD CURRENT (IF PTSD.2b IS YES) Or DX PTSD LIFETIME (IF PTSD.2a IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO PTSD.2c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)
	6B41 - COMPLEX POST TRAUMATIC STRESS DISORDER (C - PTSD) (CURRENT ONLY)
PTSD.6	DISPLAY THE BELOW IF CURRENT PTSD IS PRESENT **Since the event, have you been struggling with managing your emotions in the sense that you had strong, uncontrollable feelings, lots of emotional ups and downs, or felt numb or detached when you have been under stress, or only experienced negative feelings?** IF NO: **Have you been having emotional outbursts over small things, or have you acted recklessly because you are trying to get away from your feelings?**

	A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)
PTSD.7	DISPLAY IF PTSD.6 is rated YES **Since the event, have you believed that you are less worthy, like you aren't as good as others, or that you are a failure and have given up trying at life?** IF NO: **Since the event, have you had ongoing feelings of shame or guilt, related to the event or more generally?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)
PTSD.8	DISPLAY IF PTSD.7 IS RATED YES **Since the event, have you had trouble sustaining relationships and feeling close to others? For example, do you struggle to maintain stable relationships with partners, family and friends, or do you avoid them altogether?** IF NO: **Do your relationships tend to have a lot of ups and downs, or typically last for a short time, or do you find it very difficult to be emotionally intimate with anyone?** A YES ANSWER TO EITHER IS SUFFICIENT FOR A "YES" RATING IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)
PTSD.9	DISPLAY IF PTSD.8 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) **Since the event, do your difficulties with emotions and relationships and your negative view of yourself affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO: **Or did you still continue to get things done, but with a lot of extra effort?** YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT PRESENT AND COMPLEX PTSD CDDR MET) AND DX COMPLEX PTSD CURRENT IF NO – SKIP TO AN.1a (ANOREXIA NERVOSA SCREENING QUESTION)

H	**EATING DISORDERS** HIERARCHICAL DIAGNOSES => E.G., IF CURRENT ANOREXIA IS PRESENT, CURRENT BULIMIA CANNOT BE DIAGNOSED SIMULTANEOUSLY, BUT LIFETIME BULIMIA IS POSSIBLE DIAGNOSIS.

	6B80 - ANOREXIA NERVOSA (AN)
AN.1a	SQ: **Was there ever a time when you weighed much less than other people of your same sex and height?** If NO **– Did other people say they were worried that your weight was too low?** IF YES TO ASK **–** **At what age did you weigh the least for your height?** **AGE IN YEARS AND MONTHS: _____(month, year)** **What was your approximate weight and height ?** (PROVIDE BEST ESTIMATE IF UNSURE. VERIFY IF BEING REPORTED IN KILOGRAMS OR POUNDS AND IN CENTIMETERS OR FEET/INCHES) IF LOWEST WEIGHT FOR HEIGHT WAS BETWEEN 5 – 19 YEARS: I am asking you this question to be able to compare your weight to other people your age. What was the sex that you were assigned at birth? Male Female (THRESHOLD: LESS THAN 5TH PERCENTILE FOR SEX/AGE BETWEEN 5 – 19 YEARS OLD, OR BMI LESS THAN 18.5 FOR 20 YEARS OR OLDER – PROGRAM WILL CALCULATE THIS)
AN.1a1	**At that time, were you so preoccupied with your weight or shape that you spent a lot of time and energy trying to lose weight or making sure it stayed low?** IF NO TO EITHER OF ABOVE: **Was your weight or shape extremely important in determining your view of yourself?** IF NO: **Did it seem to you that you were/are a normal weight or overweight, despite other people thinking that you were underweight?** IF NO: **Did you repeatedly weigh yourself, check your shape in mirrors, measure yourself with a tape measures, or count calories of the foods that you had eaten?** IF NO: **Did you avoid looking at yourself in the mirror, or avoid weighing yourself, or avoid wearing tight clothes?** (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO AN.1a1)
	IF AN.1A OR AN.1A1 RATED "NO": SCREENING FOR ANOREXIA NERVOSA IS NEGATIVE. SKIP TO BN.1A - BULIMIA NERVOSA SCREENING QUESTION
AN.1b	SQ: **Over the past month, have you weighed much less than other people of your same sex and height?** If NO **– During the past month, have other people said they were worried that your weight is too low?** IF YES TO EITHER - DETERMINE BMI **– What is your current weight and height?** (VERIFY IF BEING REPORTED IN KILOGRAMS OR POUNDS AND IN CENTIMETERS OR FEET/INCHES) (THRESHOLD: < 18.5 KG/M2 – PROGRAM CALCULATES THIS)

	AN.1b = YES (I.E., CURRENTLY BELOW THRESHOLD)–, GO TO AN.1b1 IF AN.1b = NO (I.E., CURRENTLY ABOVE THRESHOLD), BUT LIFETIME THRESHOLD IS MET IN AN.1a AND AN.1a1, GO TO AN.2 AND ASK LIFETIME VERSIONS OF QUESTIONS
AN.1b1	DISPLAY IF AN.1b IS RATED YES **Over the past month, have you been so preoccupied with your weight or shape that you spent a lot of time and energy trying to lose weight or making sure it stayed low?** IF NO: **Over the past month, has your weight or shape been extremely important in determining your view of yourself?** IF NO: **Over the past month, has it seemed to you that you are a normal weight or overweight, despite other people thinking that you were underweight?** IF NO: **Over the past month, have you repeatedly weighed yourself, checked your shape in mirrors, measured yourself with a tape measures, or counted calories of the foods that you ate?** IF NO: **Over the past month, have you avoided looking at yourself in the mirror, or avoided weighing yourself, or avoided wearing tight clothes?** (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO AN.1b1.) IF YES to AN.1b and AN.1b1 – SKIP TO AN.2 (CURRENT VERSIONS OF QUESTIONS) IF NO to AN.1b or AN.1b1 – SKIP TO AN.2 (LIFETIME VERSIONS OF QUESTIONS)
AN.2	DISPLAY IF AN.1a AND AN.1a1 OR AN.1b AND AN.1b1 ARE RATED "YES" **Have you been doing / Did you do things daily (or almost daily) to lose weight or keep your weight so low?** USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: IF NO**: Do/Did you regularly try to restrict your calorie intake by fasting, skipping meals, or avoiding eating high-calorie foods?** IF NO: **Do/Did you regularly make yourself throw up or take laxatives to keep your weight this low?** IF NO: **Do/Did you regularly spend a lot of time exercising to lose weight or keep from gaining weight?** IF NO: **Do/Did you regularly take medication or substances to lose weight or prevent weight gain (for example, stimulants, appetite suppressants, laxatives)?** (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO AN.2) IF YES, DX ANOREXIA NERVOSA CURRENT (if AN.1b AND AN.1b1 ARE YES) OR DX ANOREXIA NERVOSA LIFETIME (if AN.1a AND AN.1a1 ARE YES) IF NO TO ALL – AND ENQUIRING ABOUT CURRENT SYMPTOMS – ASK LIFETIME VERSIONS OF AN.2 LOOP IF NO TO ALL – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO BN.1a (BULIMIA NERVOSA SCREENING QUESTION)

	6B81 - BULIMIA NERVOSA (BN)
BN.1a	SQ **: Was there ever a time when, over a period of at least a month, you had recurrent eating binges, that is, short periods of time when you felt out of control about your eating, when you could not stop eating, or could not limit the amount or the type of food that you ate?** IF YES **- Did these eating binges occur at least once a week?** (A YES ANSWER TO BOTH IS NEEDED FOR A "YES" RATING)
	IF BN.1a RATED "NO" - SCREENING FOR BULIMIA NERVOSA AND BINGE EATING DISORDER IS NEGATIVE. – SKIP TO SUBSTANCE USE SCREENING
BN.1b	DISPLAY IF BN.1a RATED "YES" SQ **: During the past month, have you had eating binges, that is, short periods of time when you felt out of control about your eating, when you could not stop eating, or could not limit the amount or the type of food that you ate?** IF YES **- Have these eating binges occurred at least once a week?** (A YES ANSWER TO BOTH IS NEEDED FOR A "YES" RATING)
BN.1c	DISPLAY IF BN.1a IS RATED "YES" AND BN.1b RATED "NO" **Please tell me during which month you had the most frequent eating binges?** **_____**(month, year) **During that month, did the eating binges occur at least once a week?**
BN.2	DISPLAY IF BN.1a OR BN.1b RATED YES USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: **I am now going to ask you about things people do after eating binges to keep from gaining weight from the calories they had just consumed:** **Shortly after the eating binges, do/did you often….** (CHECK ALL THAT APPLY) ☐ **…make yourself vomit?** ☐ **…use water pills (diuretics), laxatives, or enemas?** ☐ **…exercise very hard to burn calories gained from the eating binge?** ☐ **… do anything else to keep yourself from gaining weight from the calories you had just consumed, for instance, take or omit a medication that influences your metabolism?** IF ANY OF THE ABOVE IS "YES": **Of the things you just told me that you often did shortly after the eating binges [**COMPENSATORY BEHAVIOUR FROM ABOVE QUESTIONS**], do/did you do [**IT/ONE OF THEM**] at least once a week?** (REQUIRED)

	IF ANY QUESTION IS RATED "YES" CODE "YES" TO BN.2. IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BN.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO BED.1a (BINGE EATING DISORDER SCREENING QUESTION)
BN.3	DISPLAY IF BN.2 IS RATED YES USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: **Do/Did you worry or think constantly about your weight or your body shape?** IF NO: **Do/Did you repeatedly do things like constantly weighing yourself, checking your shape in mirrors or with tape measures, or counting calories of the foods that you eat?** IF NO: **Did you avoid looking at yourself in the mirror, or avoid weighing yourself, or avoid wearing tight clothes?** (IF ANY OF THE ABOVE IS "YES", CODE "YES" TO BN.3.) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BN.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SUS.1 (DISORDERS DUE TO SUBSTANCE USE SCREENING QUESTION)
BN.4	DISPLAY IF BN.3 IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: **Do/Did your eating binges, the ways you tried to counteract them, and your worries or feelings about your weight or shape affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO**: Do/Did your eating binges, the ways you tried to counteract them, and your worries or feelings about your weight or shape bother you a lot?** YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND BULIMIA NERVOSA CDDR MET) IF YES DX BULIMIA NERVOSA CURRENT (IF BN.1b IS YES) OR DX BULIMIA NERVOSA LIFETIME (IF BN.1a IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BN.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SUS.1 (DISORDERS DUE TO SUBSTANCE USE SCREENING QUESTION)

	6B83 - BINGE-EATING DISORDER (BED)
BED.1a	

	ONLY DISPLAY IF BN.1a WAS RATED "YES" AND BN.2 WAS RATED "NO" SQ **: You said that in** [TIME IN BN.1c] **you had eating binges at least once a week – did this happen over a period of 3 months or longer?**
BED.1b	ONLY DISPLAY IF BN.1b WAS RATED "YES" AND BN.2 WAS RATED "NO" SQ : **You said that over the past month you had eating binges at least once a week – has this been going on for 3 months or longer?**
	IF BED.1a AND BED.1b BOTH RATED "NO" - SCREENING FOR BINGE EATING DISORDER IS NEGATIVE SKIP TO SUS.1a - SUBSTANCE USE DISORDERS SCREENING
BED.1c	DISPLAY IF BED.1a IS RATED "YES" AND BED.1b RATED "NO" **Please tell me during which 3-month period you had the most frequent eating binges?** **_____**(3-month period, year)
BED.2	DISPLAY IF BED.1a OR BED.1b IS RATED YES DISPLAY LOGIC: ONLY DISPLAY SUBSEQUENT QUESTIONS IF INITIAL QUESTIONS ARE ANSWERED NO. (ONLY ONE QUESTION ANSWERED YES IS ENOUGH FOR A "YES" RATING) USE "Do" OR "Did" DEPENDING ON WHETHER ASKING ABOUT CURRENT OR LIFETIME SYMPTOMS: **Do/Did the eating binges and your feelings about them affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO**: Do/Did your eating binges and your feelings about them bother you a lot?** YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND BINGE EATING DISORDER CDDR MET) IF YES DX BINGE EATING DISORDER CURRENT (if BED.1b IS YES) Or DX BINGE EATING DISORDER LIFETIME (if BED.1a IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO BED.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SUBSTANCE USE DISORDERS MODULE

I	**DISORDERS DUE TO SUBSTANCE USE (SUS)** **PART 1: SCREENING (SUS are all SQs)** LOCAL PROJECT DIRECTOR SHOULD PROVIDE LOCAL EXAMPLES OF COLLOQUIAL DRUG NAMES AND TRADE NAMES OF MEDICATIONS IF NEEDED	**Lifetime use**

	NOT ALL SUBSTANCES NEED TO BE ADMINISTERED. THIS CAN BE CUSTOMIZED PER SURVEY AND THE ONES THAT ARE NOT USED SHOULD BE INCLUDED AS SPECIFIC EXAMPLES IN "OTHER".	
SUS	**Next I am going to ask you about substances you might have used, including tobacco, alcohol, and other drugs. It is important for us to get an accurate idea of the substances people use and how they use them. Please remember that your answers are confidential and will not be shared with anyone outside of this research, so we hope that you will answer as honestly as possible.**	
SUS.1	(6C4A) TOBACCO / NICOTINE **Have you ever smoked cigarettes?** **Have you used e-cigarettes or used vaping products containing nicotine?** **Have you used other tobacco or nicotine products, for example, chewing tobacco or nicotine gum or patches?**	NO / YES
SUS.2	(6C40) ALCOHOL **Have you ever had a drink of alcohol?**	NO / YES
SUS.3	(6C41) CANNABIS **Have you ever used marijuana – whether prescribed ("medicinal") or recreationally?** IF NEEDED FOR CLARIFICATION: **Also known as pot, grass, or weed.** **What about hashish or "hash"?**	NO / YES
SUS.4	(6C42) SYNTHETIC CANNABIS **Have you ever used synthetic cannabis, also known as K2 or Spice?**	NO / YES
SUS.5	(6C43) OPIOIDS **Have you ever used heroin, opium, methadone, or prescription painkillers?** IF NEEDED FOR CLARIFICATION: **Some examples are fentanyl, morphine, codeine, hydrocodone, oxycodone and oxymorphone.** **What substances? _____** IF A PRESCRIPTION MEDICATION: **Was the** [MEDICATION] **specifically prescribed to you to help control pain, for example, after a surgery or injury?** IF YES: **Was your use of the medication limited to the 2-week period immediately after the injury or surgery?** IF YES: SUS.5 = NO	NO / YES
SUS.6	(6C44) SEDATIVES/ANXIOLYTICS/HYPNOTICS **Have you taken any pills to calm you down, help you relax, or help you sleep?** IF NEEDED FOR CLARIFICATION: **Some examples are diazepam, lorazepam, clonazepam, alprazolam and midazolam.** DOES NOT INCLUDE ANTIHISTAMINES (E.G., BENADRYL) OR OPIOIDS (SEE ABOVE). **What substances? _____** IF YES: **Was** [MEDICATION] **specifically prescribed to you to help you calm down, relax, or sleep?**	NO / YES

	IF YES: **Was your use of the medication limited to the dosage and duration of prescription? That is you only took the amount that the health professional told you to take, and only for the length of time they told you to take it.** IF YES: SUS.6 = NO	
SUS.7	(6C45) COCAINE **Have you ever used cocaine or "crack"?**	NO / YES
SUS.8	(6C46) STIMULANTS (NOT INCLUDING CAFFEINE) **Have you ever used any stimulants or "uppers" to give you more energy, keep you alert, lose weight, or help you focus? I am not talking about caffeine, as in coffee, tea, energy drinks, or caffeine pills. What is included here are amphetamines, "speed", or methamphetamine (also known as crystal meth), methcathinone, stimulant diet medications, or prescription drugs for Attention Deficit Hyperactivity Disorder like Methylphenidate (Ritalin), Adderall or Dexedrine.** NOTE THAT OZEMPIC AND WEGOVY ARE NOT STIMULANTS. **What substance(s)? _____** (ENTER EACH ON SEPARATE LINE) IF A PRESCRIPTION MEDICATION: **Was** [MEDICATION] **specifically prescribed to you for attention deficit disorder, hyperactivity, narcolepsy, or another condition?** IF YES: **Was your use of the medication limited to the dosage and duration of prescription? That is you only took the amount that the health professional told you to take, and only for the length of time they told you to take it.** IF YES: SUS.8 = NO.	NO / YES
SUS.9	(6C47) SYNTHETIC CATHINONES **Have you ever used synthetic cathinones, also known as bath salts?**	NO / YES
SUS.10	(6C49) HALLUCINOGENS **Have you ever used any drugs to "trip" or heighten your senses?** IF NEEDED FOR CLARIFICATION: **Some examples include: LSD (acid), peyote, mescaline, psilocybin (magic mushrooms), DMT, and Ayahuasca.** **What substance(s)? _____** (ENTER EACH ON SEPARATE LINE)	NO / YES
SUS.11	(6C4B) INHALANTS **Have you ever used glue, paint, paint thinner, lighter fluid, gasoline, or other inhalants to get high?** **What about nitrites like amyl nitrite or butyl nitrite (also called poppers or snappers) or nitrous oxide (laughing gas)?** **What substance(s)? _____** (ENTER EACH ON SEPARATE LINE)	NO / YES
SUS.12	(6C4C) MDMA AND RELATED DRUGS **Have you ever used ecstasy (MDMA, also called Molly), or MDA?**	NO / YES
SUS.13	(6C4D) DISSOCIATIVE DRUGS **Have you ever used PCP (also called angel dust) or ketamine (called K, Special K, or Vitamin K)?** **What substance(s)? _____** (ENTER EACH ON SEPARATE LINE)	NO / YES

SUS.14	(6C4E) OTHER PSYCHOACTIVE SUBSTANCES **Have you ever used any other substance or drug to get stoned, high, or as a stimulant that was not covered in questions I just asked you? This could include local substances or over-the-counter medicine for allergies, colds, cough, or sleep, when not used as directed.** **What substance(s)? _____** (ENTER EACH ON SEPARATE LINE)	NO / YES

I	**DISORDERS DUE TO SUBSTANCE USE (SUD)** **PART 2: DIAGNOSES**
	FOR TOBACCO/NICOTINE, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED MORE THAN ONE: **You said that you have used different forms of tobacco or nicotine. For these questions, I am just going to refer to all of these together as "tobacco or nicotine". So when I ask you a question about how you have used tobacco or nicotine, I am referring to any of them.** GO TO SUD.2 FOR TOBACCO/NICOTINE FOR CANNABIS, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED BOTH MARIJUANA AND HASHISH: **You said that you have used both marijuana and hashish. For these questions, I am just going to refer to all of these together as "cannabis". So when I ask you a question about how you have used cannabis, I am referring to either marijuana or hashish.** GO TO SUD.2 FOR CANNABIS FOR OPIODS, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED MORE THAN ONE: **You said that you have used [**SUBSTANCE**] and [**SUBSTANCE**] and [**SUBSTANCE**] … For these questions, I am just going to refer to all of these together as "opioids". So when I ask you a question about how you have used opioids, I am referring to any of them.** GO TO SUD.2 FOR OPIOIDS FOR SEDATIVES, BEFORE ASKING THE CORRESPONDING QUESTIONS, IF THE PERSON HAS ENDORSED MORE THAN ONE: **You said that you have used [**SUBSTANCE**] and [**SUBSTANCE**] and [**SUBSTANCE**] … For these questions, I am just going to refer to all of these together as "sedatives". So when I ask you a question about how you have used sedatives, I am referring to any of them.** GO TO SUD.2 FOR SEDATIVES
SUD.1	FOR ALL OTHER SUBSTANCES (I.E., STIMULANTS, HALLUCINOGENS, INHALANTS, DISSOCIATIVE DRUGS, OTHER), IF MULTIPLE SUBSTANCES ARE REPORTED IN A PARTICULAR CLASS:

	You said that you have used [SUBSTANCE**] and [**SUBSTANCE**] and [**SUBSTANCE**] … Have you used** [ANY/EITHER] **of them within the past year?** IF YES TO MULTIPLE: **Which have you used most during the past year?** IF NO TO USE DURING PAST YEAR: **Would you say that [**ANY/EITHER**] of them has caused you problems in the past?** **_____** IF ONE IS IDENTIFIED, GO TO SUD.2 FOR THAT SUBSTANCE IF YES TO MULTIPLE SUBSTANCES IN THE CLASS: **Which of these substances have caused you the most problems in the past, or if you're not sure, which one have you used the most of and most often in the past?** **_____** IF NO TO PROBLEMS: **Which one have you used the most of and most often in the past? If you're not sure, please make your best estimate.** **_____** THE SUBSTANCE IDENTIFIED IN THIS WAY WILL BE THE FOCUS OF THE INTERVIEW FOR THAT PARTICULAR CLASS OF SUSTANCES.
SUD.2	FOR EACH SUBSTANCE IDENTIFIED IN SUS,AND CLARIFIED AS APPLICABLE PER SUD.1. A DEPENDENCE ASSESSMENT AND HARMFUL USE ASSESSMENT IS DONE. IF SUD.1 WAS NOT DISPLAYED: **Have you used** [SUBSTANCE] **during the past year?** OR, IF SUD.1 DISPLAYED AND PAST YEAR USE REPORTED: **You said you have used [**SUBSTANCE from SUD1**] during the past year.** IF YES**:** **During the past year, have you used** [SUBSTANCE] **at least once a week?** **During the past year, have you had periods of** [SUBSTANCE USE] **alternating with periods where you did not** [DRINK / USE] **?** IF YES to EITHER – CONTINUE WITH SUD.3: IF NO OR IF SUD.1 DISPLAYED AND NO PAST YEAR USE REPORTED: **Please tell me during which year you used the most** [SUBSTANCE]… **(**year _____) **During that year, did you use** [SUBSTANCE] **at least once a week?** **During that year, did you have periods of** [SUBSTANCE USE] **alternating with periods where you did not** [DRINK / USE]. **?** IF YES to EITHER – CONTINUE WITH SUD.3:

	IF NO – SKIP TO HARMFUL USE ASSESSMENT IF YES, PROCEED TO SUD.3, SUBSTANCE DEPENDENCE ASSESSMENT
SUD.3	SUBSTANCE DEPENDENCE ASSESSMENT FIRST PASS THROUGH = CURRENT: **During the past 12 months …** IF NO CURRENT DEPENDENCE, SECOND PASS THROUGH = LIFETIME: **During that time** (IDENTIFIED IN SUD.2**) …** **During that year, did you feel like you should stop, cut down, limit, or control your** [DRINKING / DRUG USE] **but have trouble doing that?** For above question, either did not try to stop or cut down and did not have trouble both count as NO. IF NO: **Did you find yourself** [DRINKING/USING] **much more** [SUBSTANCE] **than you had intended to?** IF NO: **Did you** [DRINK/USE] **for a much longer period of time than you were intending to?** IF NO**: Did you end up** [DRINKING/USING] **in situations in which you had decided that you wouldn't, like at work or at family occasions or in unsafe situations, where you might get hurt or taken advantage of?** ANY YES ANSWER IS ENOUGH FOR A "YES" RATING
SUD.4	**Did you experience problems because of** [DRINKING/USING DRUGS] **in the following areas in your life?** (YES/NO to each) **School/work responsibilities** **Family responsibilities (childcare, chores, relationships)** **Maintaining friendships (aside from people who** [DRINK/USE] **with you)** **Engaging in hobbies, exercise, and other things you like to do (sober)** **Financial problems** **Risky behaviours like driving under the influence, stealing money to buy** [ALCOHOL/DRUGS], **public intoxication, fighting, etc.** **Your physical health (for example, being sick, blackouts, accidents)** **Your mental health (for example, feeling low or anxious, sleeping problems, paranoia, hearing voices, seeing things, feeling like your skin is infested)** IF YES TO AT LEAST ONE: **Were you unable to stop** [DRINKING / USING]**, even though you were experiencing these problems?** If NO: **Did you find your thoughts and actions increasingly related to getting** [ALCOHOL / DRUGS] **, consuming** [ALCOHOL / DRUGS]**, recovering from** [DRINKING/USING], **and dealing with the negative fallout?** EITHER ANSWERED YES IS ENOUGH FOR A YES RATING
SUD.5	DISPLAY IF EITHER OR BOTH OF SUD.3 AND SUD.4 ARE RATED YES **Did you have noticeable symptoms when you cut down or stopped** [DRINKING/USING] **for a day or two? (Either by choice or when you did not have access to it). This might include symptoms such as racing heart, sweating, shaky hands, nausea, vomiting, difficulty sleeping, being easily distracted, being very anxious, difficulty sitting still, seeing or hearing things that other people could not see or hear, feeling bugs crawling on your skin, or having a convulsion or seizure.**

	IF NO: **Did you have any symptoms like this when you woke up in the morning?** IF NO: **Did you need to** [HAVE A DRINK / USE] **or take another drug or medication in order to prevent yourself from developing these kinds of symptoms?** IF NO: **Over time, did you have to [**DRINK/USE**] more and more** [ALCOHOL/DRUG OF CHOICE] **to get the same effect as when you first started [**DRINKING/USING**]?** IF NO: **Did you find that the effects of [**ALCOHOL/DRUG**] lessened over time even though you were [**DRINKING/USING**] the same amount?** YES TO ANY OF THE ABOVE ITEMS IS ENOUGH FOR A YES RATING ON TOLERANCE /WITHDRAWAL
	DX CURRENT OR LIFETIME SUBSTANCE DEPENDENCE IF 2 OR 3 OUT OF 3 OF (SUD.3, SUD.4 SUD.5 ARE RATED "YES" FOR THE DURATION OF 12 MONTHS FOR _____ (SPECIFY SUBSTANCE) THEN, GO TO NEXT SUBSTANCE SCREENED AS "YES" IF BELOW THRESHOLD (<2 OUT OF 3 PRESENT) FOR EITHER CURRENT OR LIFETIME, CONTINUE WITH HARMFUL USE ASSESSMENT
SUD.6	DISPLAY IF SUBSTANCE DEPENDENCE = NO HARMFUL SUBSTANCE USE ASSESSMENT FIRST PASS THROUGH = CURRENT: **During the past 12 months …** IF NO CURRENT HARMFUL USE, SECOND PASS THROUGH = LIFETIME: **During that time** (IDENTIFIED IN SUD.2**) …** **Have you been injured seriously enough that you needed medical attention because of something you did while you were under the influence of** [ALCOHOL/ DRUG]**? For example, have you been injured by getting into a car accident, falling down and hitting your head, or being involved in a physical fight that occurred while you were intoxicated?** IF NO**: Did the way in which you used** [SUBSTANCE] **cause any health problems? For example, vomiting blood, severe stomach pain, liver damage, pancreatitis or infections.** IF NO**: Was a physical health problem that you already had, like hypertension or diabetes, made worse by your use of** [SUBSTANCE]**?** IF NO: **Did the way in which you used** [SUBSTANCE] **cause any kind of emotional or behaviour problems that were bad enough to affect your ability to function in daily life, for example, your work or school, your social life, or your relationships? Examples of emotional or behaviour problems include feelings of depression or anxiety, paranoia, sleep disturbance, and self-injurious behaviour.** ONE YES IS SUFFICIENT FOR A YES RATING ON SUD.6

SUD.7	DISPLAY IF SUD.6 IS RATED "NO" FIRST PASS THROUGH = CURRENT: **During the past 12 months …** IF APPLICABLE,,SECOND PASS THROUGH (LIFETIME): **During that time** (IDENTIFIED IN SUD.2**) …** **Were other people (family, friends, or strangers) seriously harmed in any way because of the way in which you used** [SUBSTANCE]**? Examples include physically assaulting someone while you were intoxicated; injuring someone while driving; someone else developing emotional problems because of your behaviour while you were intoxicated; children or other family members getting injured because you could not care for them adequately or developing health problems because your** [DRINKING/USING] **meant there was not enough money to buy food or medicine for them.**
	DX HARMFUL PATTERN OF SUBSTANCE USE if EITHER OR BOTH SUD.5 AND SUD.6 rated "YES" _____ (SPECIFY SUBSTANCE), _____CURRENT OR LIFETIME IF NO AND ASSESSING CURRENT USE (LAST 12 MONTHS) – SKIP TO LIFETIME DEPENDENCE ASSESSMENT AT SUD.3 IF NO AND ASSESSING LIFETIME USE – SKIP TO NEXT SUBSTANCE
	WHEN EACH SUBSTANCE HAS BEEN ASSESSED FOR CURRENT AND/OR LIFETIME DEPENDENCE AND/OR HARMFUL USE BASED ON ABOVE ALGORITHMS. GO TO GD.1a (GAMBLING DISORDER SCREENING QUESTION)

J	**DISORDERS DUE TO ADDICTIVE BEHAVIOURS**
	6C50 - GAMBLING DISORDER (GD)
GD.1a	SQ: **Has there ever been a period of a year or longer when you gambled regularly, either online or offline, such as betting on races or sports or e-sports, playing poker or other card or dice games involving betting, playing slot machines or other betting games at a bar or casino, or buying lottery tickets?**
	IF GD.1a RATED "NO" - SCREENING FOR GAMBLING DISORDER IS NEGATIVE. SKIP TO GAME.1a – GAMING DISORDER SCREENING QUESTION
GD.1b	DISPLAY IF GD.1a IS RATED YES SQ: **During the past 12 months, did you gamble regularly either online or offline, such as betting on races or sports or e-sports, playing poker or other card or dice games involving betting, playing slot machines or other betting games at a bar or casino, or buying lottery tickets?**

GD.1c	DISPLAY IF GD.1a IS RATED "YES" AND GD.1b RATED NO **What was the one-year period when you were gambling the most?** **_____**(12 month period, year)
GD.2	IF GD.1b IS YES: **During the past year …** IF GD.1a IS YES: **During that time,** GD.1c **,** **Did you feel like you were losing control over your gambling, for example, did you try unsuccessfully to cut down or stop gambling, or did you spend more money and time than you planned to?** IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAME 1a (GAMING DISORDER SCREENING QUESTION)
GD.3	DISPLAY IF GD.2 IS RATED YES IF GD.1b IS YES: **During the last year …** IF GD.1a IS YES: **During that time,** GD.1c **, …** **Did you spend less time on work or school, with family or friends, or on things you previously liked doing because of your gambling?** IF NO: **Did gambling cause you to neglect other important things in your life?** (A YES ANSWER TO EITHER IS SUFFICIENT FOR A YES RATING) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAME 1a (GAMING DISORDER SCREENING QUESTION)
GD.4	DISPLAY IF GD.3 IS RATED YES IF GD.1b IS YES: **During the last year …** IF GD.1a IS YES: **During that time,** GD.1c **, …** **Did you continue gambling, or even increase the time you spent gambling, even though it was causing problems in your life? For example, did you have problems such as conflict with loved ones, being unable to pay bills and getting into debt, or getting into trouble at work or school because of absences or missing deadlines?** IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAME 1a (GAMING DISORDER SCREENING QUESTION)

GD.5	DISPLAY IF GD.4 IS RATED YES **Did the amount of gambling and the consequences of the gambling we've just talked about affect your ability to function in daily life, for example, your work or school, your social life, or your relationships?** IF NO**: Did the gambling and the consequences of the gambling bother you a lot?** YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND GAMBLING DISORDER CDDR MET) IF YES DX GAMBLING DISORDER CURRENT (if GD.1b IS YES) OR DX GAMBLING DISORDER LIFETIME (IF GD.1a IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GD.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO GAME 1a (GAMING DISORDER SCREENING QUESTION)

	6C51 - GAMING DISORDER (GAME)
GAME.1a	SQ: **Has there ever been a period of a year or longer when you regularly played video games, either online, on electronic devices like a smartphone, a tablet, a computer, or a console?**
	If GAME.1a RATED "NO" - SCREENING FOR GAMING DISORDER IS NEGATIVE SKIP TO ADHD.1a – ADHD SCREENING QUESTION
GAME.1b	DISPLAY IF GAME.1a IS RATED YES SQ: **During the past 12 months, have you regularly played video games, either online, on electronic devices like a smartphone, a tablet, a computer, or a console?**
GAME.1c	DISPLAY IF GAME.1a IS RATED "YES" AND GAME.1b IS RATED "NO" **What was the one-year period when you were gaming the most?** _____(12 month period, year)
GAME.2	IF GAME.1b IS YES: **During the last year …** IF GAME.1c IS YES: **During that time,** GAME.1c **,** **Did you feel like you were losing control over your gaming, for example, did you try to cut down or stop gaming but were not able to, or did you often spend much more time gaming than you planned to?** IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAME.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO ADHD.1a (ADHD SCREENING QUESTION)

GAME.3	DISPLAY IF GAME.2 IS RATED YES IF GAME.1b IS YES: **During the last year …** IF GAME.1a IS YES: **During that time,** GAME.1c **, …** **Did you spend less time on work or school, with family or friends, or on things you previously liked doing because of your gaming?** IF NO: **Did gaming cause you to neglect other important things in your life?** (A YES ANSWER TO EITHER IS SUFFICIENT FOR A YES RATING) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAME.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO ADHD.1a (ADHD SCREENING QUESTION)
GAME.4	DISPLAY IF GAME.3 IS RATED YES IF GAME.1b IS YES: **During the last year …** IF GAME.1a IS YES: **During that time,** GAME.1c **, …** **Did you continue gaming, or even increase the time you spent gaming, even though it was causing problems in your life? For example, did you have problems such as conflict with loved ones, getting into trouble at work or school because of absences, missing deadlines, or lack of sleep, neglecting your hygiene, sleeping problems or developing physical problems, such as dehydration or blood clots, due to gaming for prolonged periods?** IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAME.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO ADHD.1a (ADHD SCREENING QUESTION)
GAME.5	DISPLAY IF GAME.4 IS RATED YES **Did your gaming and its consequences affect your ability to function in daily life, for example, your work or school, your social life or your relationships?** IF NO**: Did your gaming and its consequences bother you a lot?** YES TO EITHER OF THE QUESTIONS: FUNCTIONAL IMPAIRMENT / DISTRESS PRESENT AND GAMING DISORDER CDDR MET) IF YES DX GAMING DISORDER CURRENT (IF GAME.1b IS YES) OR DX GAMING DISORDER LIFETIME (IF GAME.1a IS YES) IF NO – AND ENQUIRING ABOUT CURRENT SYMPTOMS – LOOP BACK TO GAME.1c IF NO – AND ENQUIRING ABOUT LIFETIME SYMPTOMS – SKIP TO SKIP TO ADHD.1a (ADHD SCREENING QUESTION)

K	**6A05 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)** *(Current only)*
ADHD.1a	SQ 1 **During the last 6 months, have you had difficulty focusing on everyday tasks, or were you easily distracted when trying to pay attention?** AND SQ 2 **During the last 6 months, have you felt uncomfortable or restless when sitting still?** IF NO: **During the last 6 months, have you had a pattern of acting without thinking, like frequently interrupting other people or making risky decisions?**
	IF ADHD.1a = NO, SCREENING FOR ADHD IS NEGATIVE – SKIP TO NEXT MODULE ANY OF THE THREE QUESTIONS ANSWERED YES IN ADHD.1a – CONTINUE BELOW
ADHD.1b	**Did you have these difficulties in focusing and paying attention or feeling restless, or acting without thinking before the age of 12?** IF NO, ADHD.1b = NO IF YES: **Was this a big enough problem that it affected your performance at school or work or relationships with other people before the age of 12?** IF NO, ADHD.1b = NO
	IF ADHD.1b = NO, SCREENING FOR ADHD IS NEGATIVE – SKIP TO NEXT MODULE IF ADHD.1b = YES, CONTINUE BELOW
	Over the last 6 months…
ADHD.2a	**Did you often have a lot of problems with paying attention to things when you didn't find them very interesting, even if they might have been important?** IF YES: **Was your difficulty with paying attention serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2b	**Did you often have problems with staying focused on things that were complex and difficult or that required long periods of attention?** IF YES: **Was your trouble staying focused serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2c	**Did you regularly miss important details of tasks that you were doing, or make silly mistakes in your work?** IF YES: **Was your trouble with details serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2d	**Did you often struggle to finish things you were supposed to do, like assignments at school or work or projects at home?** IF YES: **Was your trouble finishing tasks serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)

ADHD.2e	**Were you often easily distracted by things happening around you or by thoughts that came into your mind that were not related to the task?** IF YES: **Was your distractibility serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2f	**Did you regularly miss important details of what people were saying to you, even if they are speaking to you directly?** IF YES: **Was your difficulty understanding the details of what people were saying to you serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2g	**Did you regularly find yourself getting lost in daydreams rather than focusing on things that were happening at school or at work or in conversations?** IF YES: **Was your tendency to daydream serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2h	**Do you often lose things like articles of clothing, your keys or your phone?** IF YES: **Was your tendency to lose things serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2i	**Did you often forget about scheduled activities or assignments or tasks that were due?** IF YES: **Was the forgetfulness serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.2j	**Do you often struggle to make a plan and stick to it for managing assignments or tasks at school or work or projects at home?** IF YES: **Was your difficulty with planning and organizing serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.3	THRESHOLD SCORE FOR INATTENTION = 3 ITEMS WITH IMPACT ON SCHOOL OR WORK OR RELATIONSHIPS
	Over the last 6 months…
ADHD.4a	**Did you often find it difficult to sit still or to prevent yourself from fidgeting or moving when you were required to sit still?** IF YES: **Was your difficulty with being still serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.4b	**Did you often have a strong sense of restlessness or discomfort when you were expected to be still and quiet?** IF YES: **Was your feelings of restlessness and discomfort serious enough that they affected your performance at school or at work or your relationships with other people?** (REQUIRED)

ADHD.4c	**Did you regularly have difficulty not talking or making noise when other people were doing the same activity in silence?** IF YES: **Was your difficulty with not talking or making noise serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.4d	**Did other people often tell you that you talked too much?** IF YES: **Did other people's view that you talked too much affect your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.4e	**In conversations, did you regularly find yourself interrupting or jumping in before other people had finished what they were saying?** IF YES: **Was your interrupting serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.4f	**Did you regularly have difficulty waiting your turn when playing games or other group activities?** IF YES: **Was your difficulty with waiting your turn serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.4g	**Did you regularly act impulsively or "on a whim" or "on the spur of the moment", without considering possible negative end results? For example, spending a substantial amount of money impulsively, choosing pleasurable activities in the moment rather than taking care of responsibilities, taking physical risks like climbing on things or crossing a busy highway, driving recklessly, or having impulsive unprotected sex.** IF YES: **Was your impulsivity and failure to consider longer-term consequences serious enough that it affected your performance at school or at work or your relationships with other people?** (REQUIRED)
ADHD.5	THRESHOLD SCORE FOR HYPERACTIVITY/IMPULSIVITY = 3 ITEMS WITH IMPACT ON SCHOOL OR WORK OR RELATIONSHIPS
ADHD.6	DISPLAY IF ADHD.3 OR ADHD.5 IS RATED YES **Did your problems with focusing and sustaining your attention and controlling your activity and impulses that we have just discussed occur in more than one situation, that is, at school or work, at home, at community events or church, when you are socialising with friends or spending time with your family, or when you are practicing a hobby or playing a sport?**
	AT LEAST 3 ITEMS WITH IMPACT ON SCHOOL OR WORK OR RELATIONSHIPS RATED YES FROM EITHER ADHD.2 OR ADHD.4 FOR THE DOMAIN REACHING THRESHOLD ADHD.6 MUST BE RATED YES DX CURRENT ADHD

L	POSSIBLE SECONDARY MENTAL OR BEHAVIOURAL SYNDROME (SD)	Dx 1	Dx 2	Dx 3

	SKIP IF NO DISORDERS DIAGNOSED. FOR EACH DISORDER DIAGNOSE IN MODULES C, D, E AND F, ASK:	_____	_____	_____
SD.1	**Around the time when you started having** [SYMPTOMS of DISORDER], **did you have a medical condition that may have caused your** [SYMPTOMS]**?** IF UNKNOWN, RECORD AS NO If YES, ASK BOTH OF THE FOLLOWING QUESTIONS**:** **What medical condition did you have?** _____ NOTE THAT MEDICAL CONDITION MAY BE UNKNOWN OR UNDIAGNOSED **Did a medical practitioner tell you this medical condition could be causing your** [SYMPTOMS]**?** IF NO: SD.1 = NO FOR THAT DX	NO/ YES	NO/ YES	NO/ YES

M	**POSSIBLE SUBSTANCE-INDUCED MENTAL DISORDER**	**Dx 1**	**Dx 2**	**Dx 3**
	SKIP IF NO DISORDERS DIAGNOSED. FOR EACH DISORDER DIAGNOSE IN MODULES C, D, E AND F, ASK:	_____	_____	_____
SI.1	**Around the time when you started having** [SYMPTOMS of DISORDER], **did you start a new medication, increase or change the dose of a medication, or stop taking a medication?** **What medication did you take or stop?** _____ (MAY BE UNKOWN) **Did a medical practitioner tell you that the change in medication could be causing your** [SYMPTOMS]**?** IF NO: SI.1 = NO FOR THAT DX	NO/ YES	NO/ YES	NO/ YES
SI.2	**Around the time when you started having** [SYMPTOMS OF DISORDER], **did you use drugs or alcohol for the first time, or increase your use of drugs or alcohol, or drastically cut down or stop using drugs or alcohol?** If YES, ASK BOTH OF THE FOLLOWING QUESTIONS: **What drug (including alcohol) did you take or stop?**	NO/ YES	NO/ YES	NO/ YES

	_____ **Did a medical practitioner tell you this could be causing your** [SYMPTOMS]**?** IF NO: SI.2 = NO FOR THAT DX			

	CODE POSSIBLE SECONDARY SYNDROME FOR A PARTICULAR DIAGNOSIS IF QUESTION SD.1 = YES CODE POSSIBLE SUBSTANCE-INDUCED MENTAL DISORDER FOR A PARTICULAR DIAGNOSIS IF QUESTION SI.1 AND/OR SI.2 = YES OTHERWISE CODE LIKELY PRIMARY MENTAL DISORDER

N	SUICIDAL IDEATION AND BEHAVIOUR SCREENING (SOS)	Current
SOS.1	**In the past month, have you thought about ending your life?**	NO / YES
SOS.2	DISPLAY IF SOS.1 = YES **In the past month, have you made any preparations in order to end your life, for example, deciding on a method or writing a will?**	NO / YES
SOS.3	DISPLAY IF SOS.1 = YES **In the past month, have you tried to end your life but were interrupted, or the attempt was unsuccessful?**	NO / YES
SOS.4	**In the past month, have you hurt yourself deliberately, without wanting to end your life, for example, cutting or burning your skin?**	NO / YES
• IF ANY QUESTION RATED "YES" – ASSESS / REFER FOR ASSESSMENT - DETERMINE SUICIDE RISK AND TAKE APPROPRIATE STEPS TO CONTAIN THE RISK BASED ON CLINICAL FINDINGS AND LOCAL SERVICES AND PROTOCOLS. • IF ALL QUESTIONS RATED "NO" – **END OF INTERVIEW**		

Interview Experience Questionnaire (IEQ) – Participant feedback

Introduction

Now that we have completed the interview about your mental health, I would like you to give feedback on the experience. We would like as much feedback as possible to improve the interview where needed so that people who are interviewed have an overall good experience.

I am going to ask you to rate how much you agree or disagree with a particular "I" statement. For example, if I make the following statement "I like ice cream" - could you rate how much you agree or disagree with that statement on this scale? In other words - you have to rate how true or untrue the statement is for you.

[INTERVIEWER: PLEASE ASSIST THE PARTICIPANT AND SHOW THEM THE PRINTED PAGE WITH RATING OPTIONS. STATEMENTS ARE DENOTED BY QUOTATION MARKS]

IEQ.P.A1. How much do you agree with the following statement?
"Overall, I was able to understand what the interviewer was asking."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A1.1 Can you remember any and all questions / phrases / words you found difficult to understand? Please give as much detail as possible.

IEQ.P.A2. "There were some of the words / phrases / questions that I thought were offensive or otherwise objectionable."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A2.1. Can you tell me and any and all problematic language and explain why it bothered you? Please give as much detail as possible.

IEQ.P.A3. "I found parts of the interview upsetting."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A3.1 "Could you tell me about any and all the sections of the interview that were upsetting? Please give as much detail as possible."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A4. "I felt respected and valued during the interview."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A5. "I felt heard and understood during the interview."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A6. "The interview took an appropriate amount of time."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A7. "The questions in the interview covered all my main concerns and complaints about my mental health experience."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A8. "Some important aspects of my mental health experience were not asked about."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A9. "The questions I was asked were an accurate reflection of my mental health experience."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A10. "I found the interview tiring."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A11. "The interview process was generally a positive experience."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A12. "Due to the interview I have a better understanding of myself and my mental health."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A13. "I would participate in an interview like this again at some point in the future."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.P.A14. Is there anything else you would like to add about your experience being interviewed with this questionnaire (FLII-11-EPI)?

Interview Experience Questionnaire (IEQ) – Interviewer feedback

I_ID. Interviewer ID

I_DOB. Please enter your date of birth _____

IEQ.I.A3. I am a trained mental health professional

YES	NO

INTRO

The following questions cover your impression of the experience the participant had as interviewee, as well as your experience interviewing this particular participant. Some questions contain "I" (first person) statements - please rate your level of agreement or disagreement with these statements.

PID. Participant ID

IEQ.I.B2. Please note the duration of the Interview as accurately as possible (in minutes).

_____

IEQ.I.B3. Please estimate the proficiency of the participant in the language the interview was conducted.

Completely fluent	Advanced	Intermediate	Low

IEQ.I.B4. From your perspective as the interviewer, did any of the following impact your ability to conduct the interview or influence the accuracy of answers? Please tick all that apply.

Lack of insight	Lack of cooperation	Cognitive impairment	Other factors (please specify)	None of the above factors were present

IF IEQ.I.B4 = LACK OF INSIGHT ASK IEQ.I.B4.1

IEQ.I.B4.1. To what extent did lack of insight impact the ability to conduct the interview or influence the accuracy of answers?

A little	Moderately	A great deal

IF IEQ.I.B4 = LACK OF COOPERATION ASK IEQ.I.B4.2

IEQ.I.B4.2. To what extent did lack of cooperation impact the ability to conduct the interview or influence the accuracy of answers?

A little	Moderately	A great deal

IF IEQ.I.B4 = COGNITIVE IMPAIRMENT ASK IEQ.I.B4.3

IEQ.I.B4.3. To what extent did cognitive impairment impact the ability to conduct the interview or influence the accuracy of answers?

A little	Moderately	A great deal

IF IEQ.I.B4 = OTHER FACTORS ASK IEQ.I.B4.4

IEQ.I.B4.4. To what extent did another factor impact the ability to conduct the interview or influence the accuracy of answers?

A little	Moderately	A great deal

IEQ.I.B5. From your perspective as the interviewer, what is the level of impairment the patient is experiencing in personal, family, social, educational, occupational or other important areas of functioning?

No impairment	Mild impairment	Moderate impairment	Severe impairment	Complete impairment

IEQ.I.B6.1 Were there some questions that the interviewee / participant struggled to understand or found confusing?

YES	NO

IEQ.I.B6.2 Please specify the questions / phrases / words that they found difficult to understand. Please be as specific as possible and elaborate on the misunderstanding.

IEQ.I.B7. Were there questions that you were required to rephrase or explain?

I did not need to rephrase or explain any questions	I needed to rephrase or explain the following questions:

IEQ.I.B8. My sense was that the participant responded openly and honestly to all the questions I asked them.

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.B9. "The interviewee / participant found the interview difficult to complete or seemed uncomfortable about some of the contents."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.B10. "I often had to make a decision about making the best rating because the participant did not know or did not understand the question."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

INTRO

The following questions contain "I" statements regarding your experience using the FLII-11 as an interviewer - please rate your level of agreement or disagreement with these statements.

IEQ.I.C1.1. "I found the language (vocabulary and sentence construction) easy to understand."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.C1.2 Please specify the questions / phrases / words that you found difficult to understand. Please be as specific as possible and elaborate on what you found difficult to understand.

IEQ.I.C2 "The clarity of questions was good – i.e. I knew what information was needed in order to accurately rate the question."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.C3 "The flow of questions made sense, they followed logically from one question to another."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.C4 "I found it difficult to get all the relevant information needed to make the rating."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.C5 "I feel comfortable interviewing people with the FLII-11 EPI."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

THE FOLLOWING QUESTIONS ARE FOR HEALTH CARE PROFESSIONALS ONLY. THAT IS:
IF IEQ.I.A3. = YES

IEQ.I.D1 "The questions were familiar to me; they were similar to what I would use routinely."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D2 "The clarity of questions was good; I recognized what feature (symptom) was being enquired about."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D3 "The questions seemed to accurately elicit symptoms" (i.e. the "goodness of fit" of the questions in relation to symptoms was sufficient)

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D4 "The FLII-11 is efficient (in terms of time or number of questions) in obtaining clinical information."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D5 "I found it difficult to combine the use of the FLII-11 with my usual interview style."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D6 "The screening questions managed to find a balance between being sensitive and specific enough."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D7 "The questions were comprehensive enough to facilitate diagnosis."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D8 "The content and sequence of questions that were displayed suggested that the algorithm was selecting the relevant questions in order to reach the appropriate diagnosis/es."

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree

IEQ.I.D9 Please note any and all questions / phrases / words that were unclear and could be improved by using alternatives (please supply alternative suggestions):

IEQ.I.D10 Please provide any additional comments (E.g., about the clinical utility of the FLII-11 or ways in which the FLII-11 could be adapted to improve clinical utility in your particular setting)

SUB -SECTION A

Project 1: Feasibility Testing of the Flexible Interview for ICD-11 (FLII-11) Adult Epi version (And Results of Feasibility Testing)

Table of Contents

Table of Contents

List of Tables

Methods

The detailed methodology is presented in the **Report of Project 1**. A brief summary of the key methodological steps is provided below to highlight the overall approach undertaken during the feasibility testing of the FLII-11 Adult Epi Version.

(1) Development of the Technical Proposal and Methodology

A detailed technical proposal was developed, outlining the study framework, including a comprehensive review of relevant literature, culturally appropriate translation strategies, validation procedures, sample size determination, and analytical approaches. The methodology was carefully aligned with the World Health Organisation's global guidance while being adapted to the Sri Lankan context to ensure feasibility, cultural relevance, and adherence to national ethical standards.

(2) Translation of Instruments

The FLII-11 Adult Epi Version and the Interviewer Experience Questionnaire (IEQ) were translated into Sinhala and Tamil using the standardised forward–backwards translation method. The process included several iterative rounds of expert review by consultant psychiatrists, language specialists, and public health professionals to ensure both linguistic accuracy and cultural appropriateness. FLII-11 English version is annexed (Annexure 7). The finalised Sinhala and Tamil versions of the FLII-11 are provided separately as a downloadable link.
(https://drive.google.com/drive/folders/1JScsUe72cKnK88agwGXRBmwLsjshWOOB?usp=sharing).
Additionally, the English version of the IEQ participant and interviewer components is annexed(Annexure 8).

(3) Development of Interviewer Guides

Comprehensive interviewer manuals and data collection algorithms were developed in English to standardise the data collection process and ensure methodological consistency. The data entry algorithms were based on guidance provided by the Columbia-WHO Centre for Global Mental Health, Department of Psychiatry, and were built into the Qualtrics platform. These guides provided detailed instructions on administering the FLII-11 Adult Epi Version and the Interviewer Experience Questionnaire (IEQ), with a particular emphasis on ethical considerations, effective communication with participants, and adherence to confidentiality requirements.

(4) Training of Data Collectors

A structured training program was conducted for FLII-11 and IEQ, covering the study's background, administration of the FLII-11, ethical aspects, use of Qualtrics for digital data collection, and field protocols. The training included role-playing exercises with expert feedback. Training was conducted over two to three weeks. Training plans for the Sinhala Language (Annexure 5) and for the Tamil Language (Annexure 6) were developed separately.

(5) Data collection

Data collection was carried out in both Sinhala and Tamil languages separately. The Sinhala version of the IEQ, followed by the FLII-11 Adult Epi interview, was administered at the National Hospital of Sri Lanka, Colombo, and the Teaching Hospital, Peradeniya, involving 140 patients known to have a mental disorder, and 123 individuals did not report having a mental health disorder. The Tamil version of the IEQ, followed by the FLII-11 Adult Epi interview, was administered at the Teaching Hospital, Jaffna, with participation from 102 patients known to have a mental disorder, and 98 individuals did not report having a mental health disorder. All interviews were conducted using electronic tablets, with the questionnaires embedded in the Qualtrics platform.

(6) Ethical and Administrative Approvals

Once the technical proposal was developed, ethical clearance was obtained from the Ethics Review Committee recognised by the Ministry of Health (Annexure 1 and 2). Administration approval was obtained from the Director General of Health Services, Ministry of Health(Annexure 4).

Results

The IEQ consisted of two complementary parts: (1) an Interviewer Component, which captured the perspectives of trained data collectors on the ease of administration, clarity of instructions, and feasibility; and (2) a Participant Component, which explored respondents' understanding, comfort, and acceptability of the interview process. In the Sinhala language component, the FLII-11 was completed by 140 patients known to have a mental disorder, and 123 individuals did not report having a mental health disorder. Therefore, the same number of IEQ questionnaires were completed by the interviewers as well as the participants of the study. The Tamil language component, FLII-11 was completed by 102 patients known to have a mental disorder, and 98 individuals did not report having a mental health disorder. Therefore, the respective number of IEQ was completed by both interviewers and the participants. The detailed findings from the IEQ are presented in two sections under each language (i.e., Sinhala language and Tamil language): (1) the results of the Interviewer Component and (2) the results of the Participant Component.

Sinhala Language

Section 1: Interviewer component - IEQ

In the Sinhala language, a total of 263 IEQ questionnaires were completed by interviewers, once completed, the FLII-11 questionnaire with 140 patients and 123 healthy individuals (i.e., did not report having a mental health disorder). All FLII -11 questionnaires were administred by trained mental health professionals (i.e. pre-intern medical officers).

Language Proficiency of Participants

According to the interviewers on language proficiency in Sinhala, the majority of participants reported being completely fluent in the language. Specifically, 123 patients (87.9%) and 110 healthy individuals (89.4%) were completely fluent in the language used during the interviews. An additional 10 patients (7.1%) and 12 individuals (9.8%) were reported having an advanced level of proficiency, while seven patients (5.0%) and one control (0.8%) had an intermediate level of proficiency. In total, 233 out of 263 participants (88.6%) were fully fluent in Sinhala, while the remainder possessed at least an intermediate level of proficiency (Table 1).

Table 1: The estimate of the proficiency of the participant in the language in which the interview was conducted

Proficiency of the participant in the language	Patients	Healthy individuals	Total
Completely fluent	123 (87.9)	110 (89.4)	233 (88.6)
Advanced	10 (7.1)	12 (9.8)	22 (8.4)
Intermediate	7 (5.0)	1 (0.8)	8 (3.0)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Factors Affecting the Interview Process

Interviewers were asked whether any participant-related factors affected their ability to conduct the interview or influenced the accuracy of responses. Only four participants (2 out

of 140 patients; 2 out of 123 Healthy individuals) were identified as having a lack of insight, representing 2.9% of patients and 1.6% of Healthy individuals. This indicates that the vast majority — over 97% of patients and 98% of Healthy individuals — did not present difficulties related to insight during the administration of the FLII-11. Among the 4 participants for whom interviewers reported the presence of a lack of insight affecting the interview process, the extent of impact was described as "a little" in 2 cases and "moderately" in 2 cases.

Interviewers were also asked whether lack of cooperation on the part of participants affected the conduct of the interview or the accuracy of responses. Three patients (2.1%) and one healthy individual (0.8%)**,** totalling 4 participants (1.5%) reported to have lack of cooperation**.** These figures demonstrate that nearly all participants (over 97% of patients and more than 99% of healthy individuals) were cooperative during the interview process. For the 4 participants where interviewers identified *lack of cooperation* as a challenge, the extent of impact was reported as "a little" in 3 cases (2 patients and 1 healthy individual) and "moderately" in 1 patient. No instances were rated as having a "great deal" of impact. Overall, this suggests that when a lack of cooperation was encountered, its effect on interview quality was generally limited.

From the interviewer feedback, cognitive impairment was reported as a factor affecting the conduct of the interview or the accuracy of responses in 7 participants, all of whom were patients (7 out of 140; 5.0%)**.** No healthy individuals reported such difficulties. Among the 7 patients where interviewers identified cognitive impairment as a factor, the extent of impact was reported as "a little" in 2 cases**,** "moderately" in 3 cases**,** and "a great deal" in 2 cases. This distribution indicates that while cognitive impairment was less common overall, when present, it could range from having a minor influence to substantially affecting the conduct and accuracy of the interview.

Interviewers indicated that other factors influenced the conduct of the interview or the accuracy of responses in 25 participants (9.5%)**.** This included 17 patients (12.1% of 140) and eight healthy individuals (6.5% of 123)**.** Among the 17 patients**, six** rated as "a little," 9 rated as "moderately," and two as "a great deal". Among eight healthy controls, 4 (50.0%) rated as "a little," 3 as "moderately," and 1 (12.5%) as "a great deal."

Table 2: Factors Affecting the Interview Process

Factor reported by interviewer	Patients n (%)	Healthy individuals (%)	Total n (%)
Lack of insight	2 (2.9)	2 (0.0)	4 (1.5)
Lack of cooperation	3 (2.1)	1 (0.8)	4 (1.5)
Cognitive impairment	7 (5.0)	0 (0.0)	7 (2.7)
Other factors	17 (12.1)	8 (6.5)	25 (9.5)
None of the above factors were present	111 (79.3)	114 (92.7)	225 (85.6)
Total	140 (100)	123 (100)	263 (100)

Overall, interviewers indicated that no factors interfered with the conduct of the interview or the accuracy of responses in 225 out of 263 participants (85.6%)**.** This included 111 of 140 patients (79.3%) and 114 of 123 healthy individuals (92.7%) (Table 2)**.**

Level of Impairment in Functioning

Interviewers were asked to rate the level of impairment experienced by participants across personal, family, social, educational, occupational, or other important areas of functioning. Among patients (n = 140), the majority were rated as having some degree of impairment: 51 (36.4%) mild, 52 (37.1%) moderate, and 22 (15.7%) severe, while 15 patients (10.7%) were reported to have no impairment. In contrast, among healthy controls (n = 123), most were rated as having no impairment (97; 78.9%), with 21 (17.1%) classified as mild, 3 (2.4%) as moderate, **and** 2 (1.6%) as severe. Considering the total sample (n = 263), 112 participants (42.6%) were rated with no impairment, while 72 (27.4%) had mild, 55 (20.9%) had moderate, and 24 (9.1%) had severe impairment (Table 3).

Table 3: The level of impairment

Level of impairment	Patients	Healthy Control	Total
No impairment	15 (10.7)	97 (78.9)	112 (42.6)
Mild impairment	51 (36.4)	21 (17.1)	72 (27.4)
Moderate impairment	52 (37.1)	3 (2.4)	55 (20.9)
Severe impairment	22 (15.7)	2 (1.6)	24 (9.1)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Participant Struggles with Understanding Questions

Interviewers reported that some participants found certain questions difficult to understand or confusing (Patients – 58, 41.4%; healthy individuals – 32, 26.0%). Considering the **total** sample (n = 263), 90 participants (34.2%) were identified as having some difficulty with understanding (Table 4).

Table 4: Some questions that the interviewee/participant struggled to understand or found confusing

Interviewee / participant struggled to understand or found confusing	Patients	Healthy Control	Total
No	82 (58.6)	91 (74.0)	173 (65.8)
Yes	58 (41.4)	32 (26.0)	90 (34.2)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Need of Rephrasing or Explaining Questions

When asked whether they needed to rephrase or explain any questions, interviewers reported differing experiences across groups. Among the patients, 64 (45.7%) indicated they

did not need to rephrase, while 87 healthy individuals (70.7%) reported no need to rephrase. For the 112 participants (42.6%), the required questions needed to be rephrased or explained.

Table 5: Questions that you were required to rephrase or explain

Required to rephrase or explain	Patients	Healthy Control	Total
I did not need to rephrase or explain any questions	64 (45.7)	87 (70.7)	151 (57.4)
I needed to rephrase or explain the following questions	76 (54.3)	36 (29.3)	112 (42.6)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Perceived Openness and Honesty of Participant Responses

Interviewers were asked to rate the extent to which participants responded openly and honestly to all questions. The majority of patients indicated positive responses, with 69 (49.3%) agreeing and 60 (42.9%) strongly agreeing**.** Smaller proportions reported somewhat agree (8; 5.7%) and somewhat disagree (3; 2.1%)**.** Among healthy individuals (n = 123)**,** a similar trend was observed: 61 (49.6%) agreed**,** 55 (44.7%) strongly agreed, 5 (4.1%) somewhat agreed**,** and 2 (1.6%) somewhat disagreed**.** In brief, almost all participants were viewed as responding openly and honestly, with 130 (49.4%) agreeing and 115 (43.7%) strongly agreeing**,** while only 13 (4.9%) somewhat agreed (Table 6).

Table 6: Participants responded openly and honestly to all the questions

My sense was that the participant responded openly and honestly to all the questions I asked them.	Patients	Healthy Control	Total
Somewhat disagree	3 (2.1)	2 (1.6)	5 (1.9)
Somewhat agree	8 (5.7)	5 (4.1)	13 (4.9)
Agree	69 (49.3)	61 (49.6)	130 (49.4)
Strongly agree	60 (42.9)	55 (44.7)	115 (43.7)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Perceived Difficulty or Discomfort in Completing the Interview

When asked whether participants found the interview difficult to complete or appeared uncomfortable with some of its contents, the majority of both groups disagreed with the interviewers. Among patients, the responses were as follows: strongly disagree - 33 (23.6%); disagree - 88 (62.9%). A similar pattern was seen among healthy individuals - strongly disagreeing (28 (22.8%); disagreeing - 88 (71.5%). (Table 7).

Table 7: Difficult to complete or seemed uncomfortable about some of the contents

Difficult to complete or seemed uncomfortable about some of the contents	Patients	Healthy Control	Total
Strongly disagree	33 (23.6)	28 (22.8)	61 (23.2)
Disagree	88 (62.9)	88 (71.5)	176 (66.9)
Somewhat disagree	6 (4.3)	3 (2.4)	9 (3.4)
Somewhat agree	11 (7.9)	2 (1.6)	13 (4.9)
Agree	2 (1.4)	2 (1.6)	4 (1.5)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Need for Interviewer to Make Ratings Due to Participant Uncertainty or Lack of Understanding

Interviewers reported on how often they had to make their own judgment about the "best rating" when participants did not know or understand a question. Among the patients, it was reported that this was not a frequent issue, with 80 (57.1%) disagreeing and 23 (16.4%) strongly disagreeing that such situations occurred. Among healthy individuals, the pattern was similar, with 72 (58.5%) disagreeing and 34 (27.6%) strongly disagreeing (Table 8).

Table 8: Decide on making the best rating because the participant did not know or did not understand the question

Make a decision about making the best rating because the participant did not know or did not understand the question	Patients	Healthy Control	Total
Strongly disagree	23 (16.4)	34 (27.6)	57 (21.7)
Disagree	80 (57.1)	72 (58.5)	152 (57.8)
Somewhat disagree	14 (10.0)	3 (2.4)	17 (6.5)
Somewhat agree	14 (10.0)	8 (6.5)	22 (8.4)
Agree	6 (4.3)	6 (4.9)	12 (4.6)
Strongly agree	3 (2.1)	0 (0.0)	4 (1.5)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Clarity of Language – Vocabulary and Sentence Construction Interviewers rated the ease of understanding the language used in the FLII-11 questionnaire. The majority of patients responded positively, with 100 (71.4%) agreeing and 31 (22.1%) strongly agreein**g** that the language was easy to understand while smaller proportions reported somewhat agree (6; 4.3%), while 3 (2.1%) disagreed and none strongly disagreed.

Similarly, healthy individuals responded positively, with 87 (70.7%) agreeing and 33 (26.8%) strongly agreeing (Table 9).

Table 9: Language (vocabulary and sentence construction) is easy to understand

Language (vocabulary and sentence construction) easy to understand	Patients	Healthy Control	Total
Strongly disagree	0 (0.0)	1 (0.8)	1 (0.4)
Disagree	3 (2.1)	0 (0.0)	3 (1.1)
Somewhat agree	6 (4.3)	2 (1.6)	8 (3.0)
Agree	100 (71.4)	87 (70.7)	187 (71.1)
Strongly agree	31 (22.1)	33 (26.8)	64 (24.3)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Clarity of Questions

Interviewers were asked to rate the overall clarity of the questions in the FLII-11. Among the patients, most gave positive ratings, with 102 (72.9%) agreeing and 31 (22.1%) strongly agreeing that the questions were clear. A smaller number reported somewhat agree (7; 5.0%), while none disagreed. Among healthy individuals, the majority also provided positive feedback, with 92 (74.8%) agreeing and 29 (23.6%) strongly agreeing (Table 10).

Table 10: The clarity of questions was good; I knew what information was needed to rate the question accurately

The clarity of questions was good	Patients	Healthy Control	Total
Disagree	0 (0.0)	1 (0.8)	1 (0.4)
Somewhat agree	7 (5.0)	1 (0.8)	8 (3.0)
Agree	102 (72.9)	92 (74.8)	194 (73.8)
Strongly agree	31 (22.1)	29 (23.6)	60 (22.8)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Logical Flow of Questions

When asked whether the questions followed a logical order, interviewers reported that patients and healthy individuals reported high levels of agreement. Among patients, 95 (67.9%) agreed and 36 (25.7%) strongly agreed that the flow of questions made sense.

Among healthy individuals, responses were similarly positive as 87 (70.7%) agreed and 34 (27.6%) strongly agreed (Table 11).

Table 11: The flow of questions made sense; they followed logically from one question to another

The flow of questions made sense, they followed logically from one question to another	Patients	Healthy Control	Total
Somewhat disagree	4 (2.9)	0 (0.0)	4 (1.5)
Somewhat agree	5 (3.6)	2 (1.6)	7 (2.7)
Agree	95 (67.9)	87 (70.7)	182 (69.2)
Strongly agree	36 (25.7)	34 (27.6)	70 (26.6)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Difficulty in Obtaining Relevant Information for Ratings

When asked whether they found it difficult to obtain all the relevant information needed to make some ratings, most participants disagreed with the interviewers. Among patients, 85 (60.7%) disagreed, and 25 (17.9%) strongly disagreed. For healthy individuals, the majority disagreed (84; 68.3%) or strongly disagreed (26; 21.1%) (Table 12).

Table 12: I found it difficult to get all the relevant information needed to make some of the ratings

I found it difficult to get all the relevant information needed to make some of the ratings	Patients	Healthy Control	Total
Strongly disagree	25 (17.9)	26 (21.1)	51 (19.4)
Disagree	85 (60.7)	84 (68.3)	169 (64.3)
Somewhat disagree	13 (9.3)	2 (1.6)	15 (5.7)
Somewhat agree	14 (10.0)	7 (5.7)	21 (8.0)
Agree	2 (1.4)	4 (3.3)	6 (2.3)
Strongly agree	1 (0.7)	0 (0.0)	1 (0.4)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Interviewer Comfort in Administering the FLII-11

Most interviewers reported feeling comfortable when administering the instrument. Among patients, n = 91, 65.0% agreed, and n = 24, 17.1% strongly agreed. For healthy individuals, n = 79, 64.2% agreed, and n = 10, 8.1% strongly agreed, with n = 29, 23.6% somewhat agreeing (Table 13).

Table 13: Statement – "I feel comfortable interviewing people using the FLII-11"

I feel comfortable interviewing people using the FLII-11	Patients	Healthy Control	Total
Disagree	2 (1.4)	2 (1.6)	4 (1.5)
Somewhat disagree	7 (5.0)	3 (2.4)	10 (3.8)
Somewhat agree	16 (11.4)	29 (23.6)	45 (17.1)
Agree	91 (65.0)	79 (64.2)	170 (64.6)
Strongly agree	24 (17.1)	10 (8.1)	34 (12.9)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Familiarity of Interview Questions

When asked whether the questions felt familiar and similar to those typically asked during patient interviews, most respondents expressed agreement. Among patients, 97 (69.3%) agreed, 23 (16.4%) strongly agreed, and 20 (14.3%) somewhat agreed. None of the patients disagreed with the statement. For healthy individuals, a similar pattern was observed: 96 (78.0%) agreed, 6 (4.9%) strongly agreed, and 21 (17.1%) somewhat agreed.

In the overall sample, the vast majority found the questions familiar and aligned with routine clinical interviewing, with 193 (73.4%) agreeing, 29 (11.0%) strongly agreeing, and 41 (15.6%) somewhat agreeing.

Table 14: Statement – "The questions were familiar to me and similar to what I would ask routinely in interviewing a patient"

The questions were familiar to me and similar to what I would ask routinely in interviewing a patient.	Patients	Healthy Control	Total
Somewhat agree	20 (14.3)	21 (17.1)	41 (15.6)
Agree	97 (69.3)	96 (78.0)	193 (73.4)
Strongly agree	23 (16.4)	6 (4.9)	29 (11.0)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Clarity of Questions and Recognition of Symptoms

Most interviewers reported that the questions were clear and effectively conveyed the intended symptoms. Among patients (n = 140), 97 (69.3%) agreed and 37 (26.4%) strongly agreed that the questions were clear and understandable, while 6 (4.3%) somewhat agreed. No participants expressed disagreement.

In the healthy individuals (n = 123), a comparable pattern was observed: 91 (74.0%) agreed, 30 (24.4%) strongly agreed, and 2 (1.6%) somewhat agreed.

Across the total sample (n = 263), a large majority (188; 71.5% agreed, 67; 25.5% strongly agreed, that the questions were clear and recognisable, with only 8 participants (3.0%) somewhat agreeing, indicating overall strong clarity and comprehensibility of the interview items (Table 15).

Table 15: The clarity of questions was good; I recognised what feature (symptom) was being inquired about

The clarity of questions was good; I recognized what feature (symptom) was being enquired about	**Patients**	**Healthy Control**	**Total**
Somewhat agree	6 (4.3)	2 (1.6)	8 (3.0)
Agree	97 (69.3)	91 (74.0)	188 (71.5)
Strongly agree	37 (26.4)	30 (24.4)	67 (25.5)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Perceived Accuracy of Questions in Eliciting Symptoms

When asked whether the questions accurately elicited the intended symptoms ("goodness of fit"), responses were overwhelmingly positive. For the total sample (n = 263), 202 responses (76.8%) agreed and 34 (12.9%) strongly agreed that the questions were suitable for eliciting the targeted symptoms. Only 25 responses (9.5%) somewhat agreed (Table 16).

Table 16: The questions seemed to elicit symptoms accurately" (i.e. the "goodness of fit" of the questions in relation to symptoms was sufficient)

The questions seemed to accurately elicit symptoms (i.e. the "goodness of fit" of the questions in relation to symptoms was sufficient)	Patients	Healthy Control	Total
Strongly disagree	2 (1.4)	0 (0.0)	2 (0.8)
Somewhat agree	17 (12.1)	8 (6.5)	25 (9.5)
Agree	105 (75.0)	97 (78.9)	202 (76.8)
Strongly agree	16 (11.4)	18 (14.6)	34 (12.9)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Efficiency of the FLII-11 in Obtaining Clinical Information

Interviewers were asked to assess whether the FLII-11 was efficient in terms of the time taken and the number of questions required to obtain clinical information. When the questionnaire was administered to the patient group, the majority rated the tool positively: 104 (74.3%) agreed and 18 (12.9%) strongly agreed, while 15 (10.7%) somewhat agreed and 3 (2.1%) somewhat disagreed.

While the questionnaire was administered to the healthy individuals, 86 (69.9%) agreed and 14 (11.4%) strongly agreed, with 19 (15.4%) somewhat agreeing. A small minority 3 (2.4%) somewhat disagreed, and 1 (0.8%) disagreed (Table 17).

Table 17: The FLII-11 is efficient (in terms of time or number of questions) in obtaining clinical information

The FLII-11 is efficient (in terms of time or number of questions) in obtaining clinical information.	Patients	Healthy Control	Total
Disagree	0 (0.0)	1 (0.8)	1 (0.4)
Somewhat disagree	3 (2.1)	3 (2.4)	6 (2.3)
Somewhat agree	15 (10.7)	19 (15.4)	34 (12.9)
Agree	104 (74.3)	86 (69.9)	190 (72.2)
Strongly agree	18 (12.9)	14 (11.4)	32 (12.2)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Difficulty in Combining FLII-11 with Usual Interview Style

Interviewers were asked whether they found it difficult to integrate the FLII-11 with their

usual interviewing style. In the patient group, most responses disagreed with the statement, with 68 (48.6%) disagreeing and 20 (14.3%) strongly disagreeing. Smaller proportions

While administering the questionnaire to healthy individuals, the majority of responses expressed no difficulty, with 66 (53.7%) disagreeing and 8 (6.5%) strongly disagreeing. However, 31 (25.2%) somewhat agreed, 5 (4.1%) agreed, and 1 (0.8%) strongly agreed, while 12 (9.8%) somewhat disagreed (Table 18).

Table 18: I found it difficult to combine the use of the FLII-11 with my usual interview style

I found it difficult to combine the use of the FLII-11 with my usual interview style.	Patients	Healthy Control	Total
Strongly disagree	20 (14.3)	8 (6.5)	28 (10.6)
Disagree	68 (48.6)	66 (53.7)	134 (51.0)
Somewhat disagree	12 (8.6)	12 (9.8)	24 (9.1)
Somewhat agree	27 (19.3)	31 (25.2)	58 (22.1)
Agree	10 (7.1)	5 (4.1)	15 (5.7)
Strongly agree	3 (2.1)	1 (0.8)	4 (1.5)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Adequacy of Screening Questions – Sensitivity and Specificity

Interviewers were asked whether the screening questions in the FLII-11 achieved an appropriate balance between sensitivity and specificity. In the patient group, responses were positive, with 100 (71.4%) agreeing and 25 (17.9%) strongly agreeing. Smaller proportions reported "somewhat agree" (13, 9.3%) and "somewhat disagree" (2, 1.4%), while none strongly disagreed.

While administering the questionnaire to healthy individuals (n = 123), 103 (83.7%) agreed, 15 (12.2%) strongly agreed, and 4 (3.3%) somewhat agreed (Table 19).

Table 19: The screening questions managed to find a balance between being sensitive and specific enough

The screening questions managed to find a balance between being sensitive and specific enough	Patients	Healthy Control	Total
Strongly disagree	0 (0.0)	1 (0.8)	1 (0.4)
Somewhat disagree	2 (1.4)	0 (0.0)	2 (0.8)
Somewhat agree	13 (9.3)	4 (3.3)	17 (6.5)
Agree	100 (71.4)	103 (83.7)	203 (77.2)
Strongly agree	25 (17.9)	15 (12.2)	40 (15.2)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Comprehensiveness of Questions for Diagnosis

Interviewers were asked whether the FLII-11 questions were sufficiently comprehensive to

facilitate diagnostic assessment. Interviewers stated that they could provide positive feedback for the majority of patients (i.e., n = 111, 79.3% agreed and n = 17, 12.1% strongly agreed) regarding the comprehensiveness of the questions.

Similarly, interviewers stated that they agreed to the statement in 80.5% (n =99) and strongly agreed with 14.6% (n = 18) (Table 20).

Table 20: The questions were comprehensive enough to facilitate diagnosis

"The questions were comprehensive enough to facilitate diagnosis."	Patients	Healthy Control	Total
Somewhat disagree	5 (3.6)	0 (0.0)	5 (1.9)
Somewhat agree	7 (5.0)	6 (4.9)	13 (4.9)
Agree	111 (79.3)	99 (80.5)	210 (79.8)
Strongly agree	17 (12.1)	18 (14.6)	35 (13.3)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Algorithmic Selection of Relevant Questions

Interviewers were asked whether the algorithm appropriately selected the relevant questions to reach accurate diagnoses. In responses to the patients, the majority responded positively, with 106 (75.7%) agreeing and 31 (22.1%) strongly agreeing, while only 2 (1.4%) somewhat agreed and 1 (0.7%) somewhat disagreed. In responses to the healthy individuals, 80 (65.0%) agreed and 42 (34.1%) strongly agreed, with just 1 participant (0.8%) somewhat agreeing (Table 21).

Table 21: The algorithm was selecting the relevant questions to reach the appropriate diagnosis/es.

The algorithm was selecting the relevant questions in order to reach the appropriate diagnosis/es.	Patients	Healthy Control	Total
Somewhat disagree	1 (0.7)	0 (0.0)	1 (0.4)
Somewhat agree	2 (1.4)	1 (0.8)	3 (1.1)
Agree	106 (75.7)	80 (65.0)	186 (70.7)
Strongly agree	31 (22.1)	42 (34.1)	73 (27.8)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Section 2: Participants component – IEQ (Sinhala Language)

Understanding and Comprehension

Participants were asked to indicate the extent to which they understood what the interviewer was asking. In the patient group, the majority expressed strong comprehension,

with 89 (63.6%) strongly agreeing and 48 (34.3%) agreeing, while only 3 participants (2.1%) somewhat agreed. Among healthy individuals, responses were similarly positive: 74 (60.2%) strongly agreed and 43 (35.0%) agreed, with 6 participants (4.9%) somewhat agreeing (Table 22).

Table 22: Agreement with the statement - "Overall, I was able to understand what the interviewer was asking."

Agreement of the statement	Patients	Healthy Control	Total
Somewhat agree	3 (2.1)	6 (4.9)	9 (3.4)
Agree	48 (34.3)	43 (35.0)	91 (34.6)
Strongly agree	89 (63.6)	74 (60.2)	163 (62.0)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Participants were asked whether they found any of the words, phrases, or questions offensive or otherwise objectionable. In the **patient group**, most disagreed with the statement, including 75 (53.6%) strongly disagreeing and 55 (39.3%) disagreeing. Among healthy individuals, responses followed a similar pattern: 67 (54.5%) strongly disagreed and 45 (36.6%) disagreed (Table 23).

Table 23: There were some of the words, phrases, or questions that I thought were offensive or otherwise objectionable

Areement to the statment	**Patients**	**Healthy Control**	**Total**
Strongly disagree	75 (53.6)	67 (54.5)	142 (54.0)
Disagree	55 (39.3)	45 (36.6)	100 (38.0)
Somewhat disagree	1 (0.7)	0 (0.0)	1 (0.4)
Somewhat agree	3 (2.1)	4 (3.3)	7 (2.7)
Agree	5 (3.6)	5 (4.1)	10 (3.8)
Strongly agree	1 (0.7)	2 (1.6)	3 (1.1)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Upsetting Aspects of the Interview

Participants were asked whether they found any parts of the interview upsetting. Among the patients, the majority disagreed, with 72 (51.4%) strongly disagreeing and 61 (43.6%) disagreeing. Among healthy individuals, a similar trend was observed, with 68 (55.3%) strongly disagreeing and 45 (36.6%) disagreeing (Table 24).

Table 24: Parts of the interview were upsetting

"I found parts of the interview upsetting."	Patients	Healthy Control	Total
Strongly disagree	72 (51.4)	68 (55.3)	140 (53.2)
Disagree	61 (43.6)	45 (36.6)	106 (40.3)
Somewhat agree	3 (2.1)	7 (5.7)	10 (3.8)
Agree	2 (1.4)	2 (1.6)	4 (1.5)
Strongly agree	2 (1.4)	1 (0.8)	3 (1.1)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Feeling Respected and Valued During the Interview

Participants were asked whether they felt respected and valued during the interview. Nearly all patients were positive, with 72 (51.4%) strongly agreeing and 64 (45.7%) agreeing. Only 1 participant (0.7%) strongly disagreed, and 3 (2.1%) somewhat agreed. The responses were similarly positive among healthy individuals: 66 (53.7%) strongly agreed and 49 (39.8%) agreed, while smaller numbers indicated 4 (3.3%) disagreed, 4 (3.3%) somewhat agreed, and none strongly disagreed (Table 25).

Table 25: Statement - "I felt respected and valued during the interview"

Statement – feeling respected and valued	Patients	Healthy Control	Total
Strongly disagree	1 (0.7)	0 (0.0)	1 (0.4)
Disagree	0 (0.0)	4 (3.3)	4 (1.5)
Somewhat agree	3 (2.1)	4 (3.3)	7 (2.7)
Agree	64 (45.7)	49 (39.8)	113 (43.0)
Strongly agree	72 (51.4)	66 (53.7)	138 (52.5)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Feeling Heard and Understood During the Interview

Participants were asked whether they felt heard and understood during the interview. In the patient group (n = 140), almost all responses were positive, with 74 (52.9%) strongly agreeing and 63 (45.0%) agreeing. Very few expressed less positive views (1; 0.7% somewhat disagree, 2; 1.4% somewhat agree), and none disagreed outright.

Among healthy individuals, the majority also responded positively: 79 (64.2%) strongly agreed and 42 (34.1%) agreed. Only 2 participants (1.6%) disagreed, and none selected somewhat agree or somewhat disagree.

For the total study population, 258 participants (98.1%) agreed or strongly agreed that they felt heard and understood (105; 39.9% agreed and 153; 58.2% strongly agreed). Only 5 participants (1.9%) expressed some level of disagreement or partial agreement (Table 26).

Table 26: Statement - "I felt heard and understood during the interview."

I felt heard and understood during the interview.	Patients	Healthy Control	Total
Disagree	0 (0.0)	2 (1.6)	2 (0.8)
Somewhat disagree	1 (0.7)	0 (0.0)	1 (0.4)
Somewhat agree	2 (1.4)	0 (0.0)	2 (0.8)
Agree	63 (45.0)	42 (34.1)	105 (39.9)
Strongly agree	74 (52.9)	79 (64.2)	153 (58.2)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Appropriateness of Interview Duration

Participants were asked whether the interview took an appropriate amount of time. Over 52% patients (n= 73) agreed, and 48 (34.3%) strongly agreed. A smaller proportion indicated less positive responses: 11 (7.9%) somewhat agree, 1 (0.7%) somewhat disagree, 3 (2.1%) disagree, and 4 (2.9%) strongly disagree. Among healthy individuals (n = 123), the majority also considered the duration appropriate, with 71 (57.7%) agreeing and 40 (32.5%) strongly agreeing. Only a minority reported otherwise: 4 (3.3%) somewhat agree, 1 (0.8%) somewhat disagree, 4 (3.3%) disagree, and 3 (2.4%) strongly disagree. For the total sample (n = 263), 232 participants (88.2%) agreed or strongly agreed that the interview duration was appropriate (Table 27).

Table 27: Statement - "The interview took an appropriate amount of time."

"The interview took an appropriate amount of time."	Patients	Healthy Control	Total
Strongly disagree	4 (2.9)	3 (2.4)	7 (2.7)
Disagree	3 (2.1)	4 (3.3)	7 (2.7)
Somewhat disagree	1 (0.7)	1 (0.8)	2 (0.8)
Somewhat agree	11 (7.9)	4 (3.3)	15 (5.7)
Agree	73 (52.1)	71 (57.7)	144 (54.8)
Strongly agree	48 (34.3)	40 (32.5)	88 (33.5)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Coverage of Participant Concerns and Complaints

Participants were asked whether the interview questions covered their main concerns and complaints about their mental health experience. Among the patients, most gave positive responses, with 67 (47.9%) agreeing and 52 (37.1%) strongly agreeing. A smaller proportion selected 11 (7.9%) somewhat agree, 2 (1.4%) somewhat disagree, 7 (5.0%) disagree, and 1 (0.7%) strongly disagree. Among healthy individuals, responses followed a similar trend: 62 (50.4%) agreed and 50 (40.7%) strongly agreed, while fewer participants responded 4 (3.3%) somewhat agree, 3 (2.4%) somewhat disagree, 2 (1.6%) disagree, and 2 (1.6%) strongly

disagree. For the total sample (n = 263), 231 participants (87.8%) agreed or strongly agreed that the interview covered their main concerns (129; 49.0% agreed and 102; 38.8% strongly agreed). Only 32 participants (12.2%) reported neutral or negative responses (Table 28).

Table 28: Statement - The questions in the interview covered all my main concerns and complaints about my mental health experience.

Covered all my main concerns and complaints	Patients	Healthy Control	Total
Strongly disagree	1 (0.7)	2 (1.6)	3 (1.1)
Disagree	7 (5.0)	2 (1.6)	9 (3.4)
Somewhat disagree	2 (1.4)	3 (2.4)	5 (1.9)
Somewhat agree	11 (7.9)	4 (3.3)	15 (5.7)
Agree	67 (47.9)	62 (50.4)	129 (49.0)
Strongly agree	52 (37.1)	50 (40.7)	102 (38.8)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Participants were asked whether they felt that some important aspects of their mental health experience were not addressed during the interview. Most patients disagreed, with 58 (41.4%) disagreeing and 38 (27.1%) strongly disagreeing. Smaller proportions reported 2 (1.4%) somewhat disagree, 15 (10.7%) somewhat agree, 20 (14.3%) agree, and 7 (5.0%) strongly agree. Among healthy individuals (n = 123), the pattern was similar: 55 (44.7%) disagreed and 45 (36.6%) strongly disagreed, while fewer indicated 1 (0.8%) somewhat disagree, 6 (4.9%) somewhat agree, 9 (7.3%) agree, and 7 (5.7%) strongly agree. For the total sample, 196 participants (74.6%) disagreed or strongly disagreed that aspects of their mental health experience were not asked about (113; 43.0% disagreed and 83; 31.6% strongly disagreed). Conversely, 67 participants (25.5%) expressed some level of agreement, with 21 (8.0%) somewhat agreeing, 29 (11.0%) agreeing, and 14 (5.3%) strongly agreeing (Table 29).

Table 29: Statement - Some important aspects of my mental health experience were not asked about.

Some aspects of my mental health experience were not asked	Patients	Healthy Control	Total
Strongly disagree	38 (27.1)	45 (36.6)	83 (31.6)
Disagree	58 (41.4)	55 (44.7)	113 (43.0)
Somewhat disagree	2 (1.4)	1 (0.8)	3 (1.1)
Somewhat agree	15 (10.7)	6 (4.9)	21 (8.0)

Agree	20 (14.3)	9 (7.3)	29 (11.0)
Strongly agree	7 (5.0)	7 (5.7)	14 (5.3)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Questions as an Accurate Reflection of Mental Health Experience

Participants were asked whether the questions they were asked accurately reflected their mental health experience. Among the patients, the majority responded positively: 80 (57.1%) agreed, 44 (31.4%) strongly agreed, and 16 (11.4%) somewhat agreed. No patients reported disagreement. Among healthy individuals, most also responded positively: 65 (52.8%) agreed and 45 (36.6%) strongly agreed, with 6 (4.9%) somewhat agreeing. A small minority reported disagreement (3; 2.4% disagree, 3; 2.4% somewhat disagree, and 1; 0.8% strongly disagree) (Table 30).

Table 30: Statement - The questions I was asked were an accurate reflection of my mental health experience.

An accurate reflection of my mental health experience	Patients	Healthy Control	Total
Strongly disagree	0 (0.0)	1 (0.8)	1 (0.4)
Disagree	0 (0.0)	3 (2.4)	3 (1.1)
Somewhat disagree	0 (0.0)	3 (2.4)	3 (1.1)
Somewhat agree	16 (11.4)	6 (4.9)	22 (8.4)
Agree	80 (57.1)	65 (52.8)	145 (55.1)
Strongly agree	44 (31.4)	45 (36.6)	89 (33.8)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Perception of the Interview as Tiring

Participants were asked whether they found the interview tiring. In the patient group, the majority reported no such difficulty, with 68 (48.6%) strongly disagreeing and 58 (41.4%) disagreeing. Smaller numbers expressed 1 (0.7%). Among healthy individuals (n = 123), a similar trend was observed: 67 (54.5%) strongly disagreed and 47 (38.2%) disagreed (Table 31).

Table 31: Statement – "I found the interview tiring."

"I found the interview tiring."	Patients	Healthy Control	Total
Strongly disagree	68 (48.6)	67 (54.5)	135 (51.3)
Disagree	58 (41.4)	47 (38.2)	105 (39.9)
Somewhat disagree	1 (0.7)	1 (0.8)	2 (0.8)
Somewhat agree	8 (5.7)	4 (3.3)	12 (4.6)
Agree	2 (1.4)	1 (0.8)	3 (1.1)

Strongly agree	3 (2.1)	3 (2.4)	6 (2.3)
Total	**140 (100.0)**	**123 (100.0)**	**263 (100.0)**

Perception of the Interview as a Positive Experience

Participants were asked whether they felt the interview process was generally a positive experience. Among the patients, the majority responded favorably, with 70 (50.0%) agreeing and 60 (42.9%) strongly agreeing. Only a small minority expressed neutral or negative responses: 5 (3.6%) somewhat agree, 2 (1.4%) somewhat disagree, and 3 (2.1%) disagree. Among healthy individuals, most also viewed the process positively: 55 (44.7%) agreed and 60 (48.8%) strongly agreed. Few reported otherwise: 6 (4.9%) somewhat agree, 1 (0.8%) somewhat disagree, and 1 (0.8%) disagree. (Table 32).

Table 32: Statement - "The interview process was generally a positive experience."

The interview process was generally a positive experience	Patients	Healthy Control	Total
Disagree	3 (2.1)	1 (0.8)	4 (1.5)
Somewhat disagree	2 (1.4)	1 (0.8)	3 (1.1)
Somewhat agree	5 (3.6)	6 (4.9)	11 (4.2)
Agree	70 (50.0)	55 (44.7)	125 (47.5)
Strongly agree	60 (42.9)	60 (48.8)	120 (45.6)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Better Understanding of Self and Mental Health

Participants were asked whether the interview helped them gain a better understanding of themselves and their mental health. In the patient group (n = 140), most responded positively, with 77 (55.0%) agreeing and 53 (37.9%) strongly agreeing. Among healthy individuals, the majority also agreed: 60 (48.8%) agreed and 55 (44.7%) strongly agreed. Smaller proportions expressed 6 (4.9%) somewhat agree, 1 (0.8%) somewhat disagree, and 1 (0.8%) disagree (Table 33).

Table 33: Statement "Due to the interview, I have a better understanding of myself and my mental health"

I have a better understanding of myself and my mental health.	Patients	Healthy Control	Total
Strongly disagree	1 (0.7)	0 (0.0)	1 (0.4)
Disagree	3 (2.1)	1 (0.8)	4 (1.5)
Somewhat disagree	1 (0.7)	1 (0.8)	2 (0.8)
Somewhat agree	5 (3.6)	6 (4.9)	11 (4.2)
Agree	77 (55.0)	60 (48.8)	137 (52.1)

Strongly agree	53 (37.9)	55 (44.7)	108 (41.1)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Willingness to Participate in a Future Interview

Participants were asked if they would be willing to take part in a similar interview again in the future. The patients indicated strong willingness, with 71 (50.7%) agreeing and 61 (43.6%) strongly agreeing. Healthy individuals responded as follows: 45 (36.6%) agreed, 70 (56.9%) strongly agreed, 1 (0.8%) strongly disagreed, 1 (0.8%) disagreed, and 6 (4.9%) somewhat agreed (Table 34).

Table 34: Statement - I would be willing to participate in an interview like this again at some point in the future.

I would be willing to participate in an interview like this again at some point in the future.	Patients	Healthy Control	Total
Strongly disagree	2 (1.4)	1 (0.8)	3 (1.1)
Disagree	2 (1.4)	1 (0.8)	3 (1.1)
Somewhat agree	2.9 (71)	6 (4.9)	10 (3.8)
Agree	71 (50.7)	45 (36.6)	116 (44.1)
Strongly agree	61 (43.6)	70 (56.9)	131 (49.8)
Total	140 (100.0)	123 (100.0)	263 (100.0)

Tamil Language

Section 1: Interviewer component – IEQ

In the Tamil language, a total of 200 IEQ questionnaires were completed by interviewers following administration of the FLII-11 to 102 patients with a diagnosed mental disorder and 98 healthy individuals. Interviewer background data indicated that the majority were trained mental health professionals. All FLII-11 questionnaires were administered by trained mental health professionals (i.e. pre-intern medical officers).

Language Proficiency of Participants

Interviewers rated participants' proficiency in Tamil during the interviews. In the patient group (n = 102), 68 (66.7%) were completely fluent, 31 (30.4%) had advanced proficiency, and 3 (2.9%) were at an intermediate level. Among healthy individuals (n = 98), 91 (92.9%) were completely fluent, and 7 (7.1%) had advanced proficiency; no participants were rated as intermediate (Table 35).

Table 35: The estimate of the proficiency of the participant in the language in which the interview was conducted

Proficiency of the the language	Patients n (%)	Healthy individuals n (%)	Total n (%)

Completely fluent	68 (66.7)	91 (92.9)	**159 (79.5)**
Advanced	31 (30.4)	7 (7.1)	**38 (19.0)**
Intermediate	3 (2.9)	0 (0.0)	**3 (1.5)**
Total	**102 (100.0**	**98 (100.0)**	**200 (100.0)**

Factors Affecting the Interview Process

Interviewers were asked to indicate which factors, if any, affected their ability to conduct the interview or influenced the accuracy of responses. Among the patients, reported challenges included lack of cooperation in 19 participants (16.2%), cognitive impairment in 16 participants (13.7%), lack of insight in 14 participants (12.0%). Interviewers identified 3 participants as having "other factors" that influenced the ability to conduct the interview or the accuracy of responses, while 65 patients (55.6%) were reported as having none of the listed difficulties.

Among the 16 participants identified by interviewers as having a *lack of insight*, the majority of cases were rated as having a moderate impact on the conduct of the interview or the accuracy of responses (n = 10). Within the patient group having a *lack of insight*, 10 patients were rated as moderately impacted. Out of 20 participants who were identified as showing some *lack of cooperation* during the interview, 14 patients were rated as having a "moderate impact" on the ability to conduct the interview or the accuracy of answers. For the 16 participants identified with *cognitive impairment*, interviewers reported that this factor affected the conduct of the interview or the accuracy of responses to varying degrees. The majority (n= 11) indicated a "moderate impact", while 3 participants were rated as experiencing a little impact.

Among the healthy individuals (n = 98), 2 participants (2.0%) were noted to have a *lack of insight* and one participant (1.0%) was reported as "*lack of cooperative*". No healthy individuals were reported with cognitive impairment or other factors, while the majority — 95 (96.9%) — were assessed as having no difficulties.

Out of the total sample, interviewers reported challenges in a minority of cases: 16 (7.4%) due to lack of insight, 20 (9.3%) due to lack of cooperation, 16 (7.4%) due to cognitive impairment, and 3 (1.4%) due to other factors. Overall, 160 participants (74.4%) were noted as having none of the listed factors affecting the interview process (Table 36).

Table 36: Factors Affecting the Interview Process

Factor reported by interviewer	Patients n (%)*	Healthy individuals n (%)*	Total n (%)*
Lack of insight	14 (13.7)	2 (2.0)	16 (8.0)
Lack of cooperation	19 (18.6)	1(1.0)	20 (10.0)
Lack of cognitive impairment	16 (13.7)	0 (0.0)	16 (8.0)
Other factors	3(2.9)	0(0.0)	3 (1.5)
None of the above factors were present	65 (15.7)	95(96.9)	160 (80.0)

**Multiple responses*

Level of Impairment in Functioning

Interviewers assessed the extent of impairment that participants experienced in personal, family, social, educational, occupational, or other important areas of functioning. The majority of participants were rated as having no impairment (n = 111; 55.5%). Within the patient group (n = 102), most participants were assessed as experiencing either mild impairment or moderate impairment, while 19 (18.6%) were reported as having no impairment and 6 (5.9%) as having severe impairment. In contrast, among the healthy individuals (n = 98), nearly all (92; 93.9%) were assessed as having no impairment, with only 5 (5.1%) reporting mild impairment and 1 (1.0%) reporting moderate impairment; none were rated as having severe impairment (Table 37).

Table 37: The level of impairment

Level of impairment	Patients n (%)	Healthy individuals n (%)	Total n (%)
No impairment	19 (18.6)	92 (93.9)	111 (55.5)
Mild impairment	38 (37.3)	5 (5.1)	43 (21.5)
Moderate impairment	39 (38.2)	1 (1.0)	40 (20.0)
Severe impairment	6 (5.9)	0 (0.0)	6 (3.0)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Participant Struggles with Understanding Questions

Interviewers reported whether participants struggled to understand or found any of the questions confusing. In the patient group (n = 102), 62 participants (60.8%) were noted as experiencing some difficulty, while 40 (39.2%) did not. Among the healthy individuals (n = 98), 39 participants (39.8%) were identified as struggling with understanding, compared to 59 (60.2%) who did not. For the total sample (n = 200), difficulties with understanding were observed in 101 participants (50.5%), while 99 participants (49.5%) did not report such issues (Table 38).

Table 38: Some questions that the interviewee/participant struggled to understand or found confusing

Struggled to understand or found confusing	Patients n (%)	Healthy individuals n (%)	Total n (%)
No	40 (39.2)	59 (60.2)	99 (49.5)
Yes	62 (60.8)	39 (39.8)	101 (50.5)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Need of Rephrasing or Explaining Questions

Interviewers indicated whether they needed to rephrase or explain any questions during the administration of the interview. In the patient group (n = 102), the majority — 62 participants (60.8%) — required rephrasing or additional explanation of questions, while 40 (39.2%) did not. Among the healthy individuals (n = 98), 41 participants (41.8%) required rephrasing, whereas 57 (58.2%) did not. For the total sample (n = 200), interviewers

reported that rephrasing or explaining was needed for 103 participants (51.5%), while 97 participants (48.5%) did not require such clarification (Table 39).

Table 39:Questions that you were required to rephrase or explain

Required to rephrase or explain	Patients n (%)	Healthy individuals n (%)	Total n (%)
I did not need to rephrase or explain any questions	40 (39.2)	57 (58.2)	97 (48.5)
I needed to rephrase or explain the following questions:	62 (60.8)	41 (41.8)	103 (51.5)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Perceived Openness and Honesty of Participant Responses

Interviewers were asked whether participants responded openly and honestly to all questions. In the patient group (n = 102), the majority were rated positively, with 66 (64.7%) agreeing and 7 (6.9%) strongly agreeing. Smaller proportions indicated 9 (8.8%) somewhat agree, 12 (11.8%) somewhat disagree, and 8 (7.8%) disagree. Among the healthy individuals (n = 98), responses were even more favourable: 81 (82.7%) agreed and 5 (5.1%) strongly agreed, while 9 (9.2%) somewhat agreed and 3 (3.1%) somewhat disagreed. None of the healthy participants disagreed. For the total sample (n = 200), 159 participants (79.5%) agreed or strongly agreed that responses were open and honest (147; 73.5% agreed and 12; 6.0% strongly agreed). Smaller groups expressed neutral or negative views, with 18 (9.0%) somewhat agree, 15 (7.5%) somewhat disagree, and 8 (4.0%) disagree (Table 40).

Table 40: Participants responded openly and honestly to all the questions

Participant responded openly and honestly	Patients n (%)	Healthy individuals n (%)	Total n (%)
Disagree	8 (7.8)	0 (0.0)	8 (4.0)
Somewhat disagree	12 (11.8)	3 (3.1)	15 (7.5)
Somewhat agree	9 (8.8)	9 (9.2)	18 (9.0)
Agree	66 (64.7)	81 (82.7)	147 (73.5)
Strongly agree	7 (6.9)	5 (5.1)	12 (6.0)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Perceived Difficulty or Discomfort in Completing the Interview

Interviewers assessed whether participants found the interview difficult to complete or appeared uncomfortable with some of its contents. In the patient group (n = 102), the majority disagreed, with 62 (60.8%) disagreeing and 1 (1.0%) strongly disagreeing. Smaller proportions reported 11 (10.8%) somewhat disagree, 16 (15.7%) somewhat agree, 11 (10.8%) agree, and 1 (1.0%) strongly agree.

Among the healthy individuals (n = 98), most also disagreed, with 80 (81.6%) disagreeing and 2 (2.0%) strongly disagreeing, while 7 (7.1%) somewhat disagreed and 9 (9.2%) somewhat agreed. None of the healthy participants agreed or strongly agreed.

For the total sample (n = 200), 145 participants (72.5%) disagreed or strongly disagreed that the interview was difficult or uncomfortable (142; 71.0% disagreed and 3; 1.5% strongly disagreed). A minority expressed some level of discomfort (18; 9.0% somewhat disagree, 25; 12.5% somewhat agree, 11; 5.5% agree, and 1; 0.5% strongly agree) (Table 41).

Table 41: Difficult to complete or seemed uncomfortable about some of the contents

Difficult to complete/ uncomfortable about some of the contents	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	1 (1.0)	2 (2.0)	**3 (1.5)**
Disagree	62 (60.8)	80 (81.6)	**142 (71.0)**
Somewhat disagree	11 (10.8)	7 (7.1)	**18 (9.0)**
Somewhat agree	16 (15.7)	9 (9.2)	**25 (12.5)**
Agree	11 (10.8)	0 (0.0)	**11 (5.5)**
Strongly agree	1 (1.0)	0 (0.0)	**1 (0.5)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Need for Interviewer to Make Ratings Due to Participant Uncertainty or Lack of Understanding

Interviewers reported whether they often had to decide on the best rating because participants did not know or did not understand certain questions. In the patient group, most disagreed, with 55 (53.9%) disagreeing and 7 (6.9%) strongly disagreeing. Smaller proportions reported 11 (10.8%) somewhat disagree, while 17 (16.7%) somewhat agreed, 8 (7.8%) agreed, and 4 (3.9%) strongly agreed.

Among the healthy individuals (n = 98), the majority also disagreed, with 83 (84.7%) disagreeing and 6 (6.1%) strongly disagreeing. Only 5 (5.1%) somewhat disagreed and 3 (3.1%) somewhat agreed, while 1 (1.0%) agreed. No participants strongly agreed.

For the total sample (n = 200), 151 participants (75.5%) disagreed or strongly disagreed that interviewers had to make ratings due to participants' uncertainty (138; 69.0% disagreed and 13; 6.5% strongly disagreed). A smaller proportion indicated some level of agreement, with 20 (10.0%) somewhat agree, 9 (4.5%) agree, and 4 (2.0%) strongly agree, while 16 (8.0%) somewhat disagreed (Table 42).

Table 42: Decide on making the best rating because the participant did not know or did not understand the question

Participant did not know or did not understand the question	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	7 (6.9)	6 (6.1)	**13 (6.5)**
Disagree	55 (53.9)	83 (84.7)	**138 (69.0)**
Somewhat disagree	11 (10.8)	5 (5.1)	**16 (8.0)**
Somewhat agree	17 (16.7)	3 (3.1)	**20 (10.0)**
Agree	8 (7.8)	1 (1.0)	**9 (4.5)**
Strongly agree	4 (3.9)	0 (0.0)	**4 (2.0)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Clarity of Language – Vocabulary and Sentence Construction

Interviewers were asked whether the vocabulary and sentence construction of the instrument were easy to understand. In the patient group (n = 102), the majority responded positively, with 87 (85.3%) agreeing and 1 (1.0%) strongly agreeing. Smaller proportions indicated 9 (8.8%) somewhat agree, 3 (2.9%) somewhat disagree, and 2 (2.0%) disagree. Among the healthy individuals (n = 98), most also gave favorable responses, with 90 (91.8%) agreeing. A smaller group reported 7 (7.1%) somewhat agree and 1 (1.0%) disagree, while no participants strongly agreed or somewhat disagreed.
For the total sample (n = 200), 178 participants (89.0%) agreed or strongly agreed that the language was easy to understand (177; 88.5% agreed and 1; 0.5% strongly agreed). Only 22 participants (11.0%) expressed some level of neutrality or disagreement (Table 43).

Table 43: Language (vocabulary and sentence construction) is easy to understand

The language (easy to understand.	Patients n (%)	Healthy individuals n (%)	Total n (%)
Disagree	2 (2.0)	1 (1.0)	**3 (1.5)**
Somewhat disagree	3 (2.9)	0 (0.0)	**3 (1.5)**
Somewhat agree	9 (8.8)	7 (7.1)	**16 (8.0)**
Agree	87 (85.3)	90 (91.8)	**177 (88.5)**
Strongly agree	1 (1.0)	0 (0.0)	**1 (0.5)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Clarity of Questions

Interviewers were asked whether the questions were clear and whether they could recognise the specific information or symptoms being enquired about. In the patient group (n = 102), the majority expressed positive views, with 82 (80.4%) agreeing and 1 (1.0%) strongly agreeing. Smaller proportions reported 13 (12.7%) somewhat agree, while 3 (2.9%) disagreed and 3 (2.9%) somewhat disagreed. Among the healthy individuals (n = 98), most interviewers also responded favourably: 89 (90.8%) agreed and 2 (2.0%) strongly agreed, while 6 (6.1%) somewhat agreed and 1 (1.0%) somewhat disagreed. None reported disagreement.

For the total sample (n = 200), 174 participants (87.0%) agreed, and 3 (1.5%) strongly agreed, indicating a high overall level of clarity. A smaller proportion indicated 19 (9.5%) somewhat agree, 4 (2.0%) somewhat disagree, and 3 (1.5%) disagree (Table 44).

Table 44: The clarity of questions was good; I knew what information was needed to rate the question accurately

The clarity of questions was good	Patients n (%)	Healthy individuals n (%)	Total n (%)
Disagree	3 (2.9)	0 (0.0)	**3 (1.5)**
Somewhat disagree	3 (2.9)	1 (1.0)	**4 (2.0)**
Somewhat agree	13 (12.7)	6 (6.1)	**19 (9.5)**
Agree	82 (80.4)	89 (90.8)	**171 (85.5)**

Strongly agree	1 (1.0)	2 (2.0)	**3 (1.5)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Logical Flow of Questions

Interviewers assessed whether the questions in the FLII-11 followed a logical sequence. In the patient group (n = 102), 49 participants (48.0%) agreed, and 39 (38.2%) somewhat agreed.
Among the healthy individuals (n = 98), the responses were more strongly positive: 70 (71.4%) agreed and 2 (2.0%) strongly agreed, while 22 (22.4%) somewhat agreed and 3 (3.1%) somewhat disagreed.
For the total sample (n = 200), 121 participants (60.5%) agreed or strongly agreed that the questions followed a logical order (119; 59.5% agreed and 2; 1.0% strongly agreed). An additional 61 (30.5%) somewhat agreed, while 18 (9.0%) expressed some level of disagreement (Table 45).

Table 45: The flow of questions made sense; they followed logically from one question to another

The flow of questions made sense	Patients n (%)	Healthy individuals n (%)	Total n (%)
Disagree	5 (4.9)	1 (1.0)	**6 (3.0)**
Somewhat disagree	9 (8.8)	3 (3.1)	**12 (6.0)**
Somewhat agree	39 (38.2)	22 (22.4)	**61 (30.5)**
Agree	49 (48.0)	70 (71.4)	**119 (59.5)**
Strongly agree	0 (0.0)	2 (2.0)	**2 (1.0)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Difficulty in Obtaining Relevant Information for Ratings

Interviewers reported on whether they found it difficult to obtain all the relevant information needed to make some ratings. In the patient group (n = 102), responses were mixed: 35 (34.3%) disagreed, and 23 (22.5%) somewhat disagreed.
Among the healthy individuals (n = 98), the majority indicated no difficulty, with 49 (50.0%) disagreeing and 32 (32.7%) somewhat disagreeing. For the total sample (n = 200), 143 participants (71.5%) strongly disagreed, disagreed, or somewhat disagreed that it was difficult to obtain relevant information (Table 46).

Table 46: Difficult to get all the relevant information

Difficult to get all the relevant information	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	3 (2.9)	1 (1.0)	**4 (2.0)**
Disagree	35 (34.3)	49 (50.0)	**84 (42.0)**
Somewhat disagree	23 (22.5)	32 (32.7)	**55 (27.5)**
Somewhat agree	19 (18.6)	4 (4.1)	**23 (11.5)**

Agree	21 (20.6)	12 (12.2)	**33 (16.5)**
Strongly agree	1 (1.0)	0 (0.0)	**1 (0.5)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Interviewer Comfort in Administering the FLII-11

Interviewers were asked whether they felt comfortable interviewing participants using the FLII-11. In the patient group (n = 102), just over half reported positive experiences, with 51 (50.0%) agreeing. Among the healthy individuals (n = 98), 41 (41.8%) agreed (Table 47).

Table 47: Feel comfortable interviewing people using the FLII-11

Feel comfortable interviewing people using the FLII-11.	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	1 (1.0)	0 (0.0)	**1 (0.5)**
Disagree	4 (3.9)	0 (0.0)	**4 (2.0)**
Somewhat disagree	18 (17.6)	5 (5.1)	**23 (11.5)**
Somewhat agree	24 (23.5)	48 (49.0)	**72 (36.0)**
Agree	51 (50.0)	41 (41.8)	**92 (46.0)**
Strongly agree	4 (3.9)	4 (4.1)	**8 (4.0)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Familiarity with Interview Questions

Interviewers were asked whether the questions were familiar and similar to those they would routinely ask when interviewing a patient. For the total sample (n = 195), 127 participants (65.1%) agreed or strongly agreed that the questions were familiar and aligned with routine clinical interviewing (126; 64.6% agreed and 1; 0.5% strongly agreed). An additional 53 (27.2%) somewhat agreed, while 15 (7.7%) somewhat disagreed (Table 48). *The initial five patients were not included in the analysis as they were excluded at data entry.*

Table 48: The questions were familiar to me and similar to what I would ask routinely in interviewing a patient.

The questions were familiar to me	Patients n (%)*	Healthy individuals n (%)	Total n (%)
Somewhat disagree	10 (10.3)	5 (5.1)	**15 (7.7)**
Somewhat agree	33 (34.0)	20 (20.4)	**53 (27.2)**
Agree	53 (54.6)	73 (74.5)	**126 (64.6)**
Strongly agree	1 (1.0)	0 (0.0)	**1 (0.5)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis.*

Clarity of Questions and Recognition of Symptoms

Interviewers were asked whether the questions were clear and whether they could recognise the specific symptoms being enquired about. In the patient group (n = 97), the majority responded positively, with 83 (85.6%) agreeing and 11 (11.3%) somewhat agreeing. Among the healthy individuals (n = 98), most also endorsed clarity, with 85 (86.7%) agreeing and 12 (12.2%) somewhat agreeing. Only 1 participant (1.0%) somewhat disagreed, and

none strongly disagreed or strongly agreed (Table 49). *The initial five patients were not included in the analysis as they were excluded at data entry.*

Table 49: The clarity of questions

The clarity of questions was good	Patients n (%)*	Healthy individuals n (%)	Total n (%)
Somewhat disagree	3 (3.1)	1 (1.0)	**4 (2.1)**
Somewhat agree	11 (11.3)	12 (12.2)	**23 (11.8)**
Agree	83 (85.6)	85 (86.7)	**168 (86.2)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis as they were excluded at data entry.*

Perceived Accuracy of Questions in Eliciting Symptoms

Interviewers were asked whether the questions seemed to accurately elicit the intended symptoms, reflecting a sufficient "goodness of fit." In the patient group (n = 97), more than half responded positively, with 51 (52.6%) agreeing. Among the healthy individuals (n = 98), most also endorsed the accuracy of the questions, with 63 (64.3%) agreeing and 30 (30.6%) somewhat agreeing (Table 50). *The initial five patients were not included in the analysis as they were excluded at data entry.*

Table 50: The questions elicit symptoms accurately

The questions elicit symptoms	Patients n (%)*	Healthy individuals n (%)	Total n (%)
Strongly disagree	1 (1.0)	0 (0.0)	**1 (0.5)**
Disagree	5 (.2)	1 (1.0)	**6 (3.1)**
Somewhat disagree	13 (13.4)	4 (4.1)	**17 (8.7)**
Somewhat agree	26 (26.8)	30 (30.6)	**56 (28.7)**
Agree	51 (52.6)	63 (64.3)	**114 (58.5)**
Strongly agree	1 (1.0)	0 (0.0)	**1 (0.5)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis as they were excluded at data entry.*

Efficiency of the FLII-11 in Obtaining Clinical Information

For the total sample (n = 195), 55 participants (28.2%) agreed or strongly agreed that the FLII-11 was efficient (54; 27.7% agreed and 1; 0.5% strongly agreed). An additional 82 (42.1%) somewhat agreed, while 56 participants (28.7%) expressed some level of disagreement (50; 25.6% somewhat disagree, 6; 3.1% disagree, 2; 1.0% strongly disagree). The initial five patients were not included in the analysis as they were excluded at data entry (Table 51). *The initial five patients were not included in the analysis as they were excluded at data entry.*

Table 51: The FLII-11 is efficient (in terms of time or number of questions) in obtaining clinical information

The FLII-11 is efficient in obtaining clinical information	Patients n (%)*	Healthy individuals n (%)	Total n (%)
Strongly disagree	2 (2.1)	0 (0.0)	**2 (1.0)**
Disagree	6 (6.2)	0 (0.0)	**6 (3.1)**
Somewhat disagree	31 (32.0)	19 (19.4)	**50 (25.6)**
Somewhat agree	28 (28.9)	54 (55.1)	**82 (42.1)**
Agree	30 (30.9)	24 (24.5)	**54 (27.7)**
Strongly agree	0 (0.0)	1 (1.0)	**1 (0.5)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis as they were excluded at data entry.*

Difficulty in Combining FLII-11 with Usual Interview Style

For the total sample (n = 195), majority of participants expressed some level of agreement with the statement (82; 42.1% somewhat agree, 26; 13.3% agree, 2; 1.0% strongly agree). Meanwhile, 45 (23.1%) disagree, 37 (19.0%) somewhat disagree, and 3 (1.5%) strongly disagree (Table 52). *The initial five patients were not included in the analysis as they were excluded at data entry.*

Table 52:I found it difficult to combine the use of the FLII-11 with my usual interview style

Difficult in combining FLII-11 with usual interview style.	Patients n (%)*	Healthy individuals n (%)	Total n (%)
Strongly disagree	0 (0.0)	3 (3.1)	**3 (1.5)**
Disagree	17 (17.5)	28 (28.6)	**45 (23.1)**
Somewhat disagree	16 (16.5)	21 (21.4)	**37 (19.0)**
Somewhat agree	44 (45.4)	38 (38.8)	**82 (42.1)**
Agree	18 (18.6)	8 (8.2)	**26 (13.3)**
Strongly agree	2 (2.1)	0 (0.0)	**2 (1.0)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis as they were excluded at data entry.*

Adequacy of Screening Questions – Sensitivity and Specificity

Interviewers were asked whether the screening questions in the FLII-11 managed to strike an appropriate balance between being sensitive and specific enough. For the total sample (n = 195), 153 participants (78.5%) agreed or strongly agreed that the screening questions achieved a suitable balance (148; 75.9% agreed and 5; 2.6% strongly agreed). An additional 25 (12.8%) somewhat agreed, while 17 participants (8.7%) expressed some level of disagreement (Table 53). *The initial five patients were not included in the analysis as they were excluded at data entry.*

Table 53:The screening questions managed to find a balance between being sensitive and specific enough

"The screening questions managed to find a balance between being sensitive and specific enough."	Patients n (%)*	Healthy individuals n (%)	Total n (%)
Disagree	2 (2.1)	0 (0.0)	**2 (1.0)**
Somewhat disagree	13 (13.4)	2 (2.0)	**15 (7.7)**
Somewhat agree	12 (12.4)	13 (13.3)	**25 (12.8)**
Agree	69 (71.1)	79 (80.6)	**148 (75.9)**
Strongly agree	1 (1.0)	4 (4.1)	**5 (2.6)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis as they were excluded at data entry.*

Comprehensiveness of Questions for Diagnosis

Interviewers were asked whether the FLII-11 questions were comprehensive enough to facilitate diagnosis. Among the total sample (n = 195), 135 participants (69.3%) agreed or strongly agreed that the questions were comprehensive enough for diagnostic purposes (130; 66.7% agreed and 5; 2.6% strongly agreed). A further 43 (22.1%) somewhat agreed, while 17 participants (8.7%) expressed some level of disagreement. *The initial five patients were not included in the analysis as they were excluded at data entry (Table 54).*

Table 54: The questions were comprehensive enough to facilitate diagnosis

Comprehensive enough to facilitate diagnosis	Patients n (%)*	Healthy individuals n (%)	Total n (%)
Strongly disagree	2 (2.1)	0 (0.0)	**2 (1.0)**
Disagree	1 (1.0)	0 (0.0)	**1 (0.5)**
Somewhat disagree	11 (11.3)	3 (3.1)	**14 (7.2)**
Somewhat agree	19 (19.6)	24 (24.5)	**43 (22.1)**
Agree	60 (61.9)	70 (71.4)	**130 (66.7)**
Strongly agree	4 (4.1)	1 (1.0)	**5 (2.6)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis as they were excluded at data entry.*

Algorithmic Selection of Relevant Questions

Interviewers were asked whether the content and sequence of the questions displayed by the FLII-11 suggested that the algorithm was appropriately selecting relevant items to reach an accurate diagnosis. For the total sample (n = 195), 158 participants (80.5%) agreed or somewhat agreed that the content and sequence of the questions suggested appropriate algorithmic selection (88; 45.1% agreed and 69; 35.4% somewhat agreed). In contrast, 38 participants (19.4%) expressed some level of disagreement (34; 17.4% somewhat disagree, 3; 1.5% disagree, 1; 0.5% strongly disagree). The initial five patients were not included in the analysis as they were excluded at data entry (Table 55).

Table 55: The algorithm was selecting the relevant questions to reach the appropriate diagnosis/es.

Algorithm was selecting the relevant questions	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	1 (1.0)	0 (0.0)	**1 (0.5)**
Disagree	3 (3.1)	0 (0.0)	**3 (1.5)**
Somewhat disagree	28 (28.9)	6 (6.1)	**34 (17.4)**
Somewhat agree	34 (35.1)	35 (35.7)	**69 (35.4)**
Agree	31 (32.0)	57 (58.2)	**88 (45.1)**
Total	**97 (100.0)**	**98 (100.0)**	**195 (100.0)**

* *The initial five patients were not included in the analysis as they were excluded at data entry.*

Section 2: Participants component – IEQ. (Tamil Language)

Understanding and Comprehension

Participants were asked whether they were able to understand what the interviewer was asking. In the patient group (n = 102), the majority responded positively, with 80 (78.4%) agreeing and 4 (3.9%) strongly agreeing. Among the healthy individuals (n = 98), most also expressed strong comprehension, with 83 (84.7%) agreeing and 7 (7.1%) strongly agreeing (Table 56).

Table 56: Agreement with the statement - "Overall, I was able to understand what the interviewer was asking."

Able to understand	Patients n (%)	Healthy individuals n (%)	Total n (%)
Disagree	4 (3.9)	1 (1.0)	5 (2.5)
Somewhat disagree	2 (2.0)	1 (1.0)	3 (1.5)
Somewhat agree	12 (11.8)	6 (6.1)	18 (9.0)
Agree	80 (78.4)	83 (84.7)	163 (81.5)
Strongly agree	4 (3.9)	7 (7.1)	11 (5.5)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Participants were asked whether any of the words, phrases, or questions in the interview were offensive or otherwise objectionable. When considering the total sample (n = 200), 154 participants (77.0%) disagreed or strongly disagreed that the questions were offensive (146; 73.0% disagreed and 8; 4.0% strongly disagreed). A minority of 28 participants (14.0%) expressed agreement at varying levels, and 15 (7.5%) somewhat disagreed (Table 57).

Table 57: There were some of the words, phrases, or questions that I thought were offensive or otherwise objectionable

Some of the words, phrases, or questions - offensive or otherwise objectionable	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	3 (2.9)	5 (5.1)	8 (4.0)
Disagree	68 (66.7)	78 (79.6)	146 (73.0)
Somewhat disagree	10 (9.8)	5 (5.1)	15 (7.5)
Somewhat agree	5 (4.9)	4 (4.1)	9 (4.5)
Agree	14 (13.7)	4 (4.1)	18 (9.0)
Strongly agree	2 (2.0)	2 (2.0)	4 (2.0)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Upsetting Aspects of the Interview

Participants were asked whether they found any parts of the interview upsetting. In the patient group (n = 102), most disagreed, with 71 (69.6%) disagreeing and 10 (9.8%) strongly disagreeing, while the majority of healthy individuals (n = 98) also disagreed, with 80 (81.6%) disagreeing and 7 (7.1%) strongly disagreeing (Table 58).

Table 58: Parts of the interview were upsetting

Statement - parts of the interview upsetting	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	10 (9.8)	7 (7.1)	**17 (8.5)**
Disagree	71 (69.6)	80 (81.6)	**151 (75.5)**
Somewhat disagree	3 (2.9)	4 (4.1)	**7 (3.5)**
Somewhat agree	7 (6.9)	4 (4.1)	**11 (5.5)**
Agree	11 (10.8)	2 (2.0)	**13 (6.5)**
Strongly agree	0 (0.0)	1 (1.0)	**1 (0.5)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Feeling Respected and Valued During the Interview

Participants were asked whether they felt respected and valued during the interview. Over 90% of the participants (n = 188) agreed or strongly agreed that they felt respected and valued (164; 82.0% agreed and 24; 12.0% strongly agreed). Only 12 participants (6.0%) expressed some level of partial disagreement or agreement (Table 59).

Table 59: Statement - "I felt respected and valued during the interview"

Statement – feeling respected and valued	Patients n (%)	Healthy individuals n (%)	Total n (%)
Somewhat disagree	4 (3.9)	0 (0.0)	**4 (2.0)**
Somewhat agree	6 (5.9)	2 (2.0)	**8 (4.0)**
Agree	84 (82.4)	80 (81.6)	**164 (82.0)**
Strongly agree	8 (7.8)	16 (16.3)	**24 (12.0)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Feeling Heard and Understood During the Interview

Participants were asked whether they felt heard and understood during the interview. Among the patients, the majority gave positive feedback, with 84 (82.4%) agreeing and 8 (7.8%) strongly agreeing. Similarly, healthy individuals (n = 98) also expressed positive experiences, with 80 (81.6%) agreeing and 11 (11.2%) strongly agreeing. A further 6 (6.1%) somewhat agreed, and 1 participant (1.0%) somewhat disagreed. None disagreed strongly (Table 60).

Table 60: Statement - "I felt heard and understood during the interview."

Heard and understood	Patients n (%)	Healthy individuals n (%)	Total n (%)
Disagree	1 (1.0)	0 (0.0)	1 (0.5)
Somewhat disagree	3 (2.9)	1 (1.0)	4 (2.0)
Somewhat agree	6 (5.9)	6 (6.1)	12 (6.0)
Agree	84 (82.4)	80 (81.6)	164 (82.0)
Strongly agree	8 (7.8)	11 (11.2)	19 (9.5)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Appropriateness of Interview Duration

Participants were asked whether the interview took an appropriate amount of time. The majority of patients agree (n = 64, 62.7%). Similarly, the majority of healthy individuals also agreed (n = 69, 70.4%) (Table 61).

Table 61: Statement - "The interview took an appropriate amount of time."

Took an appropriate amount of time	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	6 (5.9)	1 (1.0)	7 (3.5)
Disagree	7 (6.9)	5 (5.1)	12 (6.0)
Somewhat disagree	12 (11.8)	5 (5.1)	17 (8.5)
Somewhat agree	8 (7.8)	10 (10.2)	18 (9.0)
Agree	64 (62.7)	69 (70.4)	133 (66.5)
Strongly agree	5 (4.9)	8 (8.2)	13 (6.5)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Coverage of Participant Concerns and Complaints

Participants were asked whether the interview questions covered all their main concerns and complaints about their mental health experience. Among the total study sample, 151 participants (75.5%) agreed or strongly agreed that the interview adequately covered their main concerns (139; 69.5% agreed and 12; 6.0% strongly agreed). A further 22 participants (11.0%) somewhat agreed, while 27 participants (13.5%) expressed some level of disagreement (Table 62).

Table 62: Statement - The questions in the interview covered all my main concerns and complaints about my mental health experience.

Covered all my main concerns and complaints	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	2 (2.0)	2 (2.0)	4 (2.0)
Disagree	8 (7.8)	5 (5.1)	13 (6.5)
Somewhat disagree	7 (6.9)	3 (3.1)	10 (5.0)
Somewhat agree	12 (11.8)	10 (10.2)	22 (11.0)
Agree	68 (66.7)	71 (72.4)	139 (69.5)
Strongly agree	5 (4.9)	7 (7.1)	12 (6.0)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Some Important Aspects of My Mental Health Experience Were Not Asked About

Participants were asked whether they felt that some important aspects of their mental health experience were not asked about during the interview. In the patient group (n = 102), the majority disagreed, with 61 participants (59.8%) disagreeing and 1 (1.0%) strongly disagreeing. Smaller proportions reported 9 (8.8%) somewhat disagree, 12 (11.8%) somewhat agree, 15 (14.7%) agree, and 4 (3.9%) strongly agree. Among the healthy individuals (n = 98), most also disagreed, with 70 (71.4%) disagreeing and 4 (4.1%) strongly disagreeing. A further 8 (8.2%) somewhat disagreed and 9 (9.2%) somewhat agreed, while 7 participants (7.1%) agreed. None strongly agreed (Table 63)

Table 63: Statement - Some important aspects of my mental health experience were not asked about.

"Some aspects were not asked about."	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	1 (1.0)	4 (4.1)	**5 (2.5)**
Disagree	61 (59.8)	70 (71.4)	**131 (65.5)**
Somewhat disagree	9 (8.8)	8 (8.2)	**17 (8.5)**
Somewhat agree	12 (11.8)	9 (9.2)	**21 (10.5)**
Agree	15 (14.7)	7 (7.1)	**22 (11.0)**
Strongly agree	4 (3.9)	0 (0.0)	**4 (2.0)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Questions as an Accurate Reflection of Mental Health Experience

Participants were asked whether the questions accurately reflected their mental health experience. Most patients responded positively, with 62 (60.8%) agreeing and 11 (10.8%) strongly agreeing, while 16 (15.7%) somewhat agreed. Smaller proportions expressed disagreement, including 6 (5.9%) disagree, 6 (5.9%) somewhat disagree, and 1 (1.0%) strongly disagree. Out of both patients and healthy individuals, 146 participants (73.0%) agreed or strongly agreed that the questions accurately reflected their mental health experience. An additional 34 participants (17.0%) somewhat agreed, while 20 (10.0%) expressed some level of disagreement (Table 64).

Table 64: Statement - The questions I was asked were an accurate reflection of my mental health experience

The questions - an accurate reflection	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	1 (1.0)	0 (0.0)	**1 (0.5)**
Disagree	6 (5.9)	3 (3.1)	**9 (4.5)**
Somewhat disagree	6 (5.9)	4 (4.1)	**10 (5.0)**
Somewhat agree	16 (15.7)	18 (18.4)	**34 (17.0)**
Agree	62 (60.8)	67 (68.4)	**129 (64.5)**
Strongly agree	11 (10.8)	6 (6.1)	**17 (8.5)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Perception of the Interview as Tiring

Participants were asked whether they found the interview tiring. Most patients disagreed (n = 72 , 70.6% and strongly disagreed(n = 4, 3.9%). The healthy individuals (n = 98), the majority also disagreed, with 78 (79.6%) disagreeing and 7 (7.1%) strongly disagreeing (Table 65).

Table 65: Statement – "I found the interview tiring."

Found the interview tiring	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	4 (3.9)	7 (7.1)	**11 (5.5)**
Disagree	72 (70.6)	78 (79.6)	**150 (75.0)**
Somewhat disagree	7 (6.9)	0 (0.0)	**7 (3.5)**
Somewhat agree	4 (3.9)	7 (7.1)	**11 (5.5)**
Agree	13 (12.7)	6 (6.1)	**19 (9.5)**
Strongly agree	2 (2.0)	0 (0.0)	**2 (1.0)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Perception of the Interview as a Positive Experience

Participants were asked whether they felt the interview process was generally a positive experience. Over 77% particpnats (n =155) agreed or strongly agreed that the interview was a positive experience (145; 72.5% agreed and 10; 5.0% strongly agreed). A further 19 (9.5%) somewhat agreed, while 26 participants (13.0%) expressed some form of disagreement (Table 66).

Table 66: Statement - "The interview process was generally a positive experience."

The interview process- positive experience	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	0 (0.0)	5 (5.1)	**5 (2.5)**
Disagree	5 (4.9)	7 (7.1)	**12 (6.0)**
Somewhat disagree	9 (8.8)	0 (0.0)	**9 (4.5)**
Somewhat agree	12 (11.8)	7 (7.1)	**19 (9.5)**
Agree	72 (70.6)	73 (74.5)	**145 (72.5)**
Strongly agree	4 (3.9)	6 (6.1)	**10 (5.0)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Better Understanding of Self and Mental Health

Participants were asked whether the interview helped them to better understand themselves and their mental health. Over 85% participants agreed or strongly agreed that the interview enhanced their understanding of themselves and their mental health (147; 73.5% agreed and 25; 12.5% strongly agreed). A smaller group of 14 participants (7.0%) somewhat agreed, while 14 (7.0%) expressed some form of disagreement (Table 67).

Table 67: Statement "Due to the interview, I have a better understanding of myself and my mental health"

Better understanding of myself	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	0 (0.0)	1 (1.0)	**1 (0.5)**
Disagree	5 (4.9)	1 (1.0)	**6 (3.0)**
Somewhat disagree	6 (5.9)	1 (1.0)	**7 (3.5)**
Somewhat agree	7 (6.9)	7 (7.1)	**14 (7.0)**
Agree	73 (71.6)	74 (75.5)	**147 (73.5)**
Strongly agree	11 (10.8)	14 (14.3)	**25 (12.5)**
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Willingness to Participate in a Future Interview

Participants were asked whether they would be willing to participate in a similar interview in the future. Among the patients, 59 (57.8%) agreed and 27 (26.5%) strongly agreed. Among the healthy individuals, responses were also largely positive, with 60 (61.2%) agreeing and 28 (28.6%) strongly agreeing (Table 68).

Table 68: Statement - I would be willing to participate in an interview like this again at some point in the future.

"Willing to participate in an interview like this again at some point in the future	Patients n (%)	Healthy individuals n (%)	Total n (%)
Strongly disagree	1 (1.0)	1 (1.0)	2 (1.0)
Disagree	6 (5.9)	1 (1.0)	7 (3.5)
Somewhat disagree	4 (3.9)	3 (3.1)	7 (3.5)
Somewhat agree	5 (4.9)	5 (5.1)	10 (5.0)
Agree	59 (57.8)	60 (61.2)	119 (59.5)
Strongly agree	27 (26.5)	28 (28.6)	55 (27.5)
Total	**102 (100.0)**	**98 (100.0)**	**200 (100.0)**

Conclusions

The conclusions will be based on the summary results presented in Tables, presented in the Sinhala Language results (Summary of IEQ – Interviewers (Table 69) and Participants (Table 70)). Similarly, the summary results of the Tamil Language, which are also presented (Summary of IEQ – Interviewers (Table 71) and Participants (Table 72)).

Table 69: Summary Results - IEQ - Interviewers (Sinhala Language)

Item	Patients n (%)	Healthy n (%)	Total n (%)
Factors affecting interview: Lack of insight	2 (2.9)	2 (0.0)	4 (1.5)
Factors affecting interview process: Lack of cooperation	3 (2.1)	1 (0.8)	4 (1.5)
Factors affecting interview process: Cognitive impairment	7 (5.0)	0 (0.0)	7 (2.7)
Factors affecting interview process: Other factors	17 (12.1)	8 (6.5)	25 (9.5)
Factors affecting interview process: None	111 (79.3)	114 (92.7)	225 (85.6)
Level of impairment (Mild/Moderate/Severe)	125 (89.2)	21.1(0.17.2)	151(57.4)
Participant struggled to understand questions (Yes)	58 (41.4)	32 (26.0)	90 (34.2)
Questions rephrased/explained (Yes)	76 (54.3)	36 (29.3)	112 (42.6)
Participant responded openly and honestly (Agree/Strongly agree)	129 (92.2)	116 (94.3)	245 (93.1)
Interview difficult/uncomfortable (Agree/Somewhat agree)	13 (9.3)	4 (3.3)	17 (6.5)
Interviewer had to rate due to participant not understanding (S. Agree/Agree/Somewhat agree)	23 (16.4)	14 (11.4)	37 (14.1)
Language easy to understand (Agree/Strongly agree)	131 (93.6)	120 (97.6)	251 (95.4)
Clarity of questions good (Agree/Strongly agree)	133 (95.0)	121 (98.4)	254 (96.6)
Logical flow of questions (Agree/Strongly agree)	131 (93.6)	121 (98.4)	252 (95.8)
Difficult to obtain relevant information (S.Agree/Agree/Somewhat agree)	17 (12.1)	11 (8.9)	32 (12.2)
Interviewer comfortable using FLII-11 (Agree/Strongly agree)	115 (82.1)	89 (72.3)	204 (77.6)
Questions familiar to routine practice (Agree/Strongly agree)	120 (85.7)	102 (82.9)	222 (84.4)
Clarity of questions – recognized symptoms (Agree/Strongly agree)	134 (95.7)	121 (98.4)	255 (97.0)
Questions elicited symptoms accurately (Agree/Strongly agree)	121 (86.4)	115 (93.5)	236 (89.7)
FLII-11 efficient in obtaining clinical information (Agree/Strongly agree)	122 (87.1)	100 (81.3)	222 (84.4)
Difficult to combine with usual interview style (S.Agree/Agree/Somewhat agree)	40 (28.6)	37 (30.1)	62 (23.6)
Screening questions balanced sensitivity/specificity (Agree/Strongly agree)	125 (89.3)	118 (95.9)	243 (92.4)
Questions comprehensive for diagnosis (Agree/Strongly agree)	128 (91.4)	117 (95.1)	245 (93.1)

Algorithm selected relevant questions (Agree/Strongly agree)	137 (97.8)	122 (99.2)	259 (98.5)

Table 70: Summary Results - IEQ - Participants (Sinhala Language)

Item	Patients n (%)	Controls n (%)	Total n (%)
A1. Understood interviewer's questions (Agree/Strongly agree)	137 (97.9)	117 (95.1)	254 (96.6)
A2. Found words/questions offensive (Disagree/Strongly disagree)	130 (92.9)	112 (91.1)	242 (92.0)
A3. Found parts of the interview upsetting (Disagree/Strongly disagree)	133 (95.0)	113 (91.9)	246 (93.5)
A4. Felt respected and valued (Agree/Strongly agree)	136 (97.1)	115 (93.5)	251 (95.4)
A5. Felt heard and understood (Agree/Strongly agree)	137 (97.9)	121 (98.4)	258 (98.1)
A6. Interview took appropriate time (Agree/Strongly agree)	121 (86.4)	111 (90.2)	232 (88.2)
A7. Interview covered concerns (Agree/Strongly agree)	119 (85.0)	112 (91.1)	231 (87.8)
A8. Some aspects not asked (Disagree/Strongly disagree)	96 (68.6)	100 (81.3)	196 (74.6)
A9. Questions reflected experience (Agree/Strongly agree)	124 (88.6)	110 (89.4)	234 (88.9)
A10. Interview tiring (Disagree/Strongly disagree)	126 (90.0)	114 (92.7)	240 (91.2)
A11. Interview was a positive experience (Agree/Strongly agree)	130 (92.9)	115 (93.5)	245 (93.1)
A12. Better understanding of self and mental health (Agree/Strongly agree)	130 (92.9)	115 (93.5)	245 (93.2)
A13. Willing to participate again (Agree/Strongly agree)	132 (94.3)	115 (93.5)	247 (93.9)

Table 71: Summary results - IEQ - Interviewers (Tamil Language)

Questions	Patients n (%)	Healthy n (%)	Total n (%)
Proficiency: Completely fluent	68 (66.7)	91 (92.9)	159 (79.5)
Factor affecting Interviewer process: Lack of insight	14 (13.7)	2 (2.0)	16 (8.0)
Factor affecting Interviewer process: Lack of cooperation	19 (16.2)	1 (1.0)	20 (10.0)
Factor affecting Interviewer process: Cognitive impairment	16 (15.7)	0 (0.0)	16 (8.0)
Factor affecting Interviewer process: Other factors	3 (2.6)	0 (0.0)	3 (1.5)
None of the factors affect the interview process	65 (55.6)	95 (96.9)	160 (80.0)
Impact of lack of insight (Moderate/Great deal)	12 (85.7)	0 (0.0)	12 (75.0)
Impact of lack of cooperation (Moderate/Great deal)	17 (89.5)	1 (100.0)	18 (90.0)
Impact of cognitive impairment (Moderate/Great deal)	13 (81.3)	0 (0.0)	13 (81.3)
Impact of other factors (Moderate/Great deal)	1 (33.3)	0 (0.0)	1 (33.3)
Level of impairment (Mild/Moderate/Severe)	83 (81.4)	6 (6.1)	89 (44.5)
Participant struggled to understand (Yes)	62 (60.8)	39 (39.8)	101 (50.5)
Questions rephrased/explained (Yes)	62 (60.8)	41 (41.8)	103 (51.5)
Participant responded openly and honestly (Agree/Strongly agree)	73 (71.6)	86 (87.8)	159 (79.5)
Interview difficult/uncomfortable (Disagree/Strongly disagree)	63 (61.8)	82 (83.6)	145 (72.5)

Had to rate due to lack of understanding (Disagree/Strongly disagree)	62 (60.8)	89 (90.8)	151 (75.5)
Language easy to understand (Agree/Strongly agree)	88 (86.3)	90 (91.8)	178 (89.0)
Clarity of questions – knew what was needed (Agree/Strongly agree)	83 (85.3)	91 (92.9)	174 (87.0)
Flow of questions logical (Agree/Strongly agree)	49 (48.0)	72 (73.5)	121 (60.5)
Difficult to get all the relevant information (Agree/ Strongly agree)	22 (21.6)	12 (12.2)	34 (17.0)
Comfortable using FLII-11 (Agree/Strongly agree)	55 (53.9)	45 (45.9)	100 (50.0)
Questions familiar to routine practice (Agree/Strongly agree)	54 (55.7)*	73 (74.5)	127 (65.1)
Clarity of questions – recognized symptoms (Agree/Strongly agree)	83 (85.6)*	85 (86.7)	168 (86.2)
Questions elicited symptoms accurately (Agree/Strongly agree)	52 (53.6)*	63 (64.3)	115 (59.0)
FLII-11 efficient for information (Agree/Strongly agree)	30 (30.9)*	25 (25.5)	55 (28.2)
Difficult to combine with usual style (Agree/Somewhat agree)	20 (20.7)*	8 (8.2)	28(14.3)
Screening balanced sensitivity/specificity (Agree/Strongly agree)	70 (72.1)*	83 (84.7)	153 (78.5)
Questions comprehensive for diagnosis (Agree/Strongly agree)	64 (66.0)*	71 (72.4)	135 (69.3)
Algorithm selected relevant questions (Agree/Strongly agree)	31 (32.0)*	57 (58.2)	88 (45.1)

*Five patients were not included in the analysis

Table 72: Summary Results - IEQ - Participants (Tamil Language)

Question	Patients n (%)	Healthy individuals n (%)	Total n (%)
A1. Understood interviewer's questions (Agree/Strongly agree)	84 (82.3)	90 (91.8)	174 (87.0)
A2. Found words/questions offensive (Disagree/Strongly disagree)	71 (69.6)	83 (84.7)	154 (77.0)
A3. Found parts of the interview upsetting (Disagree/Strongly disagree)	81 (79.4)	87 (88.8)	168 (84.0)
A4. Felt respected and valued (Agree/Strongly agree)	92 (90.2)	96 (97.9)	188 (94.0)
A5. Felt heard and understood (Agree/Strongly agree)	92 (90.2)	91 (92.8)	183 (91.5)
A6. Interview took appropriate time (Agree/Strongly agree)	69 (67.6)	77 (78.6)	146 (73.0)
A7. Interview covered concerns (Agree/Strongly agree)	73 (71.6)	78 (79.6)	151 (75.5)
A8. Aspects not asked (Disagree/Strongly disagree)	62 (60.8)	74 (75.5)	136 (68.0)
A9. Questions reflected experience (Agree/Strongly agree)	73 (71.6)	73 (74.5)	146 (73.0)
A10. Interview tiring (Disagree/Strongly disagree)	76 (74.5)	85 (86.7)	161 (80.5)
A11. Interview was a positive experience (Agree/Strongly agree)	76 (74.5)	79 (80.6)	155 (77.5)
A12. Better understanding of self and mental health (Agree/Strongly agree)	84 (82.4)	88 (89.8)	172 (86.0)

A13. Willing to participate again (Agree/Strongly agree)	86 (84.3)	88 (89.8)	174 (87.0)

Final Remarks - The feasibility testing of the FLII-11 Adult Epi Version in both Sinhala and Tamil languages demonstrated that the tool is culturally appropriate, understandable, and acceptable to both interviewers and participants in Sri Lanka.

SUB -SECTION B

Project 2 - Component 1

To validate the FLII-11 adult epi Version to adapt culturally and to identify the measures of diagnostic accuracy (Sensitivity, Specificity, Predictive values) and reliability.

Table of Contents

List of Tables

Methodology

Study Design and Setting

A cross-sectional validation study was conducted to assess the diagnostic accuracy and inter-rater reliability of the Flexible Interview for ICD-11 (FLII-11), Adult Epidemiological Version in Sinhala and Tamil languages. The study was implemented across multiple psychiatric clinic settings in Sri Lanka (i.e., National Hospital of Sri Lanka, Teaching Hospital – Peradeniya, and Teaching Hospital – Jaffna).

Participants

Adult participants (aged ≥ 18 years) were recruited from two groups: (1) Patients with a diagnosed mental disorder, attending outpatient psychiatric clinics; and (2) Healthy individuals, accompanying patients or visiting outpatient departments, without any known psychiatric diagnosis.

Sample Size

According to the study proposal, a minimum of 400 participants (approximately 200 per language group—100 patients and 100 healthy individuals each) was targeted to ensure adequate power for validity testing and subgroup analysis. In practice, a total of 456 adults were assessed: (1) Sinhala version: **259** participants (136 patients with mental disorders and 123 healthy individuals), and Tamil version: **197** participants (109 patients with mental disorders and 88 healthy individuals). For reliability testing, subsamples of 59 Sinhala-speaking and 53 Tamil-speaking participants were independently rated by two trained interviewers to evaluate inter-rater consistency.

Procedure

Each participant was independently assessed by: (1) A trained FLII-11 interviewer, using the relevant language version of the instrument; and (2) A consultant psychiatrist, whose clinical diagnosis served as the gold standard. For inter-rater reliability, a second interviewer administered the FLII-11 to a random subset of participants, remaining blinded to the results.

Data Entry Management and Analysis

Data were collected electronically using Samsung Galaxy A9 tablets with secure internet connectivity. All responses were directly entered into the QUALTRICS data platform, which was maintained and technically supported by Columbia University. The QUALTRICS system ensured real-time data capture, automatic skip logic, and reduced transcription errors through built-in validation checks. Following completion of data collection, the final anonymised datasets were exported and formally handed over by Columbia University to the Sri Lankan research team for statistical analysis. Data were stored in password-protected files accessible only to authorised investigators, ensuring confidentiality and compliance with ethical standards.

Initially, descriptive analyses were performed to summarize the sociodemographic characteristics of participants. Frequencies and percentages were calculated separately for participants with and without diagnosed mental disorders, for both Sinhala and Tamil language samples.

Subsequently, the FLII-11 diagnostic findings were summarized by domain, presenting the lifetime and current prevalence of each disorder category as defined in ICD-11. Finally, the validation analysis was conducted by comparing FLII-11 diagnostic classifications with the gold standard psychiatric diagnosis using cross-tabulation.

From these comparisons, the following validity indices were computed:

- Sensitivity
- Specificity
- Positive Predictive Value (PPV)
- Negative Predictive Value (NPV)
- Overall diagnostic accuracy
- Inter-rater reliability was evaluated using Cronbach's α and the Intraclass Correlation Coefficient (ICC) (two-way mixed-effects model, consistency definition) based on a subset of participants rated independently by two trained assessors.

Ethical Considerations

Ethical approval was obtained from the Ethics Review Committee of the National Institute of Health Sciences (NIHS), Kalutara. Administrative approval was granted by the Director-General of Health Services, Ministry of Health, Sri Lanka. Written informed consent was obtained from all participants. All data were handled in accordance with national research-ethics guidelines and international data-protection standards.

Results – Sinhala Language

A total of 263 participants who spoke Sinhala were recruited. Of these, 4 participants were excluded from the analysis as gold-standard diagnostic data were unavailable**.** Therefore, the final effective sample size for the Sinhala component was 259**.**

Demographic Information

The patients were categorised as either "patients" or "healthy" at the time of recruitment. This categorisation was completed before a psychiatrist assessed the participants, and the same categorisation was used in the demographic information section. Among these 259 participants, 137 (52.9%) were patients and 122 (47.1%) were healthy individuals, as determined by the gold standard. Among patients, the majority were employed either full-time (37.2%) or part-time (19.0%), while 21.2% were homemakers. In contrast, among healthy individuals, full-time workers accounted for 38.5%, homemakers 24.6%, and retirees 14.8%. Unemployment was higher among healthy individuals (13.1%) than among patients (5.8%) (Table 1).

Table 1: Employment Status

Employment status	Patients n (%)	Healthy individuals n (%)	Total n (%)
Working full-time	51 (37.2)	47 (38.5)	98 (37.8)
Unemployed	8 (5.8)	16 (13.1)	24 (9.3)
Working part-time (includes seasonal labour)	26 (19.0)	6 (4.9)	32 (12.4)
Homemaker or stay-at-home spouse or parent	29 (21.2)	30 (24.6)	59 (22.8)
Student	11 (8.0)	4 (3.3)	15 (5.8)
Retired	11 (8.0)	18 (14.8)	29 (11.2)
Other (none of the above)	1 (0.7)	1 (0.8)	2 (0.8)
Total	**137 (100.0)**	**122 (100.0)**	**259 (100.0)**

Most participants had education up to the Ordinary Level in both groups (47.4% of patients and 39.3% of healthy individuals). A higher proportion of healthy individuals had a tertiary education (27.9%) than patients (15.3%), suggesting slightly higher educational attainment in the healthy comparison group (Table 2).

Table 2: Sample characteristics by education and participation type

Education level	Patients n (%)	Healthy individuals n (%)	Total n (%)
Up to Ordinary Level	65 (47.4)	48 (39.3)	113 (43.6)
Grade 12 to 13	51 (37.2)	40 (32.8)	91 (35.1)
Tertiary Education	21 (15.3)	34 (27.9)	55 (21.2)
Total	**137 (100.0)**	**122 (100.0)**	**259 (100.0)**

The majority of patients (38.0%) were aged 30 years or less, whereas healthy individuals were more commonly found in the older age groups, particularly 51–60 years (27.9%) and 61 years or more (23.8%). This suggests that the patient group was generally younger than the healthy comparison group.

Table 3: Age of the study population

Age group (years)	Patients n (%)	Healthy individuals n (%)	Total n (%)
30 or less	52 (38.0)	29 (23.8)	81 (31.3)
31 to 40	24 (17.5)	13 (10.7)	37 (14.3)
41 to 50	25 (18.2)	17 (13.9)	42 (16.2)
51 to 60	20 (14.6)	34 (27.9)	54 (20.8)
61 or more	16 (11.7)	29 (23.8)	45 (17.4)
Total	**137 (100.0)**	**122 (100.0)**	**259 (100.0)**

Nearly half of the patients (49.6%) and over three-fifths of healthy individuals (62.3%) were married or living with a partner. The proportion of single participants was slightly higher among patients (29.2%) compared to healthy individuals (21.3%). Divorced or separated status was more common among patients (5.8%) than in the healthy group (2.5%) (Table 4).

Table 4: Marital or relationship status

Marital or relationship status	Patients n (%)	Healthy individuals n (%)	Total n (%)
Single	40 (29.2)	26 (21.3)	66 (25.5)
In a relationship but not living together	13 (9.5)	10 (8.2)	23 (8.9)
Married or cohabitating with a partner	68 (49.6)	76 (62.3)	144 (55.6)
Divorced / Separated	8 (5.8)	3 (2.5)	11 (4.2)
Widowed	8 (5.8)	7 (5.7)	15 (5.8)
Total	**137 (100.0)**	**122 (100.0)**	**259 (100.0)**

The majority of participants in both groups were Sinhala-speaking (90.5% of patients and 91.8% of healthy individuals). Tamil speakers accounted for 8.0% of patients and 7.4% of healthy individuals. Only a few participants reported Malay or other languages as their first language.

Table 5: First Language of participants

First language	Patients n (%)	Healthy individuals n (%)	Total n (%)
Sinhala	124 (90.5)	112 (91.8)	236 (91.1)
Tamil	11 (8.0)	9 (7.4)	20 (7.7)
Malay	1 (0.7)	1 (0.8)	2 (0.8)
Other	1 (0.7)	0 (0.0)	1 (0.4)
Total	**137 (100.0)**	**122 (100.0)**	**259 (100.0)**

Most participants whose first language was not Sinhala reported excellent or fluent understanding (46.2% of patients and 50.0% of healthy individuals). A fair level of understanding was seen among 30.8% of patients and 20.0% of healthy individuals, while poor understanding was limited to only two patients (15.4%).

Table 6: When First Language is not Sinhala, the ability to understand

Ability to understand Sinhala	Patients n (%)	Healthy individuals n (%)	Total n (%)
Poor	2 (15.4)	0 (0.0)	2 (8.7)
Fair	4 (30.8)	2 (20.0)	6 (26.1)
Good	1 (7.7)	3 (30.0)	4 (17.4)
Excellent or fluent	6 (46.2)	5 (50.0)	11 (47.8)
Total	**13 (100.0)**	**10 (100.0)**	**23 (100.0)**

A higher proportion of healthy individuals (72.1%) reported household income above the poverty line compared to patients (54.0%). Conversely, 43.8% of patients reported income levels below the poverty line, nearly double that of healthy individuals (27.0%). Only a small proportion in either group reported income about the same as the poverty line.

Table 7: Income compared to poverty line

Income compared to poverty line	Patients n (%)	Healthy individuals n (%)	Total n (%)
More	74 (54.0)	88 (72.1)	162 (62.5)
Less	60 (43.8)	33 (27.0)	93 (35.9)
About the same	3 (2.2)	1 (0.8)	4 (1.5)
Total	**137 (100.0)**	**122 (100.0)**	**259 (100.0)**

A higher proportion of patients (n = 82, 59.9%) reported that they would not be able to buy food or pay housing costs if their income were stopped, compared to 49.2% (n = 60) among healthy individuals. Conversely, over half of the healthy participants (n = 62, 50.8%) indicated they could meet their basic needs for at least one month without income, highlighting greater economic resilience among the healthy comparison group.

Table 8: Ability to meet basic needs if income were stopped

Ability to meet basic needs if income were stopped	Patients n (%)	Healthy individuals n (%)	Total n (%)
No	82 (59.9)	60 (49.2)	142 (54.8)
Yes	55 (40.1)	62 (50.8)	117 (45.2)
Total	**137 (100.0)**	**122 (100.0)**	**259 (100.0)**

FLII -11 questionnaire findings

The Flexible Interview for ICD-11 (FLII-11) was administered to all 259 Sinhala-speaking participants to assess the presence of mental and behavioural disorders according to ICD-11 diagnostic criteria. The instrument evaluates symptoms across 14 diagnostic domains, encompassing both lifetime and current conditions.

These domains include

1. Mood Episodes (Depressive, Manic, and Mixed Episodes)
2. Psychotic Symptoms
3. Primary Psychotic Disorders
4. Anxiety and Fear-related Disorders
5. Obsessive–Compulsive and Related Disorders
6. Post-Traumatic Stress Disorder (PTSD) and Complex PTSD
7. Eating Disorders
8. Substance Use Disorders
9. Addictive Behaviour Disorders (e.g., Gambling, Gaming)
10. Attention Deficit Hyperactivity Disorder (ADHD)
11. Possible Secondary Mental or Behavioural Syndromes
12. Possible Substance-Induced Mental or Behavioural Disorders
13. Suicidal Ideation and Behaviour
14. Other Specified or Residual Conditions

The following subsections present the distribution of cases within each diagnostic domain based on FLII-11 findings, with separate reporting of lifetime and current prevalence wherever applicable.

Mixed Episodes

Among the 259 Sinhala-speaking participants, one-fifth (20.5%) had experienced a lifetime depressive episode, with 21.2% currently reporting depressive symptoms. Manic episodes were less frequent, observed in 10.4% of individuals over their lifetime and in 3.9% currently. Mixed episodes were identified in 6.6% of participants during their lifetime. Overall, depressive symptoms were the most prevalent mood-related condition in both lifetime and current assessments, whereas manic and mixed episodes were comparatively less common.

Table 9: Mixed Episodes

Type of mood episode	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n n (%)	Current – No n n (%)	Total (n)
Depressive episode	53 (20.5)	206 (79.5)	55 (21.2)	204 (78.8)	259
Manic episode	27 (10.4)	232 (89.6)	10 (3.9)	249 (96.1)	259
Mixed episode	-	-	17 (6.6)	242 (93.4)	259

Psychotic Symptoms

Psychotic symptoms were relatively uncommon among the Sinhala-language participants. The most frequent lifetime symptom was passivity experiences (13.1%), followed by persecutory delusions (10.8%) and reference delusions (8.9%). Lifetime hallucinations were reported less often, with olfactory hallucinations (6.6%) being the most common sensory type. Current psychotic symptoms were rare, all under 5%, except for passivity experiences which persisted in 13.1% of participants. These findings indicate that delusional experiences—particularly persecutory and reference types—were more commonly reported than hallucinations, consistent with patterns typically seen in community-based samples rather than clinical psychosis populations.

Table 10:Psychotic Symptoms

Type of psychotic symptom	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n (%)	Current – No n (%)	Total (n)
Persecutory delusion	28 (10.8)	231 (89.2)	10 (3.9)	249 (96.1)	259
Grandiose delusion	20 (7.7)	239 (92.3)	8 (3.1)	251 (96.9)	259
Guilt delusion	6 (2.3)	253 (97.7)	4 (1.5)	255 (98.5)	259
Somatic delusion	7 (2.7)	252 (97.3)	6 (2.3)	253 (97.7)	259
Jealousy delusion	10 (3.9)	249 (96.1)	1 (0.4)	258 (99.6)	259
Reference delusion	23 (8.9)	236 (91.1)	11 (4.2)	248 (95.8)	259
Passivity experiences	34 (13.1)	225 (86.9)	34 (13.1)	225 (86.9)	259
Auditory hallucination	9 (3.5)	250 (96.5)	4 (1.5)	255 (98.5)	259
Visual hallucination	6 (2.3)	253 (97.7)	1 (0.4)	258 (99.6)	259
Tactile hallucination	4 (1.5)	255 (98.5)	2 (0.8)	257 (99.2)	259
Gustatory hallucination	8 (3.1)	251 (96.9)	8 (3.1)	251 (96.9)	259
Olfactory hallucination	17 (6.6)	242 (93.4)	9 (3.5)	250 (96.5)	259

Probable Primary Psychotic Disorder

A probable primary psychotic disorder was identified in nearly one-third of participants (30.5%) across their lifetime, while 27.0% were experiencing such symptoms at the time of assessment. These relatively high proportions reflect that the Sinhala-language sample included a significant number of participants with enduring or recurrent psychotic features, consistent with findings from earlier modules showing persistent passivity experiences and persecutory delusions.

Table 11: Probable Primary Psychotic Disorder

Condition status	**Lifetime n (%)**	**Current n (%)**	**Total (n)**
Present (Yes)	79 (30.5)	70 (27.0)	259
Absent (No)	180 (69.5)	189 (73.0)	259
Total	259 (100.0)	259 (100.0)	259

Mood Disorders

Approximately 28.6% of participants had experienced a lifetime mood disorder, while 23.2% were experiencing current mood-related symptoms at the time of assessment. Conversely, 71.4% had no lifetime history of mood disorders, and 76.8% were currently asymptomatic. These findings suggest that mood disturbances were relatively common within the Sinhala-language sample, consistent with the earlier detailed results showing depressive episodes as the most frequently identified mood condition.

Table 12: Mood Disorders

Condition status	Lifetime n (%)	Current n (%)	Total (n)
Present (Yes)	74 (28.6)	60 (23.2)	259
Absent (No)	185 (71.4)	199 (76.8)	259
Total	259 (100.0)	259 (100.0)	259

Anxiety and Fear-Related Disorders

Anxiety and fear-related disorders were generally less common among participants in the Sinhala-language sample. The most prevalent lifetime conditions were generalized anxiety disorder (15.8%) and panic attacks (15.4%), while current symptoms of panic attacks were observed in only 3.1%. Social anxiety disorder was reported by 6.9% lifetime and 5.4% currently. Agoraphobia was rare, identified in less than 1% of participants for both lifetime and current presentations. Overall, the findings indicate that while transient anxiety experiences such as panic attacks were relatively frequent, persistent anxiety disorders were less prevalent, with most participants not meeting criteria for any current anxiety-related condition.

Table 13: Anxiety and Fear-Related Disorders

Disorder	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n (%)	Current – No n (%)	Total (n)
Panic attack	40 (15.4)	219 (84.6)	8 (3.1)	251 (96.9)	259
Agoraphobia	2 (0.8)	257 (99.2)	1 (0.4)	258 (99.6)	259
Generalized anxiety disorder (GAD)	41 (15.8)	218 (84.2)	–	–	259
Social anxiety disorder	18 (6.9)	241 (93.1)	14 (5.4)	245 (94.6)	259

Obsessive-Compulsive and Related Disorders (OCD and Hypochondriasis)

Among obsessive–compulsive and related disorders, OCD was observed in 5.8% (lifetime) and 7.7% (current) of participants, whereas hypochondriasis was rare, identified in only 1.5% lifetime and none currently. Overall, these results suggest that persistent obsessive or

compulsive symptoms were present in a small proportion of individuals, while excessive health-related fears were almost absent in this Sinhala-language sample.

Table 14:Obsessive-Compulsive and Related Disorders (OCD and Hypochondriasis)

Disorder	Condition status	Lifetime n (%)	Current n (%)	Total (n)
Obsessive–Compulsive Disorder (OCD)	Present (Yes)	15 (5.8)	20 (7.7)	259
	Absent (No)	244 (94.2)	239 (92.3)	259
Hypochondriasis	Present (Yes)	4 (1.5)	0 (0.0)	259
	Absent (No)	255 (98.5)	259 (100.0)	259

Post-Traumatic Stress Disorder (PTSD) and Complex PTSD

Among the Sinhala-language participants, 3.9% reported lifetime PTSD, while 2.3% were currently experiencing symptoms consistent with the disorder. Complex PTSD was identified in 1.9% of the sample at the time of assessment. Overall, post-traumatic stress–related conditions were relatively uncommon in the sample, suggesting a limited prevalence of trauma-linked psychopathology within this population group.

Table 15: Post-Traumatic Stress Disorder (PTSD) and Complex PTSD

Disorder	Condition status	Lifetime n (%)	Current n (%)	Total (n)
Post-Traumatic Stress Disorder (PTSD)	Present (Yes)	10 (3.9)	6 (2.3)	259
	Absent (No)	249 (96.1)	253 (97.7)	259
Complex PTSD (CPTSD)	Present (Yes)	–	5 (1.9)	259
	Absent (No)	–	254 (98.1)	259

Eating Disorders

Eating disorders were exceptionally rare among participants in the Sinhala-language sample. No cases of anorexia nervosa or bulimia nervosa were identified, and only one participant (0.4%) met criteria for binge-eating disorder, both lifetime and current. This finding indicates a very low prevalence of disordered eating behaviours in the study population.

Table 16: Eating Disorders

Disorder	Lifetime – Yes n (%)	Current – Yes n (%)	Total (n)
Anorexia nervosa	0 (0.0)	0 (0.0)	259
Bulimia nervosa	0 (0.0)	0 (0.0)	259
Binge-eating disorder	1 (0.4)	1 (0.4)	259

Disorders Due to Substance Use

Alcohol (5.0%) and nicotine (2.7%) were the most frequently reported lifetime dependence disorders. Dependence on other substances such as cannabis (2.7%), sedatives, and stimulants was rare, and several categories (e.g., cocaine, inhalants, cathinones) had only isolated current cases (0.4%). Overall, current dependence across all substances was low (≤ 0.4% per category). These findings indicate that substance dependence disorders were minimal in this community-based Sinhala-speaking validation cohort, with alcohol being the most commonly identified substance of concern.

Table 17: Disorders Due to Substance Use

Substance use disorder	Lifetime – Yes n (%)	Current – Yes n (%)	Total (n)
Alcohol	13 (5.0)	1 (0.4)	259
Cannabis	7 (2.7)	1 (0.4)	259
Opiates	0 (0.0)	1 (0.4)	259
Sedatives	1 (0.4)	1 (0.4)	259
Stimulants	2 (0.8)	1 (0.4)	259
Hallucinogenics	1 (0.4)	1 (0.4)	259
MMDA	0 (0.0)	1 (0.4)	259
Other substances	2 (0.8)	1 (0.4)	259
Cathinones	0 (0.0)	1 (0.4)	259
Cocaine	0 (0.0)	1 (0.4)	259
Inhalants	0 (0.0)	1 (0.4)	259
Nicotine	7 (2.7)	1 (0.4)	259
Dissociative substances	0 (0.0)	1 (0.4)	259
Synthetic cannabis	1 (0.4)	1 (0.4)	259

Disorders Due to Addictive Behaviours

Both gambling and gaming disorders were rare among the Sinhala-language participants. Only one individual (0.4%) reported lifetime symptoms of each disorder. Current gaming-related problems were slightly higher (1.2%), while gambling disorder remained constant at 0.4%. These findings suggest that behavioural addictions were minimal, reflecting a very low prevalence of problematic gambling or gaming behaviour in the community sample.

Table 18: Disorders Due to Addictive Behaviours

Disorder	Lifetime – Yes n (%)	Current – Yes n (%)	Total (n)
Gambling disorder	1 (0.4)	1 (0.4)	259
Gaming disorder	1 (0.4)	3 (1.2)	259

Attention Deficit Hyperactivity Disorder

At the time of assessment, 5 participants (1.9%) met criteria for ADHD, while 98.1% showed no symptoms consistent with the disorder. This reflects a low prevalence of current attention-related difficulties among the Sinhala-language participants.

Table 19: Attention Deficit Hyperactivity Disorder

Condition status	Current n (%)	Total (n)
Present (Yes)	5 (1.9)	259
Absent (No)	254 (98.1)	259
Total	259 (100.0)	259

Possible Secondary Mental or Behavioural Syndrome

Only a small proportion (1.5%) of participants demonstrated a possible secondary syndrome associated with a single depressive episode (SEDD), while bipolar I disorder and generalized anxiety disorder each showed isolated cases (0.8%). No secondary syndromes were observed in relation to other conditions such as recurrent depression, psychotic, panic, or obsessive–compulsive disorders. Overall, these findings indicate that secondary mental or behavioural syndromes were uncommon, suggesting that the majority of identified conditions in this cohort were primary disorders rather than secondary to medical conditions.

Table 20:Possible Secondary Mental or Behavioural Syndrome

Disorder	Current – Yes n (%)	Total (n)
Single Episode Depressive Disorder (SEDD)	4 (1.5)	259
Recurrent Depressive Disorder (RDD)	0 (0.0)	259
Bipolar Disorder I (BD-I)	2 (0.8)	259
Bipolar Disorder II (BD-II)	0 (0.0)	259
Probable Psychotic Disorder (PPD)	0 (0.0)	259
Panic Disorder (PD)	0 (0.0)	259
Agoraphobia (AGO)	0 (0.0)	259
Generalized Anxiety Disorder (GAD)	2 (0.8)	259
Social Anxiety Disorder (SAD)	0 (0.0)	259
Obsessive–Compulsive Disorder (OCD)	0 (0.0)	259
Hypochondriasis (HYP)	0 (0.0)	259

Suicidal Ideation and Behaviour Screening

Passive suicidal ideation was reported by 17.0%, indicating thoughts about death or wishing to die without active planning. Active suicidal ideation, involving more deliberate or specific thoughts about ending one's life, was found in 5.8%. Suicide attempts were reported by 3.9% of participants, while non-suicidal self-directed injury (NSDSI) occurred in 5.8%.

Overall, approximately one in six participants expressed some form of suicidal ideation, underscoring the importance of routine screening and referral for suicide risk assessment even in non-clinical or community-based populations.

Table 21: Type of suicidal thought or behaviour

Type of suicidal thought or behaviour	**Current – Yes n (%)**	**Total (n)**
Passive suicidal ideation	44 (17.0)	259
Active suicidal ideation	15 (5.8)	259
Suicide attempt	10 (3.9)	259
Non-suicidal self-directed injury (NSDSI)	15 (5.8)	259

Validation of FLII-11 Against the Gold Standard Assessment

Criterian Validity

Out of 136 participants clinically diagnosed with a mental disorder, 77.2 % were correctly identified by the FLII-11, while 22.8 % were missed (false negatives). Among 123 clinically healthy participants, 76.4 % were correctly classified as having no mental disorder, and 23.6 % were misclassified as positive (false positives). Overall, the FLII-11 correctly classified 76.9 % of participants, showing good agreement with the Gold Standard and balanced sensitivity (77.2 %) and specificity (76.4 %).

Table 22: Cross Tabulation of FLII-11 Findings and Gold Standard Diagnosis (Sinhala)

	FLII -11 Findings		
Gold Standard Diagnosis	**No Mental disorder**	**Mental disorder**	**Total (n)**
Mental disorder	31 (22.8 %)	105 (77.2 %)	136
No Mental disorder (Healthy)	94 (76.4 %)	29 (23.6 %)	123
Total	125 (48.3 %)	134 (51.7 %)	259

The positive predictive value (PPV) of 78.4 % suggests that four out of five persons identified by the questionnaire as having a mental illness were confirmed by the clinician's diagnosis. Similarly, the negative predictive value (NPV) of 75.2 % indicates that roughly three-quarters of those screened as "no mental condition" were truly healthy according to the Gold Standard. The overall accuracy was 76.9 % (95 % CI = 71.4 % – 81.7 %), reflecting good agreement between the two assessment methods. The 95 % confidence intervals are relatively narrow, implying adequate precision of the estimates within this sample of 259 participants. Collectively, these findings confirm that the FLII-11 Sinhala version performs well as a screening and diagnostic tool, capable of detecting most true cases while maintaining acceptable specificity in a community setting.

Table 23: Diagnostic Accuracy (Sinhala)

Metric	**Formula**	**Estimate**	**95 % CI**
Sensitivity	105 / (105 + 31)	77.2 %	69.5 % – 83.3 %
Specificity	94 / (94 + 29)	76.4 %	68.0 % – 83.0 %
PPV	105 / (105 + 29)	78.4 %	70.6 % – 84.7 %
NPV	94 / (94 + 31)	75.2 %	66.7 % – 82.2 %
Overall Accuracy	(105 + 94) / 259	76.9 %	71.4 % – 81.7 %

Inter-rater reliability

The reliability analysis showed good to excellent inter-rater agreement between the two raters for the Sinhala version of the FLII-11. The Cronbach's alpha coefficient of 0.844 indicates strong internal consistency between the two raters. The Intraclass Correlation Coefficient (ICC) for Average Measures was 0.844 (95% CI: 0.738–0.907; $p < 0.001$), representing excellent reliability. The Single-Measures ICC of 0.731 suggests good reliability for individual raters. These results demonstrate that the Sinhala version of the FLII-11 produces consistent diagnostic outcomes across independent assessors, confirming that the tool maintains high inter-rater reliability when applied by trained interviewers in field conditions.

Table 24: Inter-rater reliability results

Statistic	Value	95% CI	F-test (df1, df2)	p-value
Cronbach's Alpha	0.844	–	–	–
Intraclass Correlation Coefficient (ICC)				
Single Measures	0.731	0.585 – 0.831	F = 6.427 (58, 58)	p < 0.001
Average Measures	0.844	0.738 – 0.907	F = 6.427 (58, 58)	p < 0.001
Number of raters/items	2	–	–	–
Number of cases	59	–	–	–

Results – Tamil Language

A total of 200 participants completed both the Flexible Interview for ICD-11 (FLII-11) and the Interviewer Experiencing Questionnaire (IEQ). However, the Gold Standard clinical diagnosis was not available for three participants. Therefore, validation analyses comparing the FLII-11 with the Gold Standard were conducted on a final sample of 197 participants.

Demographic Information

The patients were categorised as either “patients” or “healthy” at the time of recruitment. This categorisation was completed before a psychiatrist assessed the participants, and the same categorisation was used in the demographic information section.

Among the 197 participants included in the validation analysis, females predominated, representing 65.5% of the total sample, while males accounted for 34.5%.

Table 25: Gender distribution of the participants

Gender	Patients n (%)	Healthy individuals n (%)	Total n (%)
Male	49 (45.0)	19 (21.60)	68 (34.50)
Female	60 (55.0)	69 (78.40)	129 (65.50)
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

Among the 197 participants, nearly half (47.2%) were working full-time, followed by 21.3% homemakers and 13.7% part-time or seasonal workers. A higher proportion of healthy individuals (62.5%) were in full-time employment compared to patients (34.9%), whereas part-time or seasonal employment was more frequent among patients (22.0%) than healthy individuals (3.4%).

Table 26: Employment status

Employment status	Patients n (%)	Healthy individuals n (%)	Total n (%)
Working full-time	38 (34.9)	55 (62.5)	93 (47.2)
Unemployed	9 (8.3)	3 (3.4)	12 (6.1)
Working part-time (includes seasonal labour)	24 (22.0)	3 (3.4)	27 (13.7)
Homemaker or stay-at-home spouse or parent	26 (23.9)	16 (18.20)	42 (21.3)
Student	8 (7.3)	7 (8.0)	15 (7.6)
Retired	4 (3.7)	4 (4.5)	8 (4.1)
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

Almost half of the participants (45.2%) had education up to the Ordinary Level, while 34.0% had attained tertiary education and 20.8% had completed advanced-level studies (Grades 12–13). A higher proportion of healthy individuals (42.0%) possessed tertiary-level education compared to patients (27.5%), whereas lower educational attainment (up to O/L) was more common among patients (49.5%).

Table 27: Education Status

Education	Patients n (%)	Healthy individuals n (%)	Total n (%)
Up to Ordinary Level	54 (49.5)	35 (39.8)	**89 (45.2)**
Grade 12 to 13	25 (22.9)	16 (18.2)	**41 (20.8)**
Tertiary Education	30 (27.5)	37 (42.0)	**67 (34.0)**
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

The majority of participants were aged 40 years or below (56.3%), with the largest proportion (34.0%) in the ≤30 years category. Among healthy individuals, younger participants were more common (45.5% ≤30 years), whereas the patient group showed a broader age distribution, with similar proportions across the 31–50-year range (approximately 25% in each). Older adults (aged 51 years and above) accounted for 22.4% of the total sample, with comparable representation across groups.

Table 28: Age Distribution

Age Category	Patients n (%)	Healthy individuals n (%)	Total n (%)
30 or less	27 (24.8)	40 (45.5)	67 (34.0)
31 to 40	27 (24.8)	17 (19.3)	44 (22.3)
41 to 50	28 (25.7)	14 (15.9)	42 (21.3)
51 to 60	12 (11.0)	10 (11.4)	22 (11.2)
61 or more	15 (13.8)	7 (8.00)	22 (11.2)
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

More than half of all participants (54.8%) were married or cohabitating with a partner, while 29.9% were single and 8.1% were in a relationship but not living together. The marital distribution was similar between patients and healthy individuals, with only minor differences observed.

Table 29: Marital Status

Current marital status	Patients n (%)	Healthy individuals n (%)	Total n (%)
Single	34 (31.2)	25 (28.4)	59 (29.9)
In a relationship but not living together	6 (5.5)	10 (11.4)	16 (8.1)
Married or cohabitating with a partner	59 (54.1)	49 (55.7)	108 (54.8)
Divorced/Separated	5 (4.6)	1 (1.1)	6 (3.0)
Widowed	5 (4.6)	3 (3.4)	8 (4.1)
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

The majority of participants (92.4%) lived with others for at least half of the time, while only 7.6% lived alone. A similar pattern was observed in both groups—91.7% of patients and 93.2% of healthy individuals lived with others—indicating no major difference in living arrangements between groups.

Table 30: Living Alone or with partners

Live alone/with others (at least 50% of the time)	Patients n (%)	Healthy individuals n (%)	Total n (%)
Alone	9 (8.3)	6 (6.8)	15 (7.6)
With others	100 (91.7)	82 (93.2)	182 (92.4)
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

All participants in the validation study reported Tamil as their first language.

Table 31: Language of Participants

First language	Patients n (%)	Healthy individuals n (%)	Total n (%)
Tamil	109 (100.0)	88 (100.0)	197 (100.0)
Total	109 (100.0)	88 (100.0)	19700.0)

A majority of participants (62.4%) reported incomes above the poverty line, while 32.5% had incomes below the poverty line, and 5.1% reported an income about the same as the poverty line. Over 78% of healthy individuals reported income above the poverty line compared to 49.5% of patients.

Table 32: Income compared to poverty line

Income compared to poverty line	Patients n (%)	Healthy individuals n (%)	Total n (%)
More	54 (49.5)	69 (78.4)	123 (62.4)
Less	48 (44.0)	16 (18.2)	64 (32.5)
About the same	7 (6.4)	3 (3.4)	10 (5.1)
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

When asked whether they could meet their basic needs (such as food and housing) if their income were suddenly stopped, 56.9% of participants responded “Yes”, while 43.1% reported that they could not. A greater proportion of healthy individuals (61.4%) indicated that they could sustain their basic needs compared to patients (53.2%), suggesting better financial resilience among the healthy group.

Table 33: Ability to meet basic needs if income were stopped

Ability to meet basic needs if income were stopped	Patients n (%)	Healthy individuals n (%)	Total n (%)
No	51 (46.8)	34 (38.6)	85 (43.1)
Yes	58 (53.2)	54 (61.4)	112 (56.9)
Total	**109 (100.0)**	**88 (100.0)**	**197 (100.0)**

FLII-11 Questionnaire findings

The Flexible Interview for ICD-11 (FLII-11) was administered to all 197 Tamil-speaking participants to assess the presence of mental and behavioural disorders according to ICD-11 diagnostic criteria. The instrument evaluates symptoms across 14 diagnostic domains, encompassing both lifetime and current conditions.

These domains include:

1. Mood Episodes (Depressive, Manic, and Mixed Episodes)
2. Psychotic Symptoms
3. Primary Psychotic Disorders
4. Anxiety and Fear-related Disorders
5. Obsessive–Compulsive and Related Disorders
6. Post-Traumatic Stress Disorder (PTSD) and Complex PTSD
7. Eating Disorders
8. Substance Use Disorders
9. Addictive Behaviour Disorders (e.g., Gambling, Gaming)
10. Attention Deficit Hyperactivity Disorder (ADHD)
11. Possible Secondary Mental or Behavioural Syndromes
12. Possible Substance-Induced Mental or Behavioural Disorders
13. Suicidal Ideation and Behaviour
14. Other Specified or Residual Conditions

The following subsections present the distribution of cases within each diagnostic domain based on FLII-11 findings, with separate reporting of lifetime and current prevalence wherever applicable.

Mood Episodes (Depressive, Manic, and Mixed Episodes)

Among the 197 Tamil-speaking participants, depressive episodes were the most commonly reported mood condition, identified in 6.6% lifetime and 19.3% current cases. Manic episodes were less frequent (6.1% lifetime; 3.0% current), while mixed episodes—featuring simultaneous depressive and manic symptoms—were rare (1.0% current).

Table 34: Mood Episodes

Type of mood episode	Lifetime – Yes n (%)	Current – Yes n (%)	Total (n)
Depressive episode	13 (6.6)	38 (19.3)	197
Manic episode	12 (6.1)	6 (3.0)	197
Mixed episode	-	2 (1.0)	197

Psychotic Symptoms

Across the sample, psychotic symptoms were present in a minority of participants, though certain symptom types were relatively more frequent. Persecutory delusions (17.8% lifetime;

10.2% current) and passivity experiences (15.7% lifetime and current) were the most commonly reported. Grandiose and reference delusions were observed in around 10% lifetime, while hallucinatory experiences—especially auditory hallucinations (9.1% lifetime; 6.6% current)—were less frequent but clinically relevant. Other symptom types, such as somatic, jealousy, guilt, tactile, gustatory, and olfactory experiences, were rare (<5%).

Table 35: Type of psychotic symptom

Type of psychotic symptom	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n (%)	Current – No n (%)	Total (n)
Persecutory delusion	35 (17.8)	162 (82.2)	20 (10.2)	177 (89.8)	197
Grandiose delusion	20 (10.2)	177 (89.8)	13 (6.6)	184 (93.4)	197
Guilt delusion	13 (6.6)	184 (93.4)	9 (4.6)	188 (95.4)	197
Somatic delusion	4 (2.0)	193 (98.0)	4 (2.0)	193 (98.0)	197
Jealousy delusion	5 (2.5)	192 (97.5)	3 (1.5)	194 (98.5)	197
Delusion of reference	15 (7.6)	182 (92.4)	9 (4.6)	188 (95.4)	197
Passivity experiences	31 (15.7)	166 (84.3)	31 (15.7)	166 (84.3)	197
Auditory hallucination	18 (9.1)	179 (90.9)	13 (6.6)	184 (93.4)	197
Visual hallucination	4 (2.0)	193 (98.0)	3 (1.5)	194 (98.5)	197
Tactile hallucination	6 (3.0)	191 (97.0)	4 (2.0)	193 (98.0)	197
Gustatory hallucination	3 (1.5)	194 (98.5)	2 (1.0)	195 (99.0)	197
Olfactory hallucination	6 (3.0)	191 (97.0)	4 (2.0)	193 (98.0)	197

Primary Psychotic Disorders

Among the 197 participants, 31.0% were identified as having a lifetime probable primary psychotic disorder, while 25.9% were currently meeting criteria for such a condition.

Table 36: Probable primary psychotic disorder

Condition status	Lifetime – n (%)	Current – n (%)	Total (n)
Yes	61 (31.0)	51 (25.9)	197
No	136 (69.0)	146 (74.1)	197
Total	197 (100.0)	197 (100.0)	197

Mood Disorders

Across the 197 participants, 12.7% were identified as having experienced a lifetime mood disorder, while 21.8% were currently experiencing symptoms consistent with a mood disorder.

Table 37: The mood disorders

Condition status	Lifetime – n (%)	Current – n (%)	Total (n)
Yes (Mood disorder present)	25 (12.7)	43 (21.8)	197
No	172 (87.3)	154 (78.2)	197
Total	197 (100.0)	197 (100.0)	197

Anxiety and Fear-Related Disorders

Symptoms within the anxiety and fear-related disorder domain were relatively uncommon among the Tamil-speaking participants, though panic attacks were reported more frequently than other anxiety conditions. Panic attacks were experienced by 24.9% of participants at some point, but only 3.0% met criteria for lifetime panic disorder, and 1.5% currently. Generalised anxiety disorder (GAD) was identified in 7.1% of participants currently. Social anxiety disorder and agoraphobia were present in 4.6% and 2.5%, respectively.

Table 38: Anxiety and Fear-Related Disorders

Disorder	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n (%)	Current – No n (%)	Total (n)
Panic attack	49 (24.9)	148 (75.1)	–	–	197
Panic disorder	6 (3.0)	191 (97.0)	3 (1.5)	194 (98.5)	197
Agoraphobia	4 (2.0)	193 (98.0)	5 (2.5)	192 (97.5)	197
Generalized anxiety disorder (GAD)	–	–	14 (7.1)	183 (92.9)	197
Social anxiety disorder	3 (1.5)	194 (98.5)	9 (4.6)	188 (95.4)	197

Obsessive-Compulsive and Related Disorders (OCD) and Hypochondriasis

Within the obsessive–compulsive and related disorders domain, a small proportion of participants reported clinically significant symptoms. Obsessive–Compulsive Disorder (OCD) was identified in 2.0% of participants on a lifetime basis and 5.6% currently, suggesting that current obsessive or compulsive symptoms were more prevalent than those reported historically. Hypochondriasis (health anxiety disorder) was relatively rare, observed in 0.5% lifetime and 1.5% current cases.

Table 39: Obsessive-Compulsive and Related Disorders (OCD and Hypochondriasis)

Disorder	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n (%)	Current – No n (%)	Total (n)
Obsessive–Compulsive Disorder (OCD)	4 (2.0)	193 (98.0)	11 (5.6)	186 (94.4)	197
Hypochondriasis (Health Anxiety Disorder)	1 (0.5)	196 (99.5)	3 (1.5)	194 (98.5)	197

Post-Traumatic Stress Disorder (PTSD) and Complex PTSD

Post-Traumatic Stress Disorder (PTSD) was identified in 2.5% of participants on a lifetime basis and 2.0% currently, suggesting a low but notable presence of trauma-related symptoms. Complex PTSD (CPTSD), characterized by additional symptoms such as affect dysregulation and relational disturbances, was observed in 1.0% of participants at the time of assessment.

Table 40: Post-Traumatic Stress Disorder (PTSD) and Complex PTSD

Disorder	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n (%)	Current – No n (%)	Total (n)
Post-Traumatic Stress Disorder (PTSD)	5 (2.5)	192 (97.5)	4 (2.0)	193 (98.0)	197
Complex PTSD (CPTSD)	–	–	2 (1.0)	195 (99.0)	197

Eating Disorders

All participants reported no lifetime or current symptoms consistent with anorexia nervosa, bulimia nervosa, or binge-eating disorder.

Disorders Due to Substance Use

Substance use disorders were rare in this Tamil-speaking validation sample. Alcohol use disorder was the most commonly identified condition, with 0.5% lifetime and 4.6% current prevalence, followed by nicotine use disorder (1.0% lifetime; 3.0% current). Very few participants reported use of opiates, stimulants, or other substances (each 0.5% current). No cases were detected for cannabis, sedatives, hallucinogenics, inhalants, or synthetic drugs.

Table 41:Disorders Due to Substance Use

Substance	Lifetime – Yes n (%)	Lifetime – No n (%)	Current – Yes n (%)	Current – No n (%)	Total (n)
Alcohol	1 (0.5)	196 (99.5)	9 (4.6)	188 (95.4)	197
Cannabis	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
Opiates	0 (0.0)	197 (100.0)	1 (0.5)	196 (99.5)	197
Sedatives	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
Stimulants	0 (0.0)	197 (100.0)	1 (0.5)	196 (99.5)	197
Hallucinogenics	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
MMDA	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
Other substances	0 (0.0)	197 (100.0)	1 (0.5)	196 (99.5)	197
Cathinones	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
Cocaine	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
Inhalants	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
Nicotine	2 (1.0)	195 (99.0)	6 (3.0)	191 (97.0)	197
Dissociative substances	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197
Synthetic cannabis	0 (0.0)	197 (100.0)	0 (0.0)	197 (100.0)	197

Disorders Due to Addictive Behaviours

No participants met the criteria for gambling disorder either in lifetime or current assessment. A single participant (0.5% lifetime) was identified with past gaming-related behavioural symptoms, though no current cases were detected.

Attention Deficit Hyperactivity Disorder

No participants met criteria for Attention Deficit Hyperactivity Disorder (ADHD) either currently or by lifetime history.

Possible Secondary Mental or Behavioural Syndrome

Only two participants (1.0%) demonstrated the presence of a possible secondary mental or behavioural syndrome, specifically one case each of Bipolar Disorder I (BD-I) and Generalized Anxiety Disorder (GAD).

Table 42: Possible secondary mental or behavioural syndrome

Disorder	Yes n (%)	No n (%)	Total (n)
Single Episode Depressive Disorder (SEDD)	0 (0.0)	197 (100.0)	197
Recurrent Depressive Disorder (RDD)	0 (0.0)	197 (100.0)	197
Bipolar Disorder I (BD-I)	1 (0.5)	196 (99.5)	197
Bipolar Disorder II (BD-II)	0 (0.0)	197 (100.0)	197
Probable Psychotic Disorder (PPD)	0 (0.0)	197 (100.0)	197
Panic Disorder (PD)	0 (0.0)	197 (100.0)	197
Generalized Anxiety Disorder (GAD)	1 (0.5)	196 (99.5)	197
Social Anxiety Disorder (SAD)	0 (0.0)	197 (100.0)	197
Obsessive–Compulsive Disorder (OCD)	0 (0.0)	197 (100.0)	197
Hypochondriasis (HYP)	0 (0.0)	197 (100.0)	197

Possible Substance-Induced Mental Disorder

The most frequent category was probable psychotic disorder (PPD), identified in 3.0% of participants, suggesting a small subgroup with psychotic features possibly linked to substance use.Other conditions associated with substance use—such as depressive (1.0–1.5%) and bipolar (1.0%) disorders—were detected in only a few individuals.

Table 43: Possible Substance-Induced Mental Disorder

Disorder	**Yes n (%)**	**No n (%)**	**Total (n)**
Single Episode Depressive Disorder (SEDD)	2 (1.0)	195 (99.0)	197
Recurrent Depressive Disorder (RDD)	3 (1.5)	194 (98.5)	197
Bipolar Disorder I (BD-I)	2 (1.0)	195 (99.0)	197
Bipolar Disorder II (BD-II)	0 (0.0)	197 (100.0)	197
Probable Psychotic Disorder (PPD)	6 (3.0)	191 (97.0)	197
Panic Disorder (PD)	0 (0.0)	197 (100.0)	197
Agoraphobia (AGO)	1 (0.5)	196 (99.5)	197
Generalized Anxiety Disorder (GAD)	0 (0.0)	197 (100.0)	197
Social Anxiety Disorder (SAD)	1 (0.5)	196 (99.5)	197
Obsessive–Compulsive Disorder (OCD)	0 (0.0)	197 (100.0)	197
Hypochondriasis (HYP)	0 (0.0)	197 (100.0)	197

Suicidal Ideation and Behaviour Screening

In the Tamil-speaking sample, 11.2% of participants reported having thoughts about ending their life in the past month, reflecting a notable level of passive suicidal ideation. Among those who reported such thoughts: 2.0% had made specific preparations for suicide, and 2.5% had attempted suicide but were interrupted or unsuccessful. Additionally, 2.5% reported non-suicidal self-directed injury (e.g., cutting or burning) without suicidal intent.

Item	Yes n (%)	No n (%)	Total (n)
Passive suicidal ideation	22 (11.2)	175 (88.8)	197
Active suicidal ideation	4 (2.0)	18 (9.1)	197
Suicide attempt	5 (2.5)	17 (8.6)	197
Non-suicidal self-directed injury (NSDSI)	5 (2.5)	192 (97.5)	197

Validation of FLII-11 Against the Gold Standard Assessment

Criterian Validity

Among the participants clinically diagnosed with a mental disorder, 76.1% were correctly identified as having a mental disorder by the FLII-11, while 23.9% were not detected (false negatives). Among healthy participants, 96.6% were accurately classified as having no mental disorder, while 3.4% were misclassified (false positives). In total, 43.7% of participants were classified as having a mental disorder by the FLII-11, which closely corresponds to the clinical prevalence (55.3%) found by the Gold Standard.

Table 44: Cross Tabulation of FLII-11 Findings and Gold Standard Diagnosis (Tamil)

	FLII -11 Findings		
Gold Standard Diagnosis	**No Mental disorder**	**Mental disorder**	**Total (n)**
Mental disorder	26 (23.9%)	83 (76.1%)	109 (55.3%)
No Mental disorder (Healthy)	85 (96.6%)	3 (3.4%)	88 (44.7%)
Total	111 (56.3%)	86 (43.7%)	197 (100.0%)

The Tamil version of the FLII-11 exhibited excellent diagnostic performance when compared with the Gold Standard clinical diagnosis. The sensitivity (76.1%) indicates that the FLII-11 correctly identified over three-quarters of individuals with a mental disorder. The specificity (96.6%) demonstrates an extremely low false-positive rate, meaning nearly all healthy individuals were correctly classified. The positive predictive value (96.5%) and negative predictive value (76.6%) further confirm the high agreement between FLII-11 and clinician-based assessments. The overall diagnostic accuracy (85.3%; 95% CI: 79.6–89.7) reflects robust performance, confirming that the Tamil version of the FLII-11 is both reliable and precise for identifying mental illness in clinical and community settings.

Table 45: Diagnostic Accuracy (Tamil)

Metric	**Formula**	**Estimate (%)**	**95% Confidence Interval (CI)**
Sensitivity	83 / (83 + 26)	76.1	67.1 – 83.4
Specificity	85 / (85 + 3)	96.6	90.4 – 98.9
Positive Predictive Value (PPV)	83 / (83 + 3)	96.5	90.7 – 98.8
Negative Predictive Value (NPV)	85 / (85 + 26)	76.6	68.1 – 83.4
Overall Accuracy	(83 + 85) / 197	85.3	79.6 – 89.7

Inter-rater reliability

To evaluate the inter-rater reliability of the Flexible Interview for ICD-11 (FLII-11), a subsample of 53 participants was independently assessed by two trained raters using the Tamil version of the instrument. This analysis aimed to determine the level of agreement between raters when classifying participants as having or not having a mental disorder according to the FLII-11.

Table 46: Inter-rater reliability results

Statistic	Value	95% Confidence Interval (CI)	F-test (df1, df2)	p-value
Cronbach's Alpha	0.896	–	–	–
Intraclass Correlation Coefficient (ICC)				
Single Measures	0.811	0.694 – 0.886	F = 9.576 (52, 52)	p < 0.001
Average Measures	0.896	0.819 – 0.940	F = 9.576 (52, 52)	p < 0.001
Number of raters/items	2	–	–	–
Number of cases	53	–	–	–

The reliability analysis demonstrated excellent internal consistency and inter-rater agreement between the two assessors. The Cronbach's alpha coefficient of 0.896 indicated strong consistency between raters. The Intraclass Correlation Coefficient (ICC) for Average Measures was 0.896 (95% CI: 0.819–0.940; $p < 0.001$), confirming excellent agreement between raters according to conventional benchmarks (ICC > 0.75 = good; > 0.90 = excellent). The Single-Measures ICC of 0.811 also reflected good reliability for individual raters, suggesting that either rater independently would yield consistent results.

Conclusions and Recommendations

Conclusions

The validation of the Flexible Interview for ICD-11 (FLII-11) – Adult Epidemiological Version in both Sinhala and Tamil languages demonstrated that the instrument possesses good validity and excellent reliability when compared with the gold standard clinical diagnosis.

The Sinhala version showed a sensitivity of 77.2%, specificity of 76.4%, and overall diagnostic accuracy of 76.9%, with an average-measure ICC of 0.844, reflecting strong inter-rater consistency.

The Tamil version exhibited a sensitivity of 76.1%, specificity of 96.6%, and overall diagnostic accuracy of 85.3%, with an average-measure ICC of 0.896, indicating excellent diagnostic precision and reliability.

Both language versions demonstrated high internal consistency and excellent agreement between raters, confirming the robustness, stability, and cultural adaptability of the tool for use in Sri Lankan populations.

The FLII-11 was found to be practical and feasible for use in community and clinical settings, with a clear structure.

Recommendations

Implementation for National Surveys: The validated Sinhala and Tamil versions of the FLII-11 should be adopted for future national mental-health surveys and community-based studies to enable ICD-11-aligned diagnosis and cross-linguistic comparability.

Integration into Health Services: The tool should be introduced in primary healthcare and mental health service settings as a standardised diagnostic instrument for the early detection and referral of common mental disorders when necessary.

Training and Capacity Building: The complex structure of the questionnaire needs dedicated training. Therefore, FLII-11 requires structured training programs and periodic calibration workshops for all interviewers to maintain diagnostic reliability and minimize inter-rater variation. The training plan used for this assessment can be further tailored if a large number of data collectors are involved.

Operational Refinement: A brief interviewer guide and context-specific examples should be developed for the platform to be used in future assessments, supporting accurate symptom interpretation. The same platform used in the present study (i.e., Qualtrics), with Skip-Logic and the automatic generation of variables for different disorders, will be helpful.

Sub Section C

Project 2 - Component 2

Qualitative needs assessment for assessing the perceived needs, unmet needs, continuum of care, community-based care, gaps at the facility level, community level and gaps in the continuum of care.

Table of Contents

Introduction and Justification

Mental health stands as a cornerstone of individual and societal well-being, influencing everything from economic productivity and social cohesion to the fundamental quality of life. Globally, the burden of mental health conditions is substantial, demanding urgent attention and comprehensive interventions (1). Sri Lanka, a nation marked by its resilience and cultural diversity, faces a series of mental health challenges. The prolonged civil conflict over decades has left deep psychological impacts across Sri Lankan society. Although the war was confined to the Northern and Eastern provinces, the entire Sri Lanka faced the impacts of violence, displacement, and the loss of loved ones which contributed to widespread post-traumatic stress disorder (PTSD), anxiety, and depression (2) (3).

The 2004, Tsunami, further impacted these challenges, triggering acute stress reactions and exacerbating pre-existing mental health conditions (4,5). The psychological impact of these events continues highlighting the critical need for long-term mental health support and disaster preparedness.

More recently, Sri Lanka had economic instability, marked by inflation, unemployment, and resource scarcity. The economic stressors have significantly impacted mental well-being, contributing to increased anxiety, depression, and feelings of hopelessness (6) (7). The COVID-19 pandemic has further amplified these challenges, disrupting social support networks, increasing social isolation, and creating a climate of fear and uncertainty (8).

While the Sri Lankan government has made commendable efforts to address mental health through national policies and strategic plans, the effective implementation of these initiatives remains a significant challenge (9). The existing mental health infrastructure is often strained, characterized by a shortage of trained mental health professionals (e.g., psychiatrists), limited availability of specialised facilities, and inadequate access to community-based services. This disparity is particularly pronounced in rural and underserved areas, where access to mental health care is often severely limited (10,11). Furthermore, the cultural stigma surrounding mental illness continues to act as a formidable barrier to help-seeking behaviour, discouraging individuals from seeking professional support (12). Traditional beliefs and practices may also influence how mental health conditions are perceived and managed, highlighting the need for culturally sensitive interventions.

Existing data on mental health needs and service utilization in Sri Lanka are often fragmented, outdated, or lack the granularity necessary to inform targeted interventions. There is a critical need for a comprehensive and up-to-date assessment of mental health needs, particularly among vulnerable populations such as youth, the elderly, conflict-affected individuals, marginalised communities, and those residing in rural and underserved areas. This research aims to conduct a rapid qualitative evaluation of the current state of mental health services in Kalutara District, Sri Lanka.

This study is geographically limited to the Kalutara District of Sri Lanka due to several practical and strategic reasons. Firstly, the Kalutara District is the most populous and urbanized region in the country, comprising a diverse population with varying levels of access to healthcare services. It includes both highly developed and underserved areas, making it an ideal setting to explore a wide range of mental health service needs, utilization patterns, and system gaps.

Secondly, as the administrative and health governance hub of the country, the province houses the largest number of mental health professionals and facilities, offering a realistic ground to assess operational challenges and disparities even within better-resourced settings. Thirdly, logistical feasibility and time constraints make it practical to conduct field visits and primary data collection within the Kalutara District, allowing for deeper engagement with stakeholders and timely completion of the study. The lessons learned from this province can serve as a foundation for scaling up similar assessments in other provinces in future initiatives.

Key questions

1. What are the perceived mental health needs of the people (need for counselling, need for information, need for medication, need for practical support, need for professional support etc.)?
2. What is the extent of the 'Unmet Need' for receiving mental health services for people with
mental health diseases?
3. What is the status of people receiving facility-based follow-up or continuum of care in people with mental health diseases?
4. What is the community-based support received for people with mental health conditions?
5. What are the major gaps and perceived barriers at the facility level, community level and continuum of care?
6. What are the reasons for not accessing care/service utilization barriers/perceived barriers?

Objectives

General Objective

To assess the mental health needs, service gaps, and barriers to care in Kaluatara District, Sri Lanka

Specific Objectives

(1) To assess the perceived mental health needs of the population in Kalutara District

(2) To evaluate the extent of unmet mental health needs and the gaps in facility-based and community-based care in Kalutara District.

(3) To identify barriers to mental health service utilization in Kalutara District,

Methodology

The study followed a cross-sectional qualitative design, capturing data at a single point in time to assess the current mental health needs, service gaps, and barriers in the Kalutara District. The study comprised two phases. The results of the two phases were synthesized and triangulated to ensure a comprehensive and well-rounded assessment.

Methodology - Phase 1 – Mapping of mental health services

A **mapping exercise** was conducted using geospatial and administrative data to present the mental health landscape across the Kalutara District visually. Mapping was performed using QGIS (Quantum Geographic Information System, Version 3.34)**,** an open-source geographic information system. Information for Phase I is based on publicly available data. Based on the available services, mental health facilities and services were captured from secondary documents available from the government health sources. The data abstraction format was used to ascertain the data from different mental health data sources

Methodology - Phase II – KII and FGDs

Phase 2 included primary data collection with key informant interviews (KII) and focus group discussions (FGD). The data collection was done by the team-lead, co-investigators, or research assistants. The number of participants for KIIs and FGDs was determined based on the principle of thematic saturation, ensuring adequate representation. Over 20 key informant interviews and Focus Group Discussions were done with different stakholders, including Psychiatrist, Medical Officer – Mental Health, Medical officers in primary health care settings, Community Leaders, etc.

Data analysis of KIIs and FGDs

The study employed qualitative analysis techniques to examine the data collected from KIIs and FGDs systematically. All interviews and focus group discussions were transcribed verbatim and translated into English if conducted in another language. The content were reviewed to obtain a general sense of the collected materials. Each text segment was assigned codes, which were clustered into themes based on participant expressions to identify patterns, key themes, and issues related to mental health needs, service gaps, and barriers. Results were presented under these themes, with key informant statements as “quotations” where appropriate. Narrative descriptions were developed from the codes and themes to ensure qualitative insights were incorporated into the findings. Findings from different informants/groups were compared to identify discrepancies between perceived needs, service availability, and institutional challenges. Data from multiple sources were cross-verified to ensure reliability and validity, enhancing the robustness of the study findings. For this purpose, textual data from published policy documents and health reports (e.g., Annual Health Bulletin of the Ministry of Health) were reviewed to extract relevant information on

existing mental health services, utilisation patterns, and policy frameworks. All analysis was done using Excel sheets with manual coding.

Triangulation of data from Phase One and Phase Two

To enhance the validity and depth of the study, findings from Phase I (GIS mapping) were triangulated with the qualitative insights obtained from Phase II (KIIs and FGDs). This triangulation involved systematically comparing spatial trends and service distribution with the lived experiences and stakeholder perceptions of mental health service access, gaps, and barriers. The aim is to validate observations across both data streams and identify consistencies or contradictions between what was mapped and what was experienced. This integrated approach was helpful in understanding the mental health landscape and ensured that the final analysis is robust, credible, and policy-relevant.

Ethical Considerations

The study adhered to ethical guidelines for research involving human participants, with informed consent obtained from all participants. Special attention was given to cultural sensitivities and ensuring participant confidentiality and dignity. Before the primary data collection, formal ethical clearance was obtained from the Ethics Review Committee of the National Institute of Health Sciences.

Before participation, each individual was provided with an Information Sheet and Consent Form depending on their language preference. Ethical clearance was obtained from the Ethics Review Committee of the National Institute of Health Sciences. Administrative clearance was obtained from the Director General of Health Services.

Results – Stakeholder Mapping

Results were organised similarly to the described methodology. This will include (1) Mapping of mental health services, (2) Qualitative information.

Mapping of mental health services

In Kalutara District, specialist psychiatric services are supported by three consultant psychiatrists, each serving at the Teaching Hospital (TH) Kalutara, the Base Hospital (BH) Panadura, and the District General Hospital (DGH) Horana. Complementing their work, 17 Medical Officers in Mental Health are distributed across the district: five each at TH Kalutara, BH Panadura, and DGH Horana, with additional coverage at Divisional Hospitals in Bandaragama (1) and Ingiriya (1).
Community-level psychological support is provided by 15 counsellors, of whom one is based at the District Secretariat and 14 are placed within the Divisional Secretariat system. Social support is further strengthened by two social workers stationed at TH Kalutara.
Nursing services include four Community Psychiatric Nurses, with two serving at TH Kalutara, one at BH Panadura, and one at DGH Horana. In addition, rehabilitation and functional support are provided by three occupational therapists, distributed equally among TH Kalutara, BH Panadura, and DGH Horana.

Table 1: Different categories of Mental health staff

Category	Institution Name/Visiting Institute	Total
Consultant Psychiactrist	TH Kalutara	1
	BH Panadura	1
	DGH Horana	1
Medical Officer – Mental Health	TH Kalutara	5
	BH Panadura	5
	DGH Horana	5
	DH Bandaragama	1
	DH Ingiriya	1
Counsellors	Disctrict Secretariat - Kalutara	1
	Divisional Secretariat - Kalutara	14
Social workers	TH Kalutara	2
Community Psychiatric Nurses	TH Kalutara	2
	BH Panadura	1
	DGH Horana	1
Occupational therapists	TH Kalutara	1
	BH Panadura	1

	DGH Horana	1

The district has a range of institutional and community-based facilities supporting mental health care. An Intermediate Care Centre operates in Aluthgama, providing residential services. Outpatient services are delivered through 15 mental health clinics, comprising 12 outreach clinics and one clinic each at TH Kalutara, BH Panadura, and DGH Horana. Inpatient services are available at TH Kalutara, which maintains an indoor care facility. At the community level, additional government-operated services include a Community Centre in Panadura, which functions as a non-hospital outpatient facility, and a day-care facility at MOH Madurawala, offering rehabilitative support.

However, there are critical service gaps in the district. There are no dedicated counselling centres, and no NGOs providing counselling or indoor care facilities, limiting the scope of community and non-governmental involvement in mental health care delivery. Dilivery of facilities are mapped in Figure 1.

Table 2: Different Facilities providing mental health services

Facility	Location	Number
Facility	Intermediate Care Centre - Aluthgama	1
Mental Health Clinics/psychiactric clinics	Outreach Clinic	12
	TH Kalutara	1
	BH Panadura	1
	DGH Horana	1
Counselling centres		
Indoor care facilities	TH Kalutara	1
NGOs with councelling centers	None	
NGOs with indoor facilities		
Community-based / non-hospital mental health outpatient facility (governmental)	Community Centre - Panadura	1
Mental health day care facilities	MOH Madurawala	1

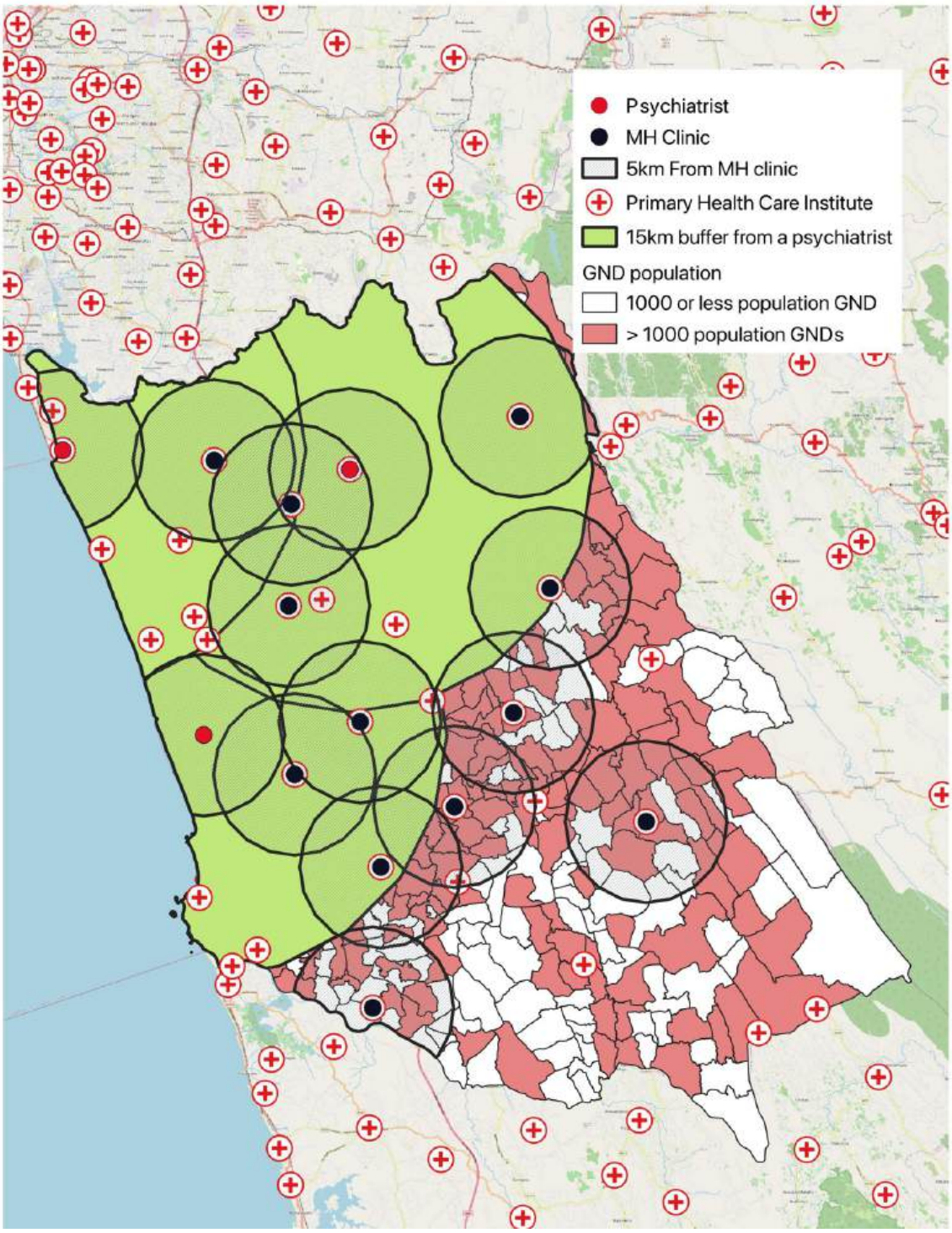

Figure 1: Distribution of psychiatrists and Mental Health Clinics in Kalutara District

Results – Qualitative Assessment

Results of the qualitative studies will be presented under the headings derived from the data analysis.

1. Perceived and Unmet Needs

Across all interviews—from hospital-based officers to community field staff—mental health conditions were recognized as a growing and diverse burden, encompassing specrume of condicitions including depression, anxiety, schizophrenia, bipolar disorder, substance use disorders, and emerging child and adolescent issues. Respondents consistently highlighted that mental health needs are expanding faster than service capacity, resulting in considerable unmet demand for both preventive and curative care.

1.1. Spectrum of perceived needs

Participants emphasized that mental health issues are highly visible in daily practice but insufficiently addressed within the existing system. ***"Now we see more cases of depression, anxiety, substance use, and even school-related stress. People are coming to the OPD with these problems every day, but only few get referred to psychiatry."*** *(Medical Officer, PMCU).* ***"Patients with long-term illnesses like schizophrenia come to the clinic regularly, but there is no system to follow-up properly when they miss appointments."*** *(Psychiatry Nurse at a District General Hospital).* ***"We have elderly people with dementia and young people with addictions—completely different needs—but we don't have separate services for them."*** *(a Consultant Psychiatrist).* Child and adolescent mental health, geriatric psychiatry, and substance-related disorders were repeatedly cited as priority areas with insufficient dedicated services or specialists.

1.2. Unmet needs in service provision

Infrastructure and clinical service gaps - Many facilities lack dedicated psychiatric wards or short-stay beds, forcing acutely disturbed patients to be managed within general medical wards or transferred to distant hospitals. ***"Only the psychiatry clinic is available — no inward care or emergency unit. If urgent treatment is needed, we use the medical wards or the PCU facilities."*** *(Nursing Officer, at a District General Hospital).* This absence of inpatient capacity contributes to treatment delays, safety risks, and discontinuity of care.

Drug supply and treatment continuity - Interrupted drug supply was a near-universal concern. Health workers reported recurrent shortages of essential psychotropics such as which directly undermine patient stability and adherence. "Methylphenidate hasn't been available for months. Parents of children with ADHD keep asking when it will come." *(Medical Officer).* ***"Sometimes depot injections are not available; then patients relapse and have to be re-admitted."*** *(Psychiatry Nursing Officer).*

Human resource limitations - All cadres emphasized the lack of adequate staffing — psychiatrists, medical officers trained in mental health, community psychiatric nurses, occupational therapists, and social workers. The resulting workload forces brief consultations and limits community outreach. ***"There are only two nurses to handle more than a hundred patients in one clinic day; counselling cannot be done properly."*** *(Nursing*

Officer, at a District General Hospital). ***"No psychologist or social worker—we have to do everything."*** *(Medical Officer at a divisional hospital).*

Special population needs - Unmet needs were pronounced among **children, adolescents, and older adults**. School-linked behavioral problems and adolescent self-harm were common, yet respondents said few preventive or early-intervention programs exist. Elderly patients, particularly those with dementia, face neglect due to mobility and caregiver issues. ***"Elderly with memory problems are ignored; their families don't understand dementia."*** *(Public Health Nursing Officer).* ***"There is no separate clinic for adolescents. We see them together with adults, which is not appropriate."*** *(a Consultant Psychiatrist).*

Community-level unmet needs - At community level, officers described a lack of counselling centres, rehabilitation facilities, and home-based care. NGOs provide some support, but coverage and coordination are limited. **"Patients have difficulties accessing clinics, and there is no proper counselling centre in the area."** *(Public Health Midwife)*
"After discharge, many patients are lost to follow-up because no one is responsible to trace them." *(Medical Officer - Mental Health)*

2. Barriers to Access and Acceptability

Across informants, a consistent theme was that even when services exist, **multiple personal, social, and systemic barriers prevent people from accessing or continuing mental health care**. These barriers can be grouped as physical, financial, social-cultural, and institutional.

2.1. Physical and logistical barriers

Distance, travel time, and the absence of dedicated patient transport were cited as major deterrents—especially for patients from rural or remote areas or for those with aggressive or disabled family members. "Patients from faraway areas like Walallawita and Ingiriya have to spend almost the whole day travelling. Sometimes they miss the clinic because of transport cost or no one to bring them." *(Medical Officer).* "For home visits we don't have a vehicle. Sometimes we use our own money or wait for another staff member with a bike." *(Community Psychiatry Nursing Officer).*

At the same time, long waiting times, congested clinics, and limited consultation rooms add to patient frustration and early dropout. ***"Our clinic is very crowded and noisy. Patients have to sit on the corridor; there is no privacy."*** *(Psychiatry Nurse at a District General Hospital).*

2.2. Financial barriers

Though services are nominally free, hidden expenses—transport, lost wages, and purchase of out-of-stock medicines—create real burdens for families. "When drugs are not available, patients have to buy them outside, and most cannot afford it." *(Medical Officer at a Divisional Hospital).* ***"Some stop coming because of bus fare. For them even 200 rupees is a big issue."*** *(Public Health Midwife.)*

2.3. Stigma and confidentiality

Stigma emerged as one of the strongest cross-cutting barriers. Patients fear being labelled as “mad” or “pissa,” and families often conceal mental illness due to social shame. Several officers noted that clinic procedures themselves unintentionally breach privacy, for example, calling names aloud in queues, or having a visibly separate counter for “mental” patients. “People are scared to come to the clinic because everyone will know they are mental patients. Even the label on the clinic book says ‘psychiatry’.” *(Psychiatry Nursing Officer).* ***“They think coming here means you are mad. That word ‘pissu gedara’ is still used in the community.”*** *(Public Health Midwife).* Stigma also affects help-seeking within the health sector. ***“Even other hospital staff sometimes treat psychiatric patients differently, like they are difficult or dangerous.”*** *(Occupational Therapist).* ***“If someone has a disease like diabetes, people do accept. But when there is a mental condition, people think it differently”*** *(Member of the hospital development committee)*

2.4. Cultural and religious influences

Beliefs in spiritual causes of illness (i.e., evil spirits, karma, etc.) lead many to first consult religious or traditional healers before medical services. These delays often result in patients presenting late, with advanced symptoms. ***“Families still take them to “Thovil” or “Bali” before coming to the hospital. Only when things get worse, they come here.”*** *(Medical Officer)* ***“Some say medicines reduce their spiritual power. They stop drugs after going to a temple or faith healer.”*** *(Community Psychiatry Nursing Officer).* While such practices sometimes provide emotional comfort, they delay medical intervention and reduce adherence**.** On the other hand, a hospital development committee member stated, ***“Nowadays, very few go to spiritual activities such as 'Thovil', and the majority go to the hospital”.*** Further, he said, ***“On the other hand, the religious leaders could help raise awareness of the conditions and reduce the myths in the community.”*** **(Member of the Hospital development community).**

2.5. Gender and family-related barriers

For women, particularly housewives and those experiencing domestic violence, dependence on family members and lack of autonomy limit clinic attendance. On the other hand, working men often delay or avoid visits due to time constraints and fear of workplace stigma. ***“Some husbands do not allow wives to come alone for treatment. They think others will talk.”*** *(Public Health Nursing Officer).* ***“Men don’t like to sit in a psychiatry clinic queue; they think others will see them.”*** *(Medical Officer in Divisional Hospital)*

2.6. Institutional and system-related barriers

Inadequate appointment scheduling, absence of appointment slips, and poor record-keeping frequently result in missed or lost follow-up**.** Moreover, the lack of coordination between hospital clinics and community health workers means no one takes responsibility for tracing absentees. ***“If a patient doesn’t come, we don’t know until months later. There is no system to trace them.”*** *(Medical Officer - Mental Health).* Some participants also reported unsympathetic attitudes among certain staff**,** further discouraging patients. ***“Some***

patients say nurses shout at them or call their name loudly; they feel humiliated." *(Public Health Midwife).*

3. Gaps in the Continuum of Care

A strong and recurrent finding across all interviews was the lack of structured linkage between different levels of mental health care from hospital to community and between preventive and curative sectors. Respondents described fragmented systems with no precise follow-up mechanisms, limited feedback on referrals, and minimal use of data to track patients.

3.1. Weak follow-up and defaulter tracing systems

Many participants emphasised that, after patients are discharged or miss appointments, **there** is no organised way to trace or re-engage them**.** Clinic records are paper-based, fragmented, and often lost when patients change facilities or misplace their clinic books. ***"There is no proper defaulter tracing system. If someone doesn't come for months, we realise only when we see the clinic book again."*** *(Medical Office - Mental Health).* ***"Sometimes the patient's clinic book is missing. Then we can't even find their previous diagnosis or drugs."*** *(Community Psychiatry Nursing Officer).* ***"No cross-check in the OPD; a patient may come for some other illness, but nobody knows he is also under psychiatry treatment."*** *(Consultant Psychiatrist).*

Several suggested introducing a **digital or electronic registry** shared between the hospital and field services to flag defaulters and maintain continuity. ***"Better to have an electronic record; then even if they go to another hospital, we can see their history."*** *(Medical Officer in a Divisional Hospital).* ***"I think we should use the government officials working at the field level for defaulter tracing and referral"*** *(Member of the hospital development committee).* ***"Another problem is we have a large health workforce, but they mostly focus on the assigned duty for them but not thinking of the mental health issues."*** *(Member of the. Hospital development committee).*

3.2. Fragmented referral and feedback mechanisms

Health workers repeatedly noted that referrals between hospital clinics, PMCU, and MOH offices are unidirectional, with almost no feedback once a patient is referred. This results in duplication, treatment gaps, and information loss. ***"When we refer a patient to psychiatry, we rarely get a report back. We don't know what happened."*** *(Public Health Midwife).* ***"We also see patients discharged from hospital without any message to the PHM or PHI. Nobody follows up."*** *(Public Health Nursing Officer).* This lack of communication prevents coordinated case management and continuity of psychosocial support.

3.3. Limited home-based care and community follow-up

While most respondents recognised the importance of community outreach, they described it as sporadic, unsupported, and sometimes unsafe due to a lack of vehicles and staff. ***"We try to visit defaulters at home, but no transport and sometimes aggressive patients; so we can't go alone."*** *(Community Psychiatry Nursing Officer).* ***"Patients without caregivers cannot come, and we don't have resources for home visits."*** *(Nursing Officer).* ***"For elderly and disabled patients, home follow-up is very important, but we have no regular schedule***

for that." *(Occupational Therapist).* These constraints cause significant discontinuity for patients needing rehabilitation or long-term medication monitoring.

3.4. Lack of structured rehabilitation and social reintegration

Another gap identified was the absence of formal rehabilitation and social reintegration pathways after symptom stabilisation. Patients discharged from the hospital rarely receive support for employment, vocational training, or social inclusion. ***"After they get better, they stay at home doing nothing. They relapse because they feel useless."*** *(Medical Officer - Mental Health).* ***"Jeewanodaya does some work, but we need more centres and proper follow-up after treatment."*** *(Public Health Nursing Officer).* "There are some NGOs, but coordination is poor. We don't know who is responsible." *(Medical Officer in a Divisional Hospital).*

4. Facility-Level Service Delivery Constraints

Health staff at both hospital and primary care levels described a range of infrastructural, human resource, and logistical constraints that directly affect the quality and continuity of mental health service delivery. These constraints collectively contribute to patient dissatisfaction, staff burnout, and limited outreach capacity.

4.1. Human resource shortages and workload

Every informant highlighted critical gaps in trained personnel. Facilities operate with minimal staff, often having one or two nurses and handling large clinic volumes with limited multidisciplinary support. ***"There are only two nurses to handle more than a hundred patients in one clinic. It's impossible to give enough time for counselling or health education."*** *(Nursing Officer).* ***"No psychologist, no social worker, no counsellor—so we have to do everything by ourselves."*** *(Medical Officer - Mental Health).* ***"Community Psychiatric Nursing Officers have to cover several MOH areas. We can't visit everyone or follow up regularly."*** *(Community Psychiatry Nursing Officer.)* The lack of dedicated counsellors, occupational therapists, and social workers was repeatedly cited as a major limitation in providing comprehensive care and psychosocial rehabilitation.

4.2. Inadequate infrastructure and space

Clinic environments were frequently described as overcrowded, poorly ventilated, and lacking privacy and unsuitable for confidential psychiatric consultations or counselling. ***"Our clinic is very congested. Patients have to sit in the corridor, and sometimes we even use the pharmacy area to talk."*** *(Nursing Officer).* ***"There is no separate room for counselling. We talk near the dispensary; other patients can hear."*** *(Occupational Therapist).* ***"At primary care units, there is no dedicated space for mental health—patients sit with others having fever or wounds."*** *(Medical Officer in a Divisional Hospital).* The absence of a dedicated short-stay psychiatric ward was universally recognized as a critical gap, forcing hospitals to manage agitated patients within general medical wards. **"If a patient becomes violent, we have no place to keep them safely. Staff have to manage somehow until we transfer to a teaching hospital."** *(Consultant Psychiatrist).* Such conditions create safety concerns for both patients and staff, especially when handling acutely disturbed individuals.

4.3. Drug supply interruptions and logistics

Irregular supply of essential psychotropic medicines was among the most frequently cited operational challenges. Interruptions affect treatment continuity and increase relapse risk. ***"Drugs like aripiprazole, mirtazapine, and donepezil go out of stock frequently. We have to switch patients to something else or ask them to buy."*** *(Medical Officer - Mental Health).* ***"Depot injections are not always available. When that happens, patients stop coming, and after some time they come back in relapse."*** *(Community Psychiatry Nursing Officer).* Other logistical issues included lack of printing materials, stationery for reporting, and no official vehicle for outreach visits. ***"We even buy paper and pens ourselves. For home visits, there is no vehicle allocated."*** *(Medical Officer - Mental Health).*

4.4. Limited interdepartmental and multidisciplinary collaboration

Multidisciplinary teamwork is minimal. Informants reported that psychiatric services function in isolation, with limited coordination with other hospital departments such as medical wards, OPD, or maternal and child health units. ***"Sometimes other doctors don't want to refer psychiatric patients because they think it's extra work."*** *(Nursing Officer).* ***"There is no regular MDT meeting. We do our own clinic and go home."*** *(Occupational Therapist).* ***"Even for suicidal cases in medical wards, follow-up by psychiatry is irregular because of workload." (****Consultant Psychiatrist).* This lack of collaboration limits integrated patient management and contributes to the underdetection of mental health issues among general patients.

4.5. Safety and staff welfare

Several participants expressed concern about staff safety when managing violent or unpredictable patients. No formal training or safety protocols were reported, and the infrastructure lacks protective design. ***"When a patient becomes aggressive, we don't have an escape route or safety button. Everyone just runs."*** *(Nursing Officer).*
"Some patients threaten staff, but we don't have security support." *(Medical Officer - Mental Health).* The emotional burden of witnessing repeated relapses and self-harm cases was also mentioned, yet no psychosocial support mechanisms exist for the staff themselves.

5. Community-Level Gaps and Coordination Issues

Informants from the field and hospital teams consistently highlighted that mental health services at the community level remain fragmented, under-resourced, and poorly coordinated.
While a few community resources exist, they are scattered, lack sustainability, and have minimal linkage with the formal health system.

5.1. Limited availability of community-based services

At present, most mental health services are clinic-based, with limited outreach or community rehabilitation programs. The field officers expressed that many patients—particularly those with chronic mental illness—remain confined at home without regular follow-up or psychosocial support. ***"Patients with long-term illness are mostly at home. Families keep them inside because they don't know where to take them."*** *(Public Health Midwife).* ***"There is no community centre or day-care for rehabilitation. If there was, patients could learn skills and interact."*** *(Public Health Nursing Officer).* ***"Sometimes we see***

people with depression or schizophrenia in the community, but we don't have a structured way to refer them." *(Public Health Midwife).*

5.2. Insufficient collaboration with NGOs and other sectors

Respondents mentioned that some NGOs and religious groups (e.g., *Sumithrayo, Sahanaya, Jeewanodaya*) and governmental social services divisions are active, but coordination is weak and duplication is common. There is no clear referral pathway or feedback mechanism between NGOs, DS offices, police, and health institutions. ***"Sumithrayo and Jeewanodaya help some patients, but we don't know what happens after referral."*** *(Community Psychiatry Nursing Officer.)*. ***"Sometimes the police or DS office calls us only when there is a crisis, not for follow-up or prevention."*** *(Medical Officer - Mental Health).* ***"Everyone is working separately. If there were a proper network, we could share cases and do better follow-up."*** *(Public Health Nursing Officer.)* This fragmentation results in gaps in support for reintegration, livelihood, and long-term rehabilitation. ***"There is a sizable number of government officers linked with the villages. They do have information about the community's residents. They can coordinate well with mental health services. But it is necessary to have good government directives for these officers."*** (Hospital development committee member).

5.3. Community awareness and stigma

Stigma remains a dominant barrier to community-level engagement. Public health officers and nurses described low mental health literacy, fear of social labelling, and reluctance to attend clinics or disclose illness to neighbours. "***Most of the people in the community do not have an idea about the mental health diseases and they don't know what actions they should take when someone has a mental health problem."*** (Hospital Development Committee member). ***"People still think mental illness is something to hide. They don't even tell close relatives."*** *(Public Health Midwife).****"Some families are ashamed to send patients to clinics. They prefer to keep them inside."*** *(Public Health Nursing Officer)*. ***"We have done few awareness programs, but coverage is poor. People attend only if we combine with something like dengue or maternal program."*** *(Medical Officer in a Divisional Hospital)*. The lack of sustained community education means misconceptions persist, and help-seeking behaviour remains low. ***"Some people with mental disease conditions have taken medicine and solved the problem, but still, the community looks at them differently."*** (Hospital Development Committee member)

5.4. Weak intersectoral coordination

Health staff highlighted minimal collaboration between hospital, MOH, police, education, and social welfare sectors, despite overlapping responsibilities. This leads to duplication, missed cases, and inconsistent responses to mental health emergencies. ***"Schools sometimes identify children with problems, but we don't get referrals. They keep the child until a crisis occurs."*** *(Public Health Nursing Officer)*. ***"There is no formal link between hospital and MOH for mental health like we have for MCH programs."*** *(Medical Officer - Mental Health).* ***"The police sometimes bring patients without family, and we struggle to decide where to keep them."*** *(Nursing Officer).* Several respondents recommended establishing a district-level coordination committee that involves all relevant sectors to improve communication and joint planning.

5.5. Community safety and outreach challenges

Community outreach activities are limited not only by lack of transport and staff but also by safety concerns, particularly when visiting homes of aggressive or substance-using patients. ***"We don't go alone for home visits; some areas are unsafe. But then we can't cover enough patients."*** *(Community Psychiatry Nursing Officer).* ***"Sometimes the family doesn't cooperate or hides the patient. We can't do much without support."*** *(Public Health Midwife).* This has resulted in inconsistent outreach and many high-risk individuals being left unsupervised in the community. ***"Also, I think, it will be beneficial to have a community-level fund and also a group to facilitate this issue at the community level"*** Member of hospital development committee).

5.6. Positive examples and opportunities

Despite gaps, some informants described encouraging experiences where community collaboration improved outcomes. As an example, joint work with social service officers or school counsellors, or using volunteers for medication delivery, can be noted. ***"In some GN divisions, volunteers help deliver medicines to patients who can't travel. That works well."*** *(Public Health Nursing Officer).* ***"When we linked with the social service officer, we could get financial aid for a few chronic patients."*** *(Medical Officer in a Divisional Hospital).* Such examples demonstrate the potential of a coordinated, community-linked mental health model if properly structured and supported.

6. Priority and Vulnerable Groups

Informants repeatedly identified several population groups who face a heightened risk of mental health problems and poor access to care**.** These include adolescents and youth**,** elderly persons**,** women (especially affected by gender-based violence or perinatal mental health issues), and individuals without family or caregiver support**.** Each group experiences distinctive barriers along the continuum of care.

6.1. Adolescents and youth

Respondents highlighted a sharp increase in psychological distress among school-aged and young people**,** including depression, anxiety, exam-related stress, relationship issues, and substance use. Several participants described self-harm and suicidal attempts among adolescents as a growing and visible trend. **"We are seeing more young people coming with self-harm, mostly due to relationship or family stress."** *(Consultant Psychiatrist).* **"School children have more anxiety and anger issues. They don't know how to handle emotions."** *(Public Health Nursing Officer).* **"Substance use among youth is increasing; they come with behavioural problems, but parents often deny it."** *(Medical Officer - Mental Health).* However, there are no specialized adolescent mental health clinics or structured counselling programs in most hospitals or Primary Medical Care Unit settings. **"There is no separate clinic for adolescents; they sit with adults, which is not suitable. They need their own space."** *(Consultant Psychiatrist).* Participants recommended integrating school-based mental health promotion, early screening, and counselling programs into routine school health activities.

6.2. Elderly persons and dementia care

The elderly were identified as a neglected group in the current service structure. Field staff reported increasing cases of dementia, depression, and isolation among older adults—often compounded by caregiver burden and poor mobility. ***"Elderly with memory problems are left alone or ignored; families don't understand it as an illness."*** *(Public Health Nursing Officer).* ***"Some elderly people can't come to clinics due to physical limitations, but we have no system to follow them at home."*** *(Public Health Midwife).* ***"Depression in the elderly is common, but they say it's just ageing. Families bring them only when the situation gets worse."*** *(Medical Officer in a Divisional Hospital).* The lack of home-based services, caregiver education, and geriatric-focused counselling was repeatedly mentioned as a critical gap.

6.3. Women's mental health (GBV and perinatal issues)

Women, particularly those exposed to domestic violence, postpartum depression, or social isolation, were identified as a priority group requiring sensitive and integrated care**.** Public health field staff noted that such problems are often detected incidentally during clinic visits, but referral pathways to psychiatric services remain weak. "***We find some mothers crying or showing signs of depression during postnatal visits, but there is no clear referral system to psychiatry."*** *(Public Health Midwife).* ***"Women facing domestic violence hide it. They say they fell or got injured accidentally."*** *(Public Health Nursing Officer).* ***"Mental health support for pregnant or lactating mothers is not routine. It depends on individual officers."*** *(Medical Officer, Mental Health).* Participants suggested training MCH staff in **screening for depression and abuse** and ensuring safe, confidential referral channels for affected women.

6.4. Individuals without caregivers or social support

Patients without family support, especially those with chronic mental illness, were described as the most vulnerable group**.** They often default on treatment, relapse frequently, and have no one to accompany them to clinics or ensure medication adherence. ***"Some patients live alone. Nobody brings them to clinics, so they stop treatment."*** *(Community Psychiatry Nursing Officer).* ***"When there is no caregiver, it's difficult even to give depot injections or home follow-up."*** *(Medical Officer - Mental Health).* ***"These patients are forgotten by everyone—family, neighbours, and system. Only when they become violent or suicidal do we hear about them."*** *(Nursing Officer, DGH Horana).* Respondents emphasized the need for supported housing facilities**,** community-based volunteers**,** or social service networks to protect and sustain this group. ***"I think there should be a community network for identifying the people with mental health issues."***(Hospital development committee member)

Limitations

This study is designed to provide a comprehensive qualitative assessment of mental health service needs in the Kalutara District, while it is subjected to several limitations.

Firstly, the cross-sectional nature of the study captures perceptions and service availability at a single point in time, which may not reflect long-term trends or emerging patterns in mental health service delivery. Changes in policy implementation or service availability following the study period may not be captured.

Secondly, the study heavily relies on qualitative data through key informant interviews and focus group discussions. While this allows for rich, contextual insights, the findings may not be generalizable beyond the settings and participants selected for this assessment. The purposive sampling method, though necessary to capture expert and stakeholder perspectives, may introduce selection bias.

Thirdly, the mapping and spatial analysis depend on the accuracy and completeness of secondary data. Data gaps, inconsistencies, or outdated records from health information systems may affect the precision of the mapping and proximity/coverage analyses conducted using QGIS.

Additionally, cultural stigma and sensitivity surrounding mental health may result in underreporting or biased responses during interviews and discussions, despite efforts to ensure a safe and confidential environment for participants.

Finally, time and resource constraints, particularly the limited duration allocated for data collection, may restrict the depth of engagement with some stakeholders, especially in underserved or remote areas.

Despite these limitations, the study is expected to yield valuable insights that can inform future planning and strengthen mental health service delivery across the Kalutara District.

Conclusions and recommendations

Conclusions

This qualitative needs assessment revealed a substantial and multifaceted mental-health burden in the Kalutara District, characterized by rising prevalence of depression, anxiety, substance-use disorders, and psychosocial problems among adolescents, women, and the elderly. Despite the presence of dedicated psychiatrists and outpatient clinics, service capacity, integration, and community outreach remain limited.

Key findings highlight that:

- **Mental-health needs are increasing faster than system readiness.** Specialist and support staff shortages, inadequate infrastructure, and drug stock-outs constrain service coverage and quality.
- **Continuum-of-care mechanisms are weak.** Paper-based records, unidirectional referrals, and a lack of digital tracking lead to poor follow-up and frequent treatment defaults.
- **Community-based and rehabilitative care are underdeveloped.** Most services are clinic-centred, with limited outreach, day-care, or vocational programs.
- **Stigma and cultural beliefs continue to impede help-seeking.** Privacy concerns and negative attitudes persist in both communities and some institutions.
- **Vulnerable groups—youth, elderly, women, and those without caregivers—remain underserved**, with no tailored interventions or cross-sectoral safety nets.
- **Inter-sectoral coordination is minimal**, leading to fragmentation among the curative health sector, preventive health sector, and social services sector, among others.

Overall, while the district possesses the essential framework for a functional mental-health system, it requires systematic strengthening, integration, and community extension to deliver truly person-centred, continuous care.

Recommendations

The following recommendations are derived from the synthesis of key-informant and focus-group insights, and mapped service data. They are organised by strategic domain.

1. Strengthen service delivery and infrastructure

- Establish short-stay psychiatric wards (4–6 beds) in each base or district general hospital with basic safety features and trained staff. That can startegically identify underutilised divisional hospitals, but adequate human resources.
- Upgrade existing clinic spaces to ensure privacy, adequate seating, and ventilation suitable for counselling.
- Maintain an uninterrupted supply of essential psychotropic drugs (including depot antipsychotics, ADHD medication, antidepressants, and dementia drugs) with buffer stock and redistribution mechanisms.

2. Human-resource development

- Recruit or allocate Community Psychiatric Nurses, psychologists, counsellors, occupational therapists, and social workers to all major hospitals.
- Conduct capacity-building programs for PMCU, MOH, and MCH staff on early detection, basic counselling, and referral pathways. Additionally, public health nursing officers are a good source of human resources. That can be align with newer primary health care reforms.
- Introduce support and safety training for staff handling aggressive or suicidal patients, and provide psychosocial support for health workers.

3. Improve information and referral systems

- Develop a district-level mental health digital registry (suitable database which can be accessed from different service points) linked to curative and preventive sectors for follow-up, defaulter tracing, and medication monitoring.
- Institute a standard referral and feedback mechanism between hospitals, PMCU, MOH offices, and NGOs with regular joint case reviews.
- Integrate mental-health indicators into existing e-IMMR or HMIS platforms for monitoring continuity of care.

4. Expand community-based and rehabilitative care

- Establish day-care and rehabilitation centres in collaboration with DS offices, NGOs, and private sector partners. Additionally, the newer concept of “Arogya” primary health care centres can be used for this purpose.
- Strengthen home-visit programs with dedicated transport days, safety protocols, and multidisciplinary participation.
- Promote satellite village clinics and outreach sessions in remote areas at least quarterly.

5. Enhance intersectoral and community coordination

- Form a District Mental-Health Coordination Committee comprising representatives from health, education, police, social services, and NGOs.
- Empower existing community networks—such as village committees, Samurdhi officers, and school counsellors—to serve as local mental health focal points.
- Encourage partnerships with religious and community leaders to reduce stigma and support early help-seeking.

6. Targeted interventions for vulnerable groups

- Introduce school-based screening and counselling for adolescents with stress, substance use, or behavioural issues.
- Integrate geriatric and dementia support into home-based and PHM visits, including caregiver education.
- Create community-supported housing or volunteer networks for individuals without caregivers.

7. Community awareness and stigma reduction

- Implement district-wide awareness campaigns through local media, schools, and religious institutions to normalise mental health discussions.
- Develop culturally appropriate materials emphasising recovery, self-care, and the treatable nature of mental illness.

References

1 WHO guidelines on mental health at work. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

2 Fernando, J. (2011). Mental health in post-conflict Sri Lanka. The Lancet, 377(9773), 1210-1211.

3 Somasundaram, D. (2007). Collective trauma in the Vanni, Sri Lanka: a qualitative study. International Journal of Mental Health Systems, 1(1), 1-9.

4 Jayawardena, P., Rajapakse, T., & Fernando, D. (2005). Psychological impact of the tsunami disaster in Sri Lanka. The British Journal of Psychiatry, 187(6), 509-510.

5 Silove, D., Steel, Z., & Watters, C. (2005). Trauma, post-traumatic stress disorder, and refugees: conceptual, methodological, and applied issues. The Lancet, 366(9501), 1915-1924.

6 Central Bank of Sri Lanka. (2023). Annual Report 2022.

7 Athukorala, P. (2022). Sri Lanka's economic crisis: Origins, prospects, and policy options. Asian Economic Papers, 21(3), 1-33.

8 Hwang, T. J., Rabheru, K., Peisah, C., Reichman, W., & Ikeda, M. (2020). Loneliness and social isolation during the COVID-19 pandemic. International psychogeriatrics, 32(10), 1217–1220. https://doi.org/10.1017/S1041610220000988

9 Ministry of Health, Sri Lanka. (2015). National Mental Health Policy and Strategic Plan.

10 Jayasuriya, R. (2009). Mental health services in Sri Lanka: a review. International Journal of Mental Health Systems, 3(1), 1-11.

11 National Institute of Mental Health, Sri Lanka. (2020). Annual Report.

12 De Silva, M. J., Hanwella, R., & Sumathipala, A. (2013). Mental health stigma in Sri Lanka: a qualitative study. International journal of mental health systems, 7(1), 1-10.

13 *Mental Health Atlas 2020 Country Profile: Sri Lanka*. (2022). Retrieved March 20, 2025, from WHO