PREVALENCE OF PSYCHIATRIC MORBIDITIES AMONG YOUNG ADULTS ENROLLED IN METHADONE ASSISTED CLINICS IN KISAUNI SUBCOUNTY, MOMBASA COUNTY

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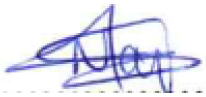
DECLARATION OF ORIGINALITY FORM

I, Dr. Nafisa Ahmed Seif hereby declare that this is my original work carried out in partial fulfilment of the award of master's degree of medicine in psychiatry at the University of Nairobi. I have not presented the same to any other institution for any award.

Signature……  **Date 14/08/2023**

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DEDICATION

I devote my thesis to my family and friends especially my husband, kids and parents whose words of encouragement gave me hope and made me work harder to achieve my goals.

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LIST OF ABBREVIATIONS/ACRONYMS

ADHD Attention Deficit Hyperactivity Disorder

ASRS-v I.I	Adult ADHD Self-Report Scale
BAI	Beck's Anxiety Inventory
CHIP	Children's Health Insurance Programs
DBDRS	Disruptive Behaviour Disorder Rating Scale
GAD	Generalized Anxiety Disorder
GBD	Global Burden of Disease
KNCHR	Kenya National Commission of Human Rights
MAT Clinic	Methadone Assisted Therapy Clinic
MDD	Major Depressive Disorder
MINI	Mini International Neuropsychiatric Interview
MMT	Methadone Maintenance Therapy
NCS	National Comorbidity Survey
NESARC	National Epidemiologic Survey on Alcohol and Related Conditions
NZMHS	New Zealand Mental Health Survey
OUD	Opioid use disorder
PHQ	Patient Health Questionnaire
TRAILS	Tracking Adolescents' Individual Lives Survey
WHO	The World Health Organization

OPERATIONAL DEFINITION OF TERMS

Anxiety: A feeling of worry, nervousness, or unease about something with an uncertain outcome (Arroll & Kendrick, 2018).

Attention Deficit Hyperactivity Disorder (ADHD): Is a clinically defined disorder, inattention and hyperactivity/ impulsivity are its main symptom domains. (Zayats & Neale, 2020)

Attention Deficit Hyperactivity Disorder: is one of the most common psychiatric conditions in children and adolescents and contributes to significant academics and functional impairments (Kumar & Gleason, 2019).

Conduct Disorder (CD): Is a psychiatric diagnosis characterized by a repetitive and persistent pattern of behaviour in which the basic rights of others and major age-appropriate social norms or rules are violated (Pisano & Muratori, 2017).

Depression: This is a common mental illness characterized by depressed mood, lack of interest or enjoyment, reduced motivation, feelings of low self-esteem, disrupted sleep or appetite, and poor focus (Cesar & Chavoushi, 2013).

PHQ-9: A patient-completed questionnaire that screens for Depressive Disorders. It can be used to identify or follow patients with co-morbid Depressive disorders (Kumar & Gleason, 2019).

Social Phobia: also known as social anxiety disorder (SAD), is characterized by a marked and persistent fear of at least one social or performance situation, in which the person is exposed to the scrutiny of others and where embarrassment or humiliation might occur (Knappe & Beesdo, 2009).

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ABSTRACT

Background: Half of all mental disorders in adulthood start by the age of 14, but most cases are undetected and untreated. According to the World Health Organization, mental health problems affect 10-20% of children and adolescents worldwide. Most common mental conditions affecting the young adults include depression, anxiety, social phobia and ADHD. However, there is limited data on the prevalence of these co-occurring mental disorders

among young adults between ages 18-35 years attending Methadone Assisted Clinics in Kenya.

Purpose: This study aimed to establish the prevalence of psychiatric morbidities among young adults between ages 18 to 35 years enrolled in methadone assisted clinics in Kisauni subcounty, Mombasa County, with specific focus in Frere town and Shimo la Tewa.

Method: This study adopted a cross-sectional study design where quantitative data was collected using a structured MINI 5.0 tool, and targeted all the 128 patients aged 18-35 years attending the methadone-assisted clinics in Kisauni Sub-County to be included in the study. A complete survey or complete enumeration census is a statistical investigation method in which data is collected for every element or unit of the population. After data collection, data entry and quantitative statistical analysis was done using Statistical Package for Social Sciences (SPSS Version 23. Frequency tables, bar graphs and pie charts were used to present the socio-demographic factors and prevalence rates.

Results: there was high prevalence of comorbidities among young adults enrolled in MAT clinics, with statistics indicating presence of Major Depressive Disorder at 73%. However, there was disparity related to marital status, with those who were single and divorced reporting highest incidences of psychiatric comorbidity of 26% and 14% respectively, against those who were married (7%) and widowed (2%). Individuals whose families had history of mental illness had higher chances of psychiatric disorder, with 32% confirming to have been affected as opposed to 18% of the individuals whose families did not have history of mental illness. Binary logistic regression findings showed that gender ($P=0.005<0.05$), age ($P=0.034<0.05$), level of education, ($P=0.023<0.05$), marital status ($P=0.041<0.05$), religion ($P=0.007<0.05$), occupation or employment status ($P=0.012<0.05$), and family history of mental illness ($P=0.009<0.05$), all significantly influenced the model or prediction. This implied that each of the predictor variables in terms of the respondents' socio-demographic characteristics can significantly contribute to prevalence of psychiatric morbidities of the youth enrolled in MAT clinics.

Conclusions: evidently, the most prevalent mental health conditions included major depressive disorder, Generalized Anxiety Disorder, Social Phobia, Panic Disorder, Mood Disorder, and Psychotic Disorder, which all significantly aggravated deterioration of the health conditions of MAT patients. These psychiatric conditions, if not properly addressed in a timely manner, could cause more harm to the MAT patients. Additionally, socio-demographic characteristics such as occupation or employment status, religion, level of education, and gender, significantly impacted prevalence of mental health disorders among young adults enrolled in methadone assisted clinics in Kenya

Recommendations: the study made the following recommendations: regular clinical assessments should be conducted among young adult MAT patients for easier and more effective management of their situations; and proper management of psychiatric morbidities is important in order to ensure quality of life for MAT patients.

CHAPTER ONE: INTRODUCTION AND BACKGROUND INFORMATION

1.1 Introduction

The World Health Organization (WHO) reports that globally at least half of all mental health disorders in adulthood start by age 14, but most cases are undetected and untreated (WHO, 2022). Depression is one of the leading causes of illness and disability among adolescents, and suicide is the second leading cause of death in people aged 15–19 years. Mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years. Many factors have an impact on the wellbeing and mental health of adolescents. Violence, poverty, stigma, exclusion, and living in non-humanitarian and fragile settings can increase the risk of developing mental health problems (WHO, 2022).

Mental health disorders among young adults are increasingly becoming prevalent in different countries around the world. These include but are not limited to depression, anxiety, social phobia, ADHD and conduct disorders (Bagley et al, 2021). Depression, generalized Anxiety Disorders, Social Phobias, ADHD conduct disorders are the leading cause of health related disability in children and young adult age group. According to the Journal of the American Academy of Child and Adolescent Psychiatry 2022, most Psychiatric Disorders commonly presenting in Paediatric practices are Anxiety, Depression and Attention Deficit Hyperactivity Disorder. The American Academy of Paediatrics (2016) reports that more than 14 million (21% to 23%) of children and adolescent or 1 in 5, in the United States have a diagnosable Mental health condition or Substance Use Disorder. Among paediatrics patients in the Emergency Departments, 70% screen positive for at least one Mental Health Disorder, 23% meet criteria for two or more mental health concerns, while 45% had a Mental Health Problem resulting in impaired psychosocial functioning (Chun et al, 2016).

The presentation of major depressive disorder is often complicated by the co-occurrence of substance use disorders, such as alcohol and illicit drug abuse or dependence. Nearly one-third of patients with major depressive disorder also have substance use disorders, and the comorbidity yields higher risk of suicide and greater social and personal impairment as well as other psychiatric conditions (Mihretu, Teferra & Fekadu, 2017). There is limited data and information about the co-occurrence of mental disorders among young adults between ages 18 to 35 years attending MAT clinic in Kenya and worldwide (Musyoka et al, 2020). The number of children and adolescents seen in emergency departments (EDs) and primary

care settings for mental health problems has skyrocketed in recent years, with up to 23% of patients in both settings having diagnosable mental health conditions (Chun et al, 2016).

In Paediatric Primary Care setting, the reported prevalence of Mental Health and Behavioural Disorders is between 12% to 22% of children and adolescents respectively. Prevalence of depression and anxiety among children and adolescents has increased over time. In children aged 6-17 years, the rate of ever being diagnosed with anxiety or depression was 5.4% in 2003, 8% in 2007, and 8.4% in 2011-2012 (Chun et al, 2016). In the United States, Parent-reported surveys from 2011 and 2016 suggest 9.4% to 11% of children had received an ADHD diagnosis, with a 42% increase in the rates of diagnosis between 2004 and 2011 (Kumar & Gleason, 2019). Overall, 48% of Irish adolescents with Substance Use Disorders had a lifetime history of psychiatric disorders. (James et al, 2013). The prevalence of co-occurring other substance use disorder and mental health disorders was very high in youth with Opioid use disorder (OUD), particularly for 16–17 year olds (Bagley et al, 2021).

Most studies that were done in the United States only determined the racial or ethnic differences in the prevalence, patterns and the correlation of co-occurring substance use and mental disorders among whites, Blacks, Latinos and Asians in the US, and results showed rates of mental disorders varied significantly by race or ethnicity. Furthermore, most individuals were reported to exhibit symptoms of mental disorders occurred before symptoms of substance use disorders (Mericle et al, 2012). This was supported by Tucker et al (2021), who found out that the association between alcohol and drug disorders and any mood disorders among Blacks was stronger than among Whites in the US.

The largest study done in 2004 on co-occurring mental disorders to date is the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) found that approximately 20% of all persons in the general population with a current substance use disorder had at least one current independent mood disorder and 18% had at least one current independent anxiety disorder (Cadigan et al, 2019). Another study done by Gomes et al (2019) was used to assess the prevalence of some mental disorders and suicide risk in youth. The findings showed that Generalized Anxiety Disorder (GAD) and Social Anxiety Disorder (SAD) were the most prevalent and about 20% of youths had at least one mental disorder. Children and young people with Neurodevelopmental and Emotional Problems (NDEP) including behavioural problems such as ADHD, ASD, Tics Disorder/Tourette's,

developmental delay, Learning Disorders have three to four-fold increase in prevalence of co-occurring mental disorders into adulthood.

Methadone is a long-acting opioid agonist maintenance treatment used to treat opioid addiction by preventing opioid withdrawal and reduce cravings. Most mental conditions remain undetected while patients are undergoing methadone maintenance treatment and may even persist. Psychiatric disorders have been cited as a significant barrier for individuals to optimally adhere to opioid-dependent treatment (Duresso et al, 2016). Mental health problems can cause diminished treatment outcomes in patients undergoing Methadone Maintenance Therapy (MMT) such as higher rates of involvement in HIV-related risk behaviours, interfering with therapeutic compliance to treatment (Le et al, 2019). The study further showed that approximately one-third of MMT patients in the community had moderate to severe depression. Thus, this study aimed to identify and give treatments of psychiatric comorbidities for opioid-addiction patients early enough in order to enhance the efficacy of MMT programs.

Adherence to and retention in medications for opioid use disorders (MOUD) is defined as continuous engagement in treatment among adolescents and young adults. Younger age was consistently associated with shorter adherence and retention in MOUD. Several factors at the individual level (including comorbid psychiatric conditions), interpersonal, and institutional levels, such as concurrent substance use, MOUD adherence, family conflict, and MOUD dosage and flexibility, appeared to have roles in MOUD retention and adherence among adolescents and young adults. In this review, a study by Viera et al (2020) established that adolescents and young adults with OUD demonstrated heightened risk for dropout from Methadone Assisted Therapy programmes in more than half of analyzed articles. More specifically, adherence to MAT reduces opioid use and subsequent risk of HIV and hepatitis C transmission, while improving mental health and reducing drug-related and all-cause morbidity and mortality.

Even when adolescents and young adults are able to access services offered through the Methadone Assisted Clinics, young people still experience challenges with adherence to medications at the MAT clinics. As such, there is an urgent need to identify the factors causing young people to prematurely drop out of Methadone Assisted therapy programmes (Weinstein et al, 2017). Thus, the aim of this study is to identify the psychiatric comorbidities mainly Major Depressive Disorder, Generalized Anxiety Disorder, Social Phobia, Panic

disorder, mood and psychotic disorders in opioid-addiction patients early enough in order to enhance the efficacy of MMT programs by ensuring adherence and retention in medications for opioid use disorders.

1.2 Background Information

Mental health disorders in children and young adults cause a lot of distress and can have a negative impact on educational attainment and social relationships, as well as affecting physical health and can lead to risky behaviours such as drugs and substance abuse (Ngoc et al, 2020). Medication-assisted treatment (MAT) is a highly effective intervention for OUD, and there is strong evidence for its use with adolescents; however, most adolescents with OUD are unable to access MAT or remain in MAT long term to achieve substantial recovery (Pro et al, 2020). According to Pro et al (2020), nearly a third of the OUD patients received MAT treatment among American women of colour.

In 2002, the US Food and Drug Administration (FDA) approved the use of buprenorphine for patients aged ≥16 years. Buprenorphine is a partial opioid agonist, available in dissolvable films or tablets, which patients may self-administer as an outpatient or as a monthly injectable depot preparation. In 2016, the American Academy of Paediatrics published a policy statement endorsing the use of MAT for opioid addiction among adolescents and young adults and noted oral buprenorphine as the preferred medication.

Opioid use disorder (OUD) is a complex problem that most commonly originates during the adolescent and young adult period. Most young adults (aged <25 years) in treatment programs report initiating use before 25 years of age, and there are lifelong impacts from early substance use necessitating early screening for opioid use and subsequent treatment. The prevalence of Opioid Use Disorders (OUD) increases by ascending age groups. About half of the youth with OUD had documented common mental conditions like depression or anxiety and one-third had co-occurring substance use disorder. (Bagley et al, 2021).

The 2017 National Survey on Drug Use and Health reports in the US showed that for heroin use, the average number of youths who initiated use each day was 25 and 126 persons aged 12–17 years and 18–25 years, respectively. Among young adults aged 18–30 years in Substance Use Disorders facilities primarily for treatment of heroin use, 27% report initiation between ages 18 and 24 years, 17% between ages 15 and 17 years, 15% between ages 12 and

14 years, and 10% aged <12 years (US Preventive Services Task Force et al, 2020). This demonstrates that young adults are at high risk of drug use which eventually has a negative impact on their mental health.

1.3 Problem Statement

Mental Disorders are often underdiagnosed, especially in young adults with a history of substance use, because symptoms are either not recognized or are masked by drug use or are wrongly attributed to spiritual or behavioural issues, this trend has commonly been reported in the Coastal regions of Kenya. Overview Mental health disorders in children and young adults are common and account for a significant proportion of the burden of ill health in this age range. The World Health Organization (WHO) defines mental health as not simply the absence of disorder but 'a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.

The Coast Region is often associated with stigmatization especially when one is labelled mentally unstable or ill. This situation creates a high sense of fear of stigma or abuse from stigmatized individuals' families, with this potentially preventing a lot of young adults from seeking treatment or reporting psychological symptoms that they may have been experiencing. Eventually, a number of such young people end up in drugs and substance use, as an escapist strategy**.** Depression, Generalized Anxiety Disorder, Social Phobia, panic disorders, mood disorders and psychotic disorders are the leading causes of health related disabilities in the young adult age group. There is limited data and information in Kenya about the prevalence of these mental disorders among young adults between the ages of 18 to 35 years who are attending the Methadone Assisted Treatment Centres in Kenya.

Anxiety Disorders are among the most common psychiatric disorders in children and adolescents affecting 31.9% of children under the age of 18 years at some point in their lives, with 8.3% having a severely impairing disorder (Donnelly & Rhoads, 2012). ADHD appears to be highly comorbid with other Psychiatric Disorders and it is a life-long chronic disorder affecting 8.1% of the general population in the United States and it was significantly associated with Impulse Control Disorder, Bipolar Disorder, and most commonly Social Phobia and Major Depressive Disorder (Koyuncu et al, 2015). The same situation may apply in the Kenyan situation, hence the need for the current study.

1.4 Significance and Rationale

Mental health disorders in children and young people cause distress and can have wide-ranging effects, having an impact on social functioning as well as affecting physical health and they can be long-lasting. Using 2015–2017 National Survey on Drug Use and Health data, prevalence of co-occurring substance use and mental disorders and receipt of mental health and substance use treatment services was estimated for adults aged 18–64 with OUD. It is known that 50% of mental illness in adult life (excluding dementia) starts before age 15 and 75% by age 18 (Aguirre et al, 2020). In addition, there are well-identified increased physical health-related problems associated with mental health. There are strong links between mental health problems in children and young adults and social disadvantage, with children and young adults in the poorest households who are more likely to have a mental health problem than those growing up in better-off financially stable homes. The findings of this study will be critical in highlighting this disparity and providing recommendations for improved policy and practice.

Parental mental illness is associated with increased rates of mental health problems in children and young adults who have an increased likelihood of experiencing difficulties themselves. The mental health care needs of young people are not acknowledged. Little data is available on the co-occurring of Mental Disorders in young adults who are attending Methadone Assisted Treatment Clinics in the country and whatever little that is available is not disaggregated by age. Early detection of these mental conditions would lead to improved ability to design and implement effective and age-appropriate mental health services in Kenya that would improve the quality of life of young people in the country hence reducing the rates of drug and substance misuse in the young population.

According to Morse et al (2017), co-occurring substance use and mental disorders are common among adults with OUD. Therefore, expanding access to comprehensive service delivery models that address the substance use and mental health co-morbidities of this population is urgently needed. Chronic opioid use is linked to diminished quality of life and functionality and a greater risk of mortality than other illicit drugs. Typical onset of illicit drug use and of drug dependence occurs in the teenage years. The problem of substance misuse in the Coastal Region of Kenya is growing at an alarming rate, and there is little evidence showing whether there is an underlying mental condition that actually predisposes the young adult age group in abusing substances. Situating the study in two geographical

areas within Kisauni subcounty provided room for giving the research a comparative approach for a richer data to influence mental health policy and action.

1.5 Research Question

1. What is the prevalence of psychiatric morbidities mainly Major depressive disorder, Generalized Anxiety Disorder, Social Phobia, Panic Disorder, Mood and Psychotic Disorders among young adults aged 18 to 35 years enrolled in Methadone Assisted Treatment Clinics in Kisauni Sub-county in Mombasa County?
2. What are the socio-demographic characteristics of young adults aged 18 to 35 years enrolled in MAT Clinics in Kisauni Sub-county?

1.6 Broad Objective

To assess the prevalence of underlying psychiatric morbidities among young adults aged 18 to 35 years enrolled in MAT Clinics in Kisauni Sub-county in Mombasa County, specifically in Frere Town and Shimo la Tewa.

1.7 Specific Objectives

a. To determine the socio-demographic characteristics of young adults aged 18 to 35 years enrolled in MAT Clinics in Kisauni Sub-county.
b. To determine the prevalence of psychiatric morbidities among young adults aged 18 to 35 enrolled in MAT Clinics in Kisauni Sub-county.

1.8 Conceptual Framework

The conceptual framework below demonstrates the relationship between independent or predictor variables and the dependent variable, which is the outcome of the study.

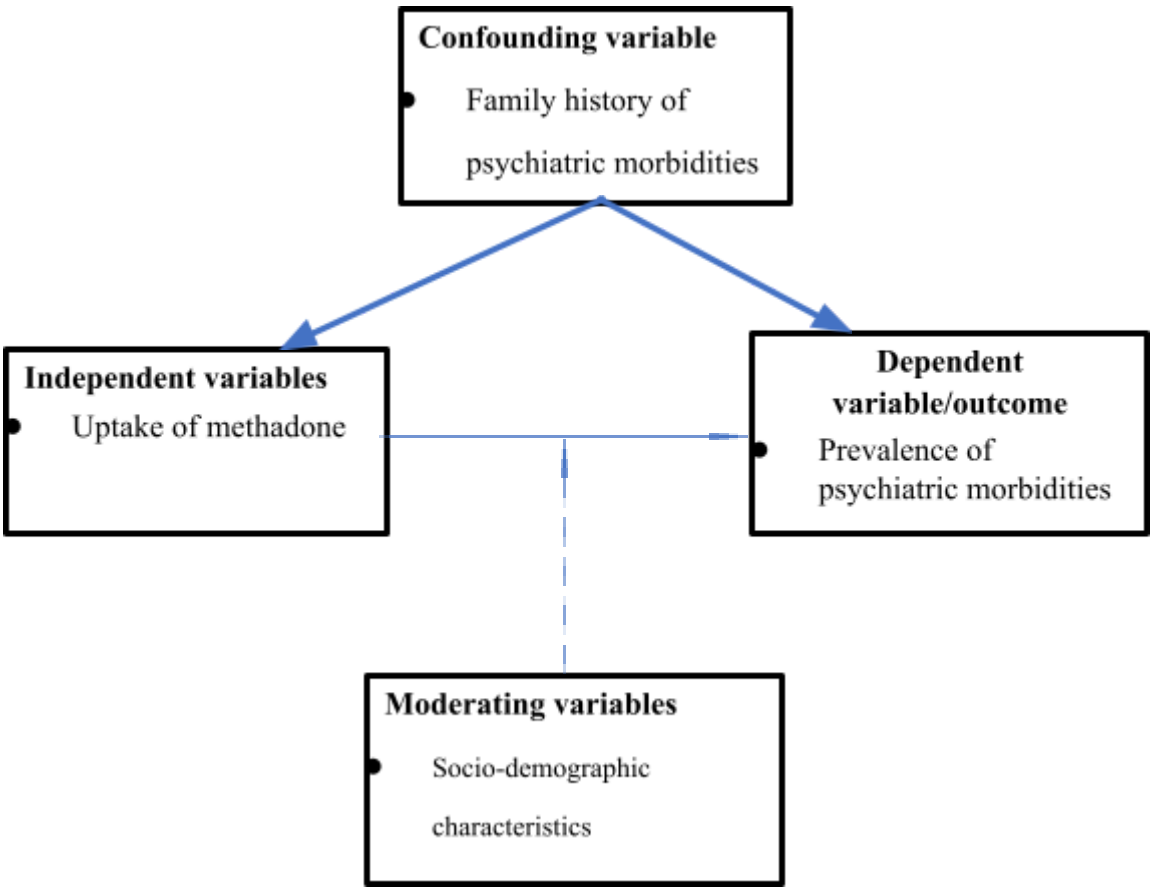


Figure 1.1 Conceptual Framework

As demonstrated in figure 1.1, the independent variables comprise of uptake of methadone by youth aged 18-35 years whereas dependent variable entails prevalence of psychiatric morbidities. The moderating variable comprise of socio-demographic characteristics of the respondents. There is also confounding variable which comprises of family history of psychiatric morbidities. Each of those variables will be further broken into smaller sub-variables that will enable the researcher to measure how specifically the predictor or independent variables influence the outcome of the study or the dependent variable.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter highlights theoretical framework of the study and a critical analysis of literature of several related empirical studies on the prevalence of co-occurring psychiatric morbidities mainly Major depressive disorder, Generalized Anxiety Disorder, Social Phobia, Panic Disorder, Mood and Psychotic Disorders in young adults ages 18 to 35 attending MAT clinics.

2.2 Theoretical Framework: Self-Regulation Theory

This study was guided by self-regulation theory by Albert Bandura that will be used to explore the relationship between prevalence of psychiatric morbidities and uptake of methadone among the youth aged 18 to 35 years enrolled in methadone assisted clinics in Kisauni subcounty in Mombasa County.

Self-regulation theory was initiated by Albert Bandura in 1960-70s as a social cognitive model for individuals' self-regulatory behaviours. The theory postulates that individuals are active players in their own destinies where they have control over important decisions and actions through guiding of their thoughts, actions, and environmental factors in order to achieve personal goals (Bandura, 1986). According to Sandars and Cleary (2011), at any given time any of these domains can determine one's actions or behaviours that can eventually influence the direction that individual's life takes. Four key aspects of the self-regulation theory have been proposed as setting standards for desirable behaviours, motivation to meet those standards, monitoring and maintaining those standards, and the determination to control the urge to backtrack on the standards an individual has set (Bandura, 2005).

Related to the current study, self-regulation theory describes the need for recurring control of individual behaviour, thoughts, environment, and actions by being strong-willed. The coast region of Kenya is widely associated with drug abuse due to a number of social, environmental, and individual-related factors. Poverty, relative ease of access to drugs, and high level of joblessness are just some of the commonly contributing factors to drug and substance abuse and mental health conditions. Applying the tenets of self-regulation theory, potentially drug addicts have the ability to self-regulate their behaviours, beliefs, thoughts,

and actions in order to avoid the temptation of indulging in the antisocial behaviours which can then eventually negatively affect their mental health. In this sense, self-regulation is viewed as an important step towards healthy behaviour and practice as individuals adjust to responsible behaviours into their adulthood. On the contrary, lack of self-regulation could easily lead to overreliance on drugs and substance misuse in order to gain and maintain physical and psychological balance – eventually leading to mental health conditions that may require MAT clinic services to deal with.

2.3 Review of Studies

Critical analysis of empirical literature is considered from global, regional, national, and local perspectives in order to provide wider perspectives of the relationship between the prevalence of co-occurring mental disorders among adults aged 18 to 35 years attending Methadone Assisted Treatment Clinics and substance abuse.

2.3.1 Global Studies on Mental Disorders and Substance Use among Young Adults

According to the most recent Global Burden of Disease Study, opioid dependence is estimated to be the most common substance use disorder worldwide after alcohol use disorder and poses a considerable burden in the form of disability-adjusted life-years, responsible for 86,200 deaths and 3,656,100 years of life lost (GBD 2016 Alcohol and Drug Use Collaborators, 2018).

The United States (US) has experienced an opioid epidemic over the last two decades. Drug overdose deaths increased by 21% from 2015 to 2016, with two-thirds of these deaths attributed to opioid use disorder (OUD). In 2018, an estimated 2.8% of adolescents and 5.6% of young adults in the US had past-year risky opioid use (Lipari and Park-Lee, 2019). A study conducted last year which used data collected from 171,766 non-institutionalized US adults in the pooled National Survey on Drug Use and Health from 2015–2018 indicated that OUD was prevalent among drug users. Based on the performed survey-weighted descriptive, bivariate, and multivariable analyses, about 0.85% of the respondents reported having OUD in the past year. About one-quarter (26.3%), one-sixth (14.8%), and half (47.3%) of the respondents with OUD reported alcohol, marijuana, and nicotine dependence, respectively. One-sixth (16.7%) had a criminal justice involvement history, and almost one-third (30.8%) experienced a major depressive episode (MDE) in the past year (Moitra et al, 2022).

Studies have also shown that if left untreated, patients with co-occurring disorders typically exhibit poorer health outcomes including greater depressive symptomatology, more severe functional impairment, poorer recovery rates, increased suicidal ideation and attempt, and higher rates of healthcare utilization compared to those with a diagnosis of MDD alone (Vekaria et al 2021). People with opioid use disorder (OUD) often have a co-occurring psychiatric disorder, which elevates the risk of morbidity and mortality (Harris et al, 2021). Factors associated with developing OUD and other risky opioid use often emerge when individuals are adolescents or young adults and include opioid use as well as mental health conditions and alcohol, tobacco, marijuana, and other substance use (Moitra et al, 2022).

The prevalence of risky opioid use, opioid use disorder, and related harms continue to rise among youth (adolescents and young adults age 15–25) in North America. With an increasing number of opioid overdoses, there remain significant barriers to care for youth with opioid use disorder, and there is an urgent need to expand evidence-based care for treatment of opioid use disorder among this population (Chang et al, 2018). However, to date, no studies estimate the prevalence of risky opioid use and other substance use risk factors for OUD among adolescents and young adults in the Medicaid and the Children's Health Insurance Programs (CHIP), (Adams et al, 2019).

Another study conducted by Radez et al (2021) found out that a history of alcohol use disorder and/or Major Depressive Disorder among adolescents is associated with OUD. The findings further revealed that despite the high prevalence of mental health disorders among children globally, this problem is often underreported. Using both quantitative and qualitative data for literature review where 53 past studies were analyzed, the study reported barriers to children and adolescents seeking mental help as lack of mental health knowledge and negative perception of seeking help for mental health problems. Furthermore, 92% of the respondents indicated social factors, such as perceived social stigma and embarrassment, to be the reason they did not seek help for mental health issues. It also emerged that therapeutic relationship between the patients and the mental health professionals played a significant role in discouraging seeking for help among children and adolescents, with 68% of the respondents holding this view. This included perceived violation of confidentiality and failure to maintain trust with unknown persons during treatment seeking encounters.

Radez et al (2021) also noted systemic and structural barriers, such as high financial costs for treating mental health diagnosis and other related services, with 58% of the respondents

citing this as one of the main reasons. There was also the question of logistical challenges and inadequate access to mental health professionals as some of the systemic and structural barriers to seeking mental health related help. Overall, these findings revealed a complex nature handling mental health problems among children and adolescents, where the interplay between internal and external barriers made it difficult for young people to readily seek professional help. According to Tumenta et al (2021), the level of depression among mental health patients using opioid was dependent on a number of factors, with more non-whites likely to be less inclined to using opioids than Whites. However, frequent opioid overuse related to insomnia and stress was observed in depressed patients in general.

The findings by Tumenta et al (2021) corroborated revelations by the British Child and Adolescent Mental Health Surveys in 1999 and 2004 which found that 1 in every 10 children and young people under the age of 16 diagnosed with mental disorder were put under opioid use. Among the 5 to 10 year olds, 10% of boys and 5% of girls had a mental health problem while among the 11 to 16 year olds the prevalence was 13% for boys and 10% for girls. The most common problems were conduct disorders, attention deficit hyperactivity disorder (ADHD), anxiety, depression and autism spectrum disorders. Rates of mental health problems in children and young people in the UK is said to have significantly risen over the years, with common mental disorder symptoms of particularly conduct, anxiety and depression. Both studies concluded that besides needed effective social support, more public sensitization was required to reduce social stigma, improve young people's knowledge of mental health issues, and create an environment where mental health diagnoses were openly discussed.

A study by Catherine et al (2019) shows a high prevalence of ADHD among primary schoolchildren where the overall prevalence of ADHD was 8.8%. The Global Burden of Disease Study 2015 (GBD 2015) estimated that seven of the top 25 causes of years lived with disability (YLD) globally were mental disorders, with major depressive disorder (MDD) ranked second and anxiety disorders ranked ninth. The study further showed that mental disorders remained among the top ten leading causes of mental disease burden worldwide, with no evidence of global reduction in the burden since 1990. Findings from the New Zealand Mental Health Survey (NZMHS), the Dutch Tracking Adolescents' Individual Lives Survey (TRAILS), the US National Comorbidity Survey (NCS) and its replication (NCS-R), and the Children in the Community Study (CICS) from the US, show 12-month prevalence of MDD between 8.3 and 12.4% among people aged between 18 and 33 years. The 12-month

prevalence was between 19.4 and 22.3% for anxiety disorders (including specific phobias), between 2.5 and 10.3% for alcohol dependence, and between 7.1 and 18.4% for alcohol abuse.

A study conducted by Gustavson et al (2018) showed that the 12-month prevalence of any mental disorder among people in the 20s was 19.8% (men) and 32.4% (women), anxiety disorders: 9.6% (men) and 26.7% (women), anxiety disorders excluding specific phobias: 2.5% (men) and 6.9% (women), major depressive disorder (MDD): 4.4% (men) and 7.2% (women), and alcohol use disorder (AUD): 8.7% (men) and 4.4% (women). Anxiety disorders in the 20s predicted anxiety disorders and MDD ten years later, even when controlling for the association between these disorders in the 20s. Werlen et al (2020) found that a quarter of young Swiss adults aged between 17 and 21 years reported symptoms indicating the presence of at least one of the common mental disorders. Among these disorders, the most prevalent was depression at 17.7% followed by anxiety (13.2%) and ADHD (8.7%).

The research by Bagley et al (2021) where 303,262 eligible youth aged 16 to 25 years were involved noted that 2131 (0.7%) of the respondents had a documented Opioid Use Disorder (OUD) diagnosis. The prevalence of OUD increased with age of the research participants. About half of youth with OUD had documented depression or anxiety and one third had co-occurring substance use disorders, thereby indicating that OUD among the young people in primary care was not easily expressed. The findings further showed that utilization of OUD treatment was lowest among the group of young people aged 16-17 years, accounting for only 14% against those in the age bracket of 22-25 years which accounted for 39% of the total respondents. The study concluded by observing that there was generally low uptake of medication treatment for OUD among adolescents, thereby calling for enhanced efforts by all stakeholders to improve the situation and encourage integrated treatment for other substance use and mental health disorders.

The volatile opioid epidemic is associated with higher levels of opioid use disorder (OUD) and negative health outcomes in adolescents and young adults. Opioid misuse is increasing among young people between the ages of 10 and 24 years, especially in high-income countries, mainly due to increasing availability and nonmedical use of prescription opioids (Viera A et al, 2020). Among adolescents, the prevalence of OUD and other risky opioid use was more than 4 and 2 times higher respectively among those who had a major depressive

episode compared to other adolescents, (1.7% and 6.0% respectively among those who had a major depressive episode compared to 0.4% and 2.5% among others) (Adams et al, 2019). There is limited research and data available that shows that there may be an underlying psychiatric comorbid condition that has remained undetected hence predisposing adolescents and young adults into opioid misuse.

2.3.2 Regional Studies on Mental Disorders and Substance Use among Young Adults

The World Drug Report 2019 states that 17.3% of people treated for a drug problem in South Africa use heroin as their primary drug of choice. Globally, and in South Africa, cannabis is the most commonly used non-regulated drug, while opioids are associated with the most negative health impacts. Opioids were associated with 76% of drug-related deaths in 2015. Approximately 0.7% of the global population aged 15 - 64 years were estimated to have used opioids for non-prescription purposes in 2016 (Gloeck et al, 2020). The United Nations Office on Drugs and Crime estimates that 0.5% of the population aged 15–64 in South Africa has used opioids in the past year, translating to around 184,030 people. Though there is no reliable empirical data concerning the prevalence of heroin use and there is limited data on the prevalence of co-occurring psychiatric disorders amongst heroin users in South Africa (Scheibe et al, 2020).

It is evident that there is a nexus between mental disorders and substance abuse among young adults across different geographical areas and social backgrounds worldwide. Different studies have been carried out to provide systematic and grounded ways of understanding how and why certain individuals are involved in drug use and the processes of treatment. Also critical is the analysis of how prevalence of co-occurring mental disorders among young adults attending methadone assisted clinics is addressed in order to save the addicts from their current situations.

A study by Richert, Anderberg and Dahlberg (2020) to examine substance abuse treatment, prevention and policy among young people experiencing mental health problems in Sweden noted that there were a significant number of self-reported mental health problems among young adults in the country. Using a sample of 1970 young people enrolled in outpatient mental health clinics in 11 Swedish cities, the findings revealed that at least 54% of the respondents reported mental health problems. Some of these included troubled concentration, sleeping challenges, anxiety and depression. The study also showed that just approximately

20% of those interviewed reported diagnosed mental health disorders, with girls doing better than boys when it came to openly sharing such information. Inferential statistics confirmed strong correlation between drug use and metal health problems, such as anxiety, aggression, mental stress, and hallucinations among others. The study recommended multipronged approach to treatment of mental health disorders among young people under substance abuse treatment.

Research by Brownlie et al (2019) on utilization of substance abuse treatment services among young adults in Canada noted that there were internal and external factors that influenced the uptake of mental health treatment services. For instance, youth hooked into cannabis had 10-times better chances of succeeding in their treatment than those involved in other substances, such as heroin or cocaine. Users of substances other that alcohol and/or cannabis experienced poorer self-rated mental health among the young people, with girls doing worse than boys. The research established a strong association between low level of mental health service utilization and the time of identification and initiation of treatment processes. Early identification and intervention had higher chances of successful prevention of development of concurrent disorders.

Jones and McCance-Katz (2019) did a study on co-occurring substance use and mental disorders among adults with opioid use disorder in the United States of America and established that adults with OUD addicted to alcohol stood about 26% chances of co-occurring substance use disorders as opposed to those using methamphetamine. The findings also showed that people addicted to different substances tended to seek treatment services for both mental health and substance use at different frequency levels. The research concluded that it was imperative for people to address co-occurring conditions in a timely manner for the purpose of improving treatment and health outcomes. It was also apparent from the research findings that co-occurring substance use and mental disorders are common among people with opioid use disorder. Recommendations by the study called for comprehensive and integrated mental health service delivery models to more effectively address substance use and mental health co-morbidities among this population group.

In a systematic literature review by Naveed et al (2020) on the prevalence of common mental health disorders in South Asian countries, the study noted that about 26% of the participants exhibited depressive symptoms, 12% alcohol abuse, 25% anxiety, 18% tobacco smoking, PTSD 17%, and mixed anxiety and depression 18%. At the same time, 21% of the

participants were associated with tobacco chewing, 0.8% misuse of opiates, 3% cannabis, 0.6% bipolar disorder, and 0.9% on use of stimulants. Overall, the study found out that there was a high prevalence of common mental disorders in South Asia, thus calling for extensive studies on psychiatric diseases among the target population. The research further recommended effective culturally sensitive multipronged mental health policy and practice interventions.

In South Africa, research was undertaken by Nyashanu and Visser (2022) on treatment barriers among young adults experiencing substance use disorders in Tshwane region. Using a mixed method approach where, surveys, FGDs and in-depth interviews were employed in data collection, descriptive and thematic content analyses showed that there were more contextual than attitudinal barriers to the uptake of mental health services. However, there were several barriers which generally made it difficult for the patients to embrace and/or access the services, including stigma, unavailability of stable services due to insufficient resources and support, and information gap. Ineffective treatment models, privacy concerns, cultural issues, and denial by the patients also emerged as common barriers to treatment of people suffering from mental disorders as a result of substance abuse. The study recommended comprehensive and integrated approaches to treatment based on realistic policy guidelines.

In a research by Memiah et al (2022) on mental health gaps and how to address them among adolescents and young adults in Kenya, the findings showed that there is a significant mental health services gap for adolescents and young people in Kenya, and elsewhere in low and middle-income countries. The study used 41 participants to identify existing strategies for dealing with mental health needs among young adults, and give recommendations on how to improve systems and processes. Ministry of health officials at national and county levels, academic experts, young people experiencing various forms of mental health challenges, and other different key implementation agencies were involved in the research. The research concluded that interventions were required in terms of enhanced insurance access, accelerated community health interventions, friendly mental health services seeking processes for young adults, and development of comprehensive systems assessment tools. There was also the question of incorporating technology in mental health services. Despite these recommendations, these could not be actualized without sufficient resources.

2.3.3 Socio-Demographic Data and Symptoms of Major Depressive Disorder, Generalized Anxiety Disorder, Social phobia, Panic Disorder, Mood and Psychotic Disorders among Young Adults.

From existing empirical data, both internal and external factors influence individual methadone assisted patients in seeking services to their mental health problems (Memiah et al, 2022; Nyashanu & Visser, 2022; Naveed et al, 2020). In a nationwide survey by Mohammadi et al (2020) in Iran on social anxiety disorder (SAD) among children and adolescents where 29,878 participants were involved, the findings noted various factors that influenced the rate of prevalence of different mental health disorders. Out of the 585 people diagnosed with SAD, older adolescents exhibited higher odds of this disorder. Similarly, individuals who had past paternal psychiatric hospitalization were more highly disposed to SAD compared to those without paternal history of psychiatric problems. The study further indicated that persistent depression disorder and melancholic personal trait in mothers were associated with SAD in children. At the same time, paternal history of schizophrenia and anxiety to social anxiety disorder in their children. Other anxiety and behavioural disorders occurred as co-morbidities.

Jystad et al (2021) carried out research on the relationship between socio-demographic characteristics and mental health co-morbidities among adolescents experiencing social anxiety in Norway. The study revealed that social anxiety affected adolescents to a great extent, and that this was often linked to functional impairment or other forms of individual suffering. Psychiatric co-morbidity played a significant role in heightening this burden. Involving 388 adolescents positively associated with SAD where professional nurses conducted the interviews using Anxiety Disorders Interview Schedule, more than two-thirds of the respondents diagnosed with SAD were reported to have at least one comorbid psychiatric disorder. Self-reported social anxiety symptoms, sleep challenges, poor family financial status, and low physical activity were some of the factors commonly linked to individuals who were diagnosed with SAD. Yet, there was need for the current study to highlight how these factors impacted patients attending methadone assisted clinic within different urban settings, such as in Frere and Shimo la Tewa towns.

A study was conducted by Alves, Figueiredo and Vagos (2022) on the relationship between prevalent social fears and social anxiety disorder, and social anxiety disorder (SAD) among Portuguese school adolescents. The study used a sample of 1,495 students where nearly 30%

of this number reported to be intensely impacted by social fears. Close to 54% of this population indicated a prevalence of 9.4% SAD among adolescents. The statistics further showed that the most feared social event was social performance, with about 13% of the school adolescents receiving treatment, 12% having refused intervention, while 65% accepted intervention. The findings therefore showed SAD as a highly prevalent mental disorder among young adults. The study recommended diversified mental disorder identification and intervention mechanisms tailored to specific needs of those affected by mental disorders. Despite these recommendations however, other socio-economic factors and policy interventions should be addressed based on unique needs of social groups.

2.3.4 Association between Major Depressive Disorder, Generalized Anxiety Disorder, Social phobia, Panic Disorder, Mood and Psychotic Disorders with Clinical Variables

Khanal et al (2022) did a study to examine a nationwide Finnish children and adolescents experiencing mental disorders within different social and healthcare settings. The study involved 22,388 children born in Finland between 1992 and 2006 who were experiencing anxiety disorder. The respondents were disaggregated into age cohorts and gender and matched with different control variables from the general population while logistic regression used to explain socio-demographic risk factors and anxiety disorder. The findings indicated that children whose mothers came from low socio-economic backgrounds stood higher chances of being affected by anxiety disorder compared to those with mothers from higher socio-economic class. Children whose mothers were single at the time of their birth were also more likely to suffer from anxiety disorder compared to those who were married or in a relationship. It also emerged that the environment of where an individual was born had some influence on social anxiety disorder, with those born in rural or semi-rural showing lower risk of anxiety disorder compared to those born in urban areas. As a conclusion, the study by Khanal et al (2022) noted that adolescents in Finland were increasingly experiencing overall anxiety disorders and/or decreasing treatment seeking. Generally, environmental risk factors were progressively occupying a central debate when it came to issues of anxiety disorders among children and adolescents.

Research by Anjum et al (2022) investigating prevalence and associated factors of anxiety among school adolescents in rural and urban Bangladeshi schools revealed that slightly more than 20% of the school adolescents were having moderate or severe anxiety, with 49.9% of

them being girls compared to 40.1% boys. Other associated risk factors of anxiety among adolescents included age, student's class performance, level of father's education achievement, number of household members, and residential environment for the adolescents' home. There were also lifestyle factors, such as physical activity, sleep deficiency, and underweight as well as perceived unsatisfactory or unattractive body image which were significantly determinants of anxiety among adolescents in rural, semi-urban, and urban living environments. The research by Anjum et al (2022) concluded that evidence-based health initiatives were needed to help Bangladeshi school adolescents to deal with anxiety. Some of the remedial steps included policy-related and practice.

According to Anyanwu (2023), there was high prevalence of psychological distress among school-going adolescents in Uganda, partly due to risky sexual behaviours, substance use, and chronic illnesses. In a cross-sectional study to examine psychological distress among students in Mbarara Municipality in Uganda where multistage cluster sampling was applied to enlist 921 adolescent students from 12 schools and 10-item Kessler Psychological Distress Scale used to measure level of distress, it emerged that psychological distress affected the respondents in various ways. These included negatively impacting the students' academic performance, relationships with kin and friends, and involvement in community development activities. Statistics indicated that 57% of the students experienced psychological distress, with substance use, and risky sexual behaviour significantly associated with mental health stability of the learners. The findings by Anyanwu (2023) further noted that the type of school was also associated with psychological distress among Ugandan adolescent students. As part of the recommendations, the research suggested the need for policymakers and other shareholders in the health and education sectors to seriously focus on mental health issues through effective policy measures and appropriate actions.

In Kenya, Ogachi, Karega and Oteyo (2019) undertook research on the relationship between depression and irrational use of the internet among university students in Kenya. Using a correlational design and targeting university students in Kenya where convenience sampling technique was used to sample 400 respondents, the findings noted a prevalence of 17% of pathological internet use against a prevalence of 24% of depression among the Kenyan university students. The study further indicated that female students were more likely be negatively affected by pathological internet use compared to their male counterparts. Conclusion by the research included the need to proactively identify and help affected

students to observe moderation and self-control when using the internet to avoid wasting too much time at the expense of their academic and life goals and objectives.

2.3.5 Co-Occurring Mental Disorders among Young Adults Attending Methadone Assisted Clinics

Studies on co-occurring mental disorders among young people attending methadone assisted clinics indicate different dynamics across different social groups in different settings. A study by Bråbäck et al (2022) on substance use, hospitalizations, and co-occurring disorders among patients on opioid maintenance treatment which reviewed 71 medical records for patients established that 72% of patients were diagnosed with psychiatric as opposed to OUD. The study further revealed that increased attention to psychiatric co-occurring disorders in the treatment of OUD was required and the importance of addressing sedative-hypnotics use when initiating OMT emphasized.

Matandika et al (2022) conducted research to examine prevalence of factors and their association with mental disorders among children and adolescents in Malawi. The respondents included 6-17 year olds who were interviewed to determine socio-demographic variables that influenced their mental health status. Based on the findings of the research, 5.4% of children aged 6-12 years experienced mental disorders while those aged 13-17 years accounted for about 8% of mental disorder burden. In terms of gender differentials, male children and adolescents showed higher prevalence of 7.1% while the female counterparts had 4.7% prevalence level. In terms of type of disorders, conduct disorder had the most prevalence of 3.4% while ADHD recorded 2.0% prevalence. Single parenthood, living with a guardian as opposed to parents, involvement in paid work, not currently attending school, and having difficulties with a teacher all had significant positive correlation with mental disorders. The research recommended socio-demographic mental health-related risk factors to be targeted in mental health intervention initiatives and programmes.

Wang et al (2021) did a study to explore the intervening role of internet gaming disorder, social network utilization, and pathological internet use on the relationship between loneliness and depression among junior high school students in China. The study used quantitative data obtained from 2,211 junior high school students aged 10-16 years using questionnaires on loneliness, internet gaming disorder, social network use, and depression. The findings indicated that loneliness was positively correlated with depression, but

loneliness was a direct predictor of depression through GPIU. At the same time, the study revealed that there were general interrelations among all the study variables. The intricate relationship between the various factors provided justification for the prevention and treatment of depression in Chinese junior high school students.

In Kenya, Kiburi, Mwangi and Maina (2022) carried out a qualitative research on the experiences of patients receiving OUD treatment from methadone clinic in Kenya and noted that several factors impacted on the treatment process and outcome. The study employed exploratory qualitative design where 17 participants were identified purposively and sampled from individuals attending methadone clinic for a period not less than 2 years. The respondents were interviewed on their history of substance use as well as their experiences before and after they started methadone treatment. The findings indicated that there were both benefits and challenges of methadone treatment. Prior to commencement of methadone treatment, the study revealed that the patients had been adversely affected by opioid use disorder. The treatment therefore gave the respondents an opportunity to regain their self-esteem and generally begin a new journey of building their lives. However, the downside to this approach was related to the patients' consistence in seeking treatment.

A study by Ngarachu et al (2022) on the prevalence and use of cannabis among adult patients attending methadone clinic in Nairobi noted that the treatment significantly helped the patients to reduce cannabis use. From 86% use at the baseline to 63% during follow-ups, the declining pattern of cannabis use appeared to be associated with methadone treatment. The study also established a correlation between gender, level of education, employment status, and marital status, and use of cannabis. Among the respondents seeking methadone treatment due to use of cannabis, a greater majority were male. At the same time, 76% of the patients were unemployed, about 51% had primary level education, while 49% were either divorced or separated. It was also established that individuals with university education stood the lowest risk for cannabis use, thus indicating that socio-demographic factors played a significant role when it came to being hooked into drug use. In conclusion, the study observed that there was widespread use of cannabis among patients attending methadone treatment clinic in Kenya. Hence, there was need for targeted interventions to deal with the problem of cannabis use during the treatment.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter highlighted methods to be used to undertake the study and achieve the research objectives. Specific areas covered in the chapter included study design, study site, study population, sample size determination, and sampling method. The chapter also focused on participants' recruitment and data collection procedures, data collection and quality control,

data management, data coding and data entry, data cleaning, statistical analysis, quality assurance procedures, ethics and informed consent, obtaining informed consent, potential benefits to study participants, potential risks, confidentiality, and voluntary participation.

3.2 Study Design

The study employed cross-sectional study design where quantitative data will be collected using a structured MINI 5.0 tool. Cross-sectional study design will be important in helping the researcher to measure the prevalence of psychiatric morbidities among the study participants at a specific point in time. This approach also allowed collection of data on individual characteristics of the target population, including their exposure to risk factors, while comparing many different variables at the same time with minimal costs (Thomas, 2022).

3.3 Study Site

The study was conducted in Shimo la Tewa and Frere Towns in Kisauni subcounty in Mombasa County, Kenya. The two towns fall within the coastal region of Kenya which is thought to have one of the highest rates of mental disorders among the adult population. The Kenya National Commission of Human Rights (KNCHR) estimates that 25-40% of patients suffer from a mental health condition (Muhia et al, 2021), with the statistics in Mombasa County likely to be higher due to the high prevalence of drug abuse in the coastal region in general (Nyongesa et al, 2021).

3.4 Study Population

The study population targeted all the 128 young adults between the ages 18 to 35 years who are enrolled in the methadone assisted clinics from 2015 to 2022 in the Kisauni Subcounty in Mombasa County, mainly Frere Town and Shimo la Tewa townships. All the study participants included were patients currently undergoing MAT treatments in local clinics who were expected to offer crucial information to answer the research questions.

3.5 Inclusion and Exclusion Criteria

Inclusion criteria were patients in MAT clinics aged 18-35 years who were enrolled in 2015-2022 for treatment in methadone-assisted clinics, amounting to 128. Both female and

male patients who gave consent to participate in the study were included. Exclusion criteria were patients who were not stable enough or too sick or deemed incapable to participate in the study, for example patients with intellectual disability.

Based on the available records, table 3.1 provides summary of the target population.

Table 3.1 Target Population

Year of Enrolment at MAT Clinic	Gender		Total	Percentage (%)
	Male	Female		
2022	5	2	7	5.5
2021	8	9	17	13.3
2020	30	4	34	26.6
2019	0	1	1	0.8
2018	16	4	20	15.6
2017	15	5	20	15.6
2016	7	3	10	7.8
2015	18	1	19	14.8
Total	**99**	**29**	**128**	**100.0**

3.6 Sample Size Determination

All the 128 young adults (18-35 years) currently enrolled for treatment in methadone assisted clinics in Frere and Shimo la Tewa townships in 2015-2022 were involved in the study. Also known as complete survey or complete enumeration, census is a statistical investigation method in which data is collected for each and every element or unit of the population. This method is useful when the study population is limited (Aggarwal & Ranganathan, 2019).

Table 3.2 presents summary of sample size to be used in the study.

Table 3.2 Sample Size

Year of Enrolment at MAT Clinic	Sample Size
2022	7
2021	17

2020	34
2019	1
2018	20
2017	20
2016	10
2015	19
Total	**128**

3.7 Sampling Method

Respondents were recruited using purposive sampling technique where the researcher relied on available information in the MAT clinics to select the participants based on the minimal inclusion criteria, such as age category of 18-35 years old. Purposive or subjective sampling is a non-probability sampling technique which allows the researcher to selectively pick a sample which bears the basic characteristics (Nikolopoulou, 2022). In this case, the age category of 18-35 years formed the basis of involving the patients in the study. Each individual eligible for the study was approached for data until the sample size was met.

3.8 Recruitment and Data Collection Procedures

Approximately all 128 young adults aged 18 to 35 years recruited from methadone clinics and were enrolled for treatment at the MAT clinics in Kisauni subcounty (Frere and Shimo la Tewa townships) from 2015 to 2022 came daily to the MAT clinics for their daily dose of methadone. However, the number could vary. Therefore, the researcher targeted all these respondents.

Once the respondents were identified as they came in to the MAT clinics using the Electronic database of the methadone patients at the clinics that was used to identify the eligible participants who were thereafter accessed for the structured questionnaires to be administered accordingly by the researcher, they were approached kindly and requested to participate in the study.

If the inclusion criteria were met, then informed consent was obtained to indicate that their participation was voluntary. Prior to the respondents' consent, they were adequately informed

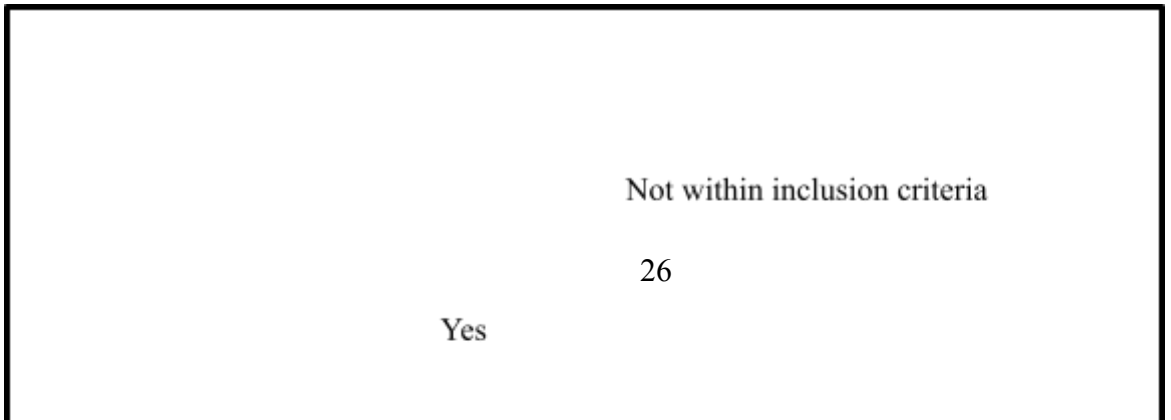
about the purpose and aim of the study expectations and their roles as participants and reassuring them, that confidentiality of the information given was maintained.

Four different interviewer-administered questionnaires were used to collect primary data on demographic and socioeconomic characteristics of the respondents, their attitude on MAT, efficacy of drug use, and utilization of harm reduction services, among different aspects related to the objectives of the study.

Mini International Neuropsychiatric Interview (MINI) 5.0 tool was used to collect data from the research participants. The MINI is the most widely tool used psychiatric structured diagnostic interview tool globally, and therefore was very relevant for this study. The MINI 5.0 tool was successfully used locally by Sane (2019) in her study on psychiatric comorbidities among epileptic patients attending the Mathari outreach psychiatric clinic in Kariobangi, Nairobi County. This made the tool viable for the current study. The MINI 5.0 questionnaire was self-administered and collected data on the psychiatric morbidities among young adults aged 18 to 35 years. However, the researcher administered the MINI tool to illiterate respondents and those who might have been reluctant to self-administer the tool.

A questionnaire refers to a list of questions or items intended for gathering information from respondents about their experiences, attitudes, or opinions regarding a given subject of study (Cleave, 2021). Questionnaires have various advantages for application in primary research. These include the ability to collect large amounts of data within a short duration of time, fast, more efficient and relatively cheaper administering process, and ease of organization and processing of data after fieldwork. A questionnaire was also most appropriate for collection of quantitative data for measuring objective variables of the research while allowing all the participants to have a common interpretation of the questions (Patten, 2016). The questionnaire consisted of close-ended questions in order to elicit statistical responses from the respondents. Likert scale was used to collect data on attitude regarding MAT.

3.9 Flow Chart of Data Collection Process



3.10 Data Collection and Quality Control

A number of steps were taken to guard against data breaches and guarantee high quality data throughout the entire process of data collection. Institutional approvals were obtained from the University of Nairobi and relevant Medical Research Committees before commencement of data collection. Written permission was obtained from the county and subcounty medical superintends to allow carrying out of the research and involving of the select MAT clinics in the study. The researcher was supervised by two University of Nairobi supervisors from the Department of Psychiatry to ensure strict adherence in all research protocols. High level of respect to the respondents was maintained throughout fieldwork to encourage their open interaction with the researcher, thereby engendering mutual honesty and enhancing the quality of data shared.

3.11 Data Management and Quality Assurance Procedures

Collected data was stored with utmost care. Hard copies of the data were safely kept under lock and key in secure cabinets where only the researcher can access them. Data in soft copies was stored in a password-protected Microsoft database to guarantee their confidentiality. These measures also ensured that no unauthorized access to or diversion of

the data was allowed; and that it woulf only be used for its intended purpose without unlawful intrusions.

3.12 Data Cleaning, Coding and Data Entry

Before data entry was done, the researcher gave a unique code to every questionnaire for easier reference. Administered data collection forms (questionnaires) were also thoroughly checked for completeness and only complete ones included in the final tally for analysis purposes. Data consistence was checked in order to identify and remove any incomplete cases, outliers as well as unreadable data. At the same time, open ended data was coded in order to make them easier for analysis and storage. Data entry entailed double entry and thorough checking in order to minimize errors.

3.13 Statistical Analysis

After Data collection, Data will be entered in Excel worksheets before analysis is carried out using the Statistical Package for Social Sciences-SPSS version 23 and analysed data will be stored in a password-protected database. Data will be analysed descriptively and inferentially. Association between the variables was presented using Chi-square tests; correlation between variables was determined by Pearson's correlation. Frequency tables, bar graphs and pie charts were used to present the socio-demographic factors and prevalence rates. Binary logistic regression was used to evaluate the factors which were predictive of uptake of MAT, and the correlation between uptake of MAT and prevalence of psychiatric morbidities, with the threshold for statistical significance set at $p<0.05$. The following are dummy tables for planned data analysis. Dummy table 1 helped to address specific objective g, which was on the respondents' socio-demographic characteristics, while table 2 & 3 helped to address objectives a-f.

Dummy Tables for Planned Data Analysis

Dummy Table 1: Respondents' socio-demographic characteristics

Variable		**Outcome**	
		Frequency (n)	**Percentage (%)**
Age	18-24 years		
	25-35 years		

Gender	Male		
	Female		
Marital status	Single		
	Married		
	Widowed		
	Divorced		
Level of education	Primary		
	Secondary		
	College/ University		
Occupation status	Employed		
	Unemployed		
	N/R		
Religion	Christianity		
	Islam		
	Others		
Family history of mental illness	Yes		
	No		

Dummy Table 2: Prevalence of psychiatric morbidities of youth enrolled in MAT clinics

	Frequency (n)	**Percentage (%)**
Psychiatric morbidity present		
Psychiatric morbidity absent		

,

Dummy Table 3: Psychiatric Morbidities among youth enrolled in MAT clinics

Psychiatric morbidity	**Frequency (n)**	**Percentage (%)**
Major Depressive Disorder		
Generalized Anxiety Disorder		

Social Phobia		
Panic Disorder		
Mood Disorder		
Psychotic Disorder		

3.14 Ethical Considerations

All the necessary ethical research protocols were strictly observed throughout the entire process of carrying out this study. The approval from the Hospital and University of Nairobi ethics and research committee and the study site administration were sought before commencement of the study. The respondents were assured of their anonymity as no names were indicated on the tools.

The benefits of the study included the early identification of psychiatric morbidities and ensuring better and early management was commenced hence improving the patient's outcome and their quality of life. Also, the efficacy and compliancy in the methadone treatment was maintained as a result.

There were possible risks that included distressing the patient while doing the data collection especially if they found out that they were suffering from a psychiatric disorder. Hence, patients were carefully monitored for any signs or changes in behaviour for instance irritability or signs of aggression during the interview, and they were explained about the psychiatric morbidities and the outcomes before commencing with the questionnaire. This was meant to prepare them psychologically and give them a little bit of psycho-education to ensure that they do understand what they might be suffering from and also provided reassurance on how to cope and get better with treatment. For those who were yet in denial of their diagnosed psychiatric morbidity, they were referred to a psychologist for psychotherapy.

The proposal was presented to the Mombasa County Hospitals/University of Nairobi Review Committee for ethical approval. A research permit was obtained from the National Commission of Science, Technology and Innovation (NACOSTI) as part of the steps for preparation for data collection. Before engaging the research participants, the researcher paid courtesy calls to the Mombasa County Director of Heath and other relevant senior healthcare services offices in Kisauni subcounty in order to explain the aim of this study and seek authorization to undertake it.

Management of the MAT clinics was also informed about the purpose of this study ahead of data collection process so that they could issue written permits for easier interaction of the researcher with key individuals in these institutions. Respect to the respondents was upheld by observing the principles of informed consent, confidentiality, anonymity, and voluntary participation in the research. All these ensured that potential risks to the participants were minimized as much as possible. Observing ethics and obtaining informed consent from the respondents required the researcher to clearly explain to the respondents the potential benefits and any possible risks of their participation before they could make fully informed decisions to voluntarily participate in the study.

At the same time, the researcher strove to keep confidential all shared data by not allowing access to the respondents' personal data by any third party without their consent. This also included publishing any data anonymously, without revealing the actual names of the respondents or directly associating any part of the shared data to specific individuals. As a general rule, all participants signed a consent form before they were asked to provide any data for the research. The form outlined the purpose of the study, potential benefits and/or risks involved if one decided to participate in the study. Overall, medical ethics were highly observed throughout the entire process of this research.

CHAPTER FOUR
FINDINGS

4.1 Introduction

The chapter presents the findings of the study based on the objectives of the study. This study assessed the prevalence of underlying psychiatric morbidities among young adults aged 18 to 35 years enrolled in MAT Clinics in Kisauni Sub-county in Mombasa County, specifically in Frere Town and Shimo la Tewa. The study specifically sought to determine the prevalence of Major depressive disorder, Generalized Anxiety Disorder, Social Phobia, Panic Disorder, Mood Disorder, and Psychotic Disorder among young adults aged 18 to 35 enrolled in MAT

Clinics in Kisauni Sub-county. Additionally, the study sought to determine the socio-demographic characteristics of young adults aged 18 to 35 years enrolled in MAT Clinics in Kisauni Sub-county.

4.2 Response Rate

The study intended to use all the 128 patients enrolled in MAT Clinics in Kisauni Sub-county. However, 113 of the sample of 128 were able to successfully participate in the study by completing the research tool, translating into 88% response rate. The failure of 15 of the respondents who were not able to participate in the study was attributed to the severity of their mental health state which forced the researcher to exclude them.

4.3 Socio-Demographic Characteristics of the Respondents

The respondents' socio-demographic characteristics were considered in terms of age, gender, and marital status, level of education, occupation status, religion, and family history of mental illness.

4.3.1 Gender of the Respondents

The respondents were asked about their gender, and the findings are presented in figure 4.1 as summarized below.

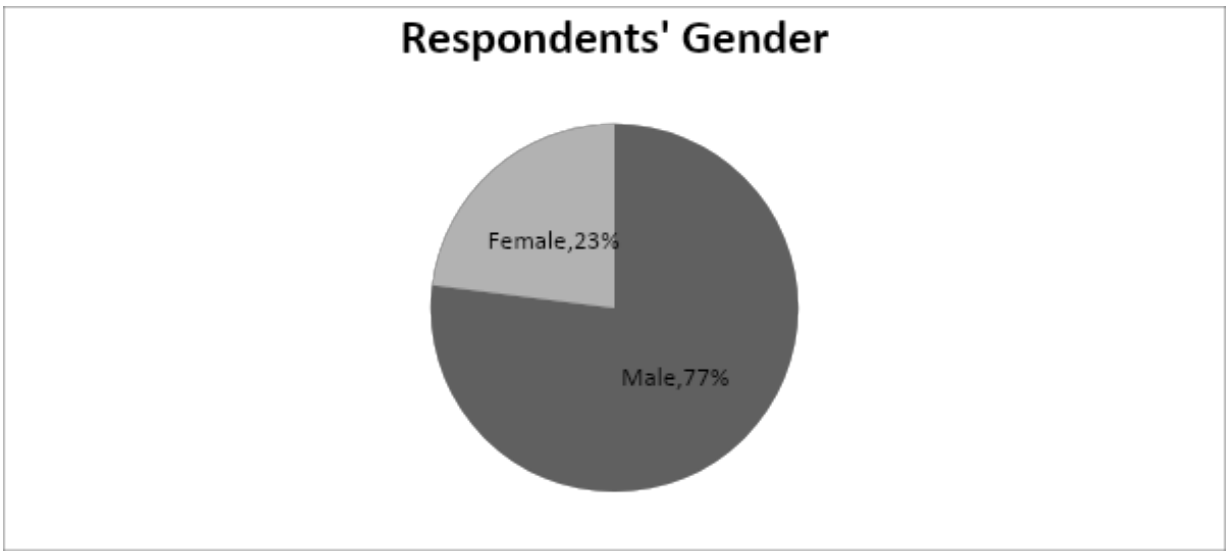


Figure 4.1 Gender of the Respondents

As presented in figure 4.1, 77% (87) of the respondents were male while 23% (26) of them were female.

4.3.2 Age Category of the Respondents

The age categories of the respondents are presented in figure 4.2.

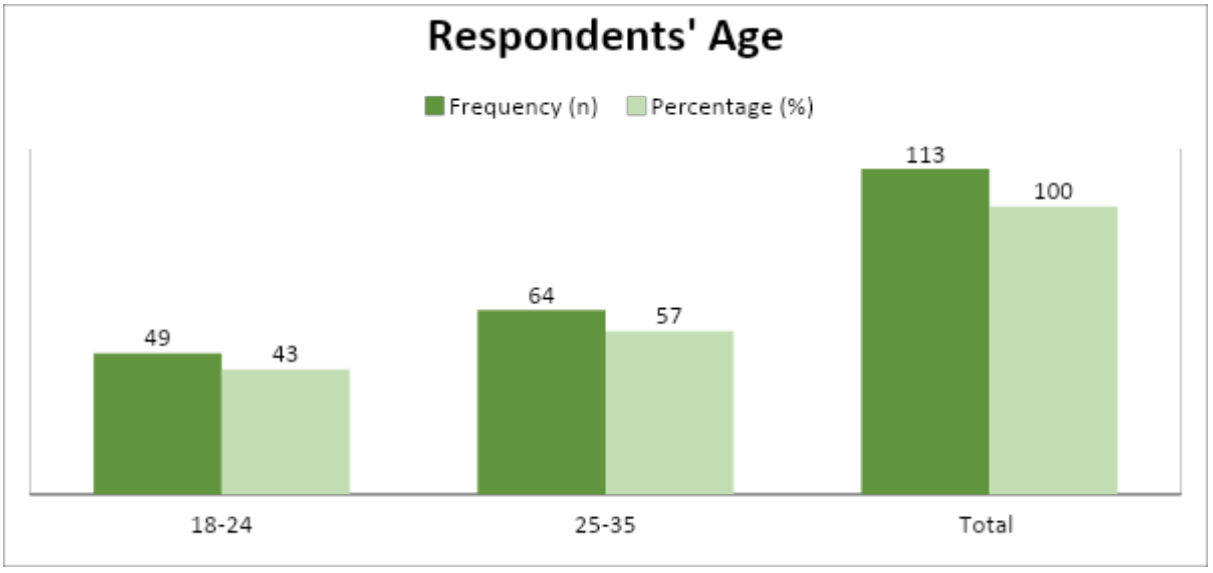


Figure 4.2 Age Categories of the Respondents

Majority of the respondents were aged 25-35 years which accounted for 57% (64), against 43% (49) that were aged 18-24 years. However, the difference between the age categories

was not very big. This may imply that young adult patients enrolled in MAT Clinics in Kisauni Sub-county were generally affected by psychiatric morbidities.

4.3.3 Level of Education of the Respondents

A summary of the level of education of the respondents was provided in table 4.1.

Table 4.1 Respondents' Level of Education

Level	Frequency (n)	Percentage (%)
Primary	48	42
Secondary	22	19
College	12	11
University	1	1
Dropped out	30	27
Total	**113**	**100**

From the findings in table 4.1, 42% (48) of the respondents had primary level of education, 19% (22) secondary level, 11% (12) college education, 1% (1) university, whereas 27% (30) of them were school dropouts. These statistics generally implied that majority of the young adult patients attending MAT clinics in Kisauni Sub-county had either obtained primary education or had dropped out of school, altogether accounting for 69% of the respondents.

4.3.4 Marital Status of the Respondents

Figure 4.3 summarizes marital status of the respondents.

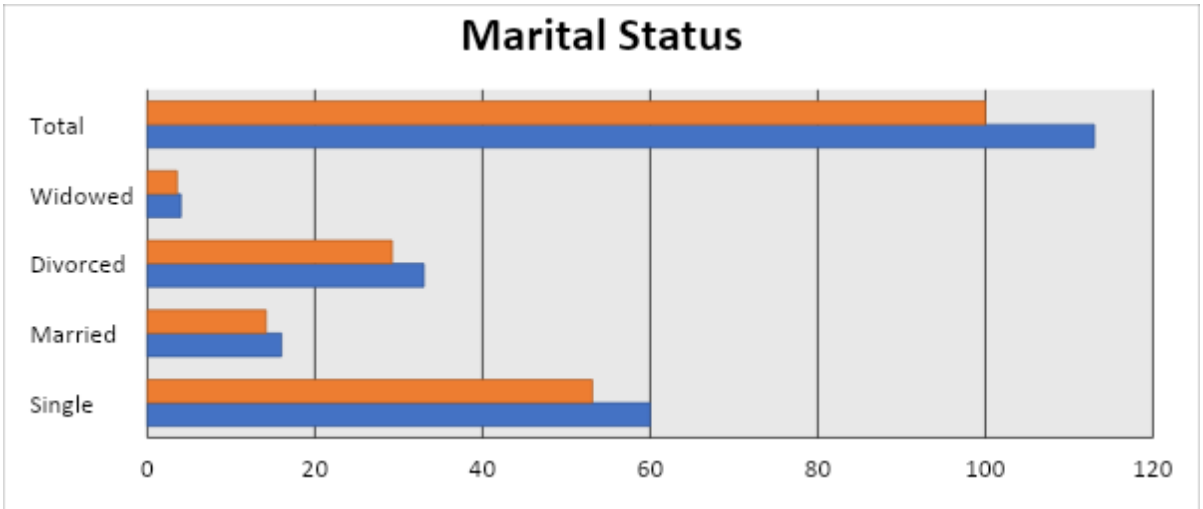


Figure 4.3 Marital Status of the Respondents

As illustrated in figure 4.3, majority of the respondents were single, which was 53% (60) of the respondents, 14% (16) were married, 29% (33) divorced, whereas 4% (4) of them were widowed. Overall, the findings indicated that just a handful of the respondents were currently in a marriage relationship, which was only 14% (16). This may further implied that young adult patients attending MAT clinics in Kisauni sub-county were single, divorced, or widowed.

4.3.5 Religion of the Respondents

The respondents' religious affiliations are captured in figure 4.4.

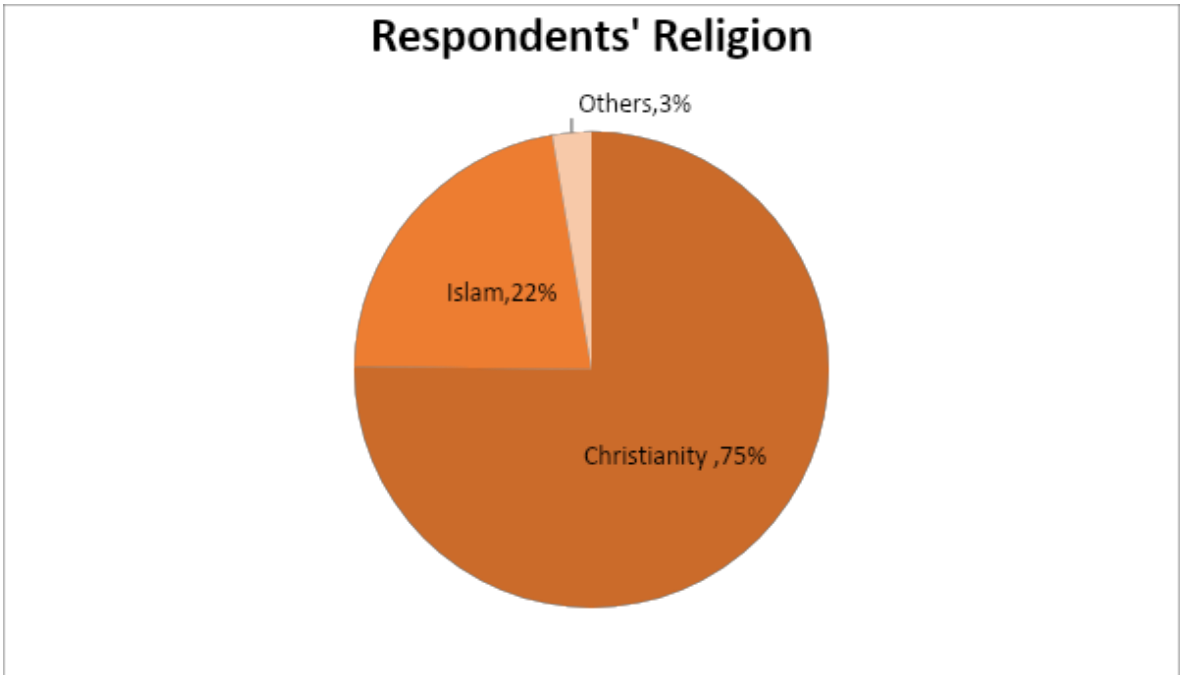


Figure 4.4 Religion of the Respondents

As summarized in figure 4.4, a greater majority (75%; n=85) of the respondents were Christians, 22% (25) belonged to the Islamic religion, while 3% (3) of them fell under the 'others' category.

4.3.6 Occupation Status of the Respondents

The respondents were also asked about their occupation or employment status, and the findings are summarized in figure 4.5.

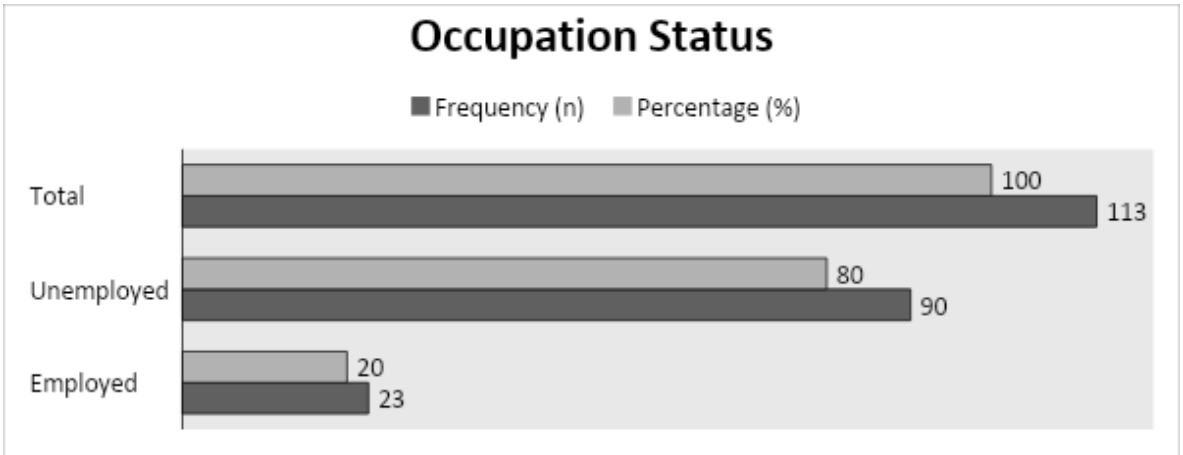


Figure 4.5 Occupation Status of the Respondents

Regarding the occupation status of the respondents, 80% (90) of them were unemployed while only 20% (23) were employed at the time of the study. These findings may imply that there was a relationship between having a job or gainful economic activity and attending MAT clinics by young adult patients living in Kisauni sub-county.

4.3.7 Family History of Mental Illness of the Respondents

Finally, the study inquired about family history of mental illness of the respondents, as demonstrated in figure 4.6.

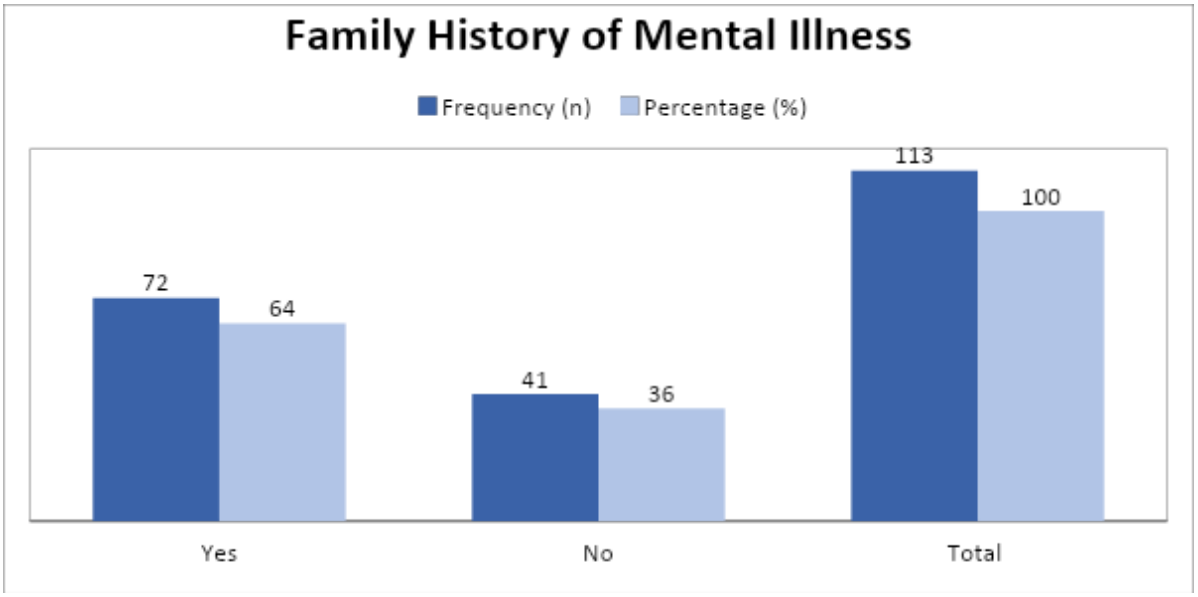


Figure 4.6 Family History of Mental Illness of the Respondents

About whether the respondents had family history of mental illness, 64% (72) of them said yes whereas of the remaining 36% (41) said no. From the distribution of these findings, it can be inferred that there was a link between the young adults' MAT status and their families' history of mental health illness.

4.4 Psychiatric Disorders among Youth Enrolled in MAT Clinics

The psychiatric disorders of youth enrolled in MAT clinics was analysed based on Major Depressive Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder (SAD), Panic Disorder, Hypomania, Mania, No Mood Disorder, Psychotic Disorder only, Mood Disorder with psychotic features, No Psychotic Disorder, and Suicidality. The analysis was done based on the responses of present and absent.

Table 4.2 Prevalence of Psychiatric Morbidities among Youth Enrolled in MAT Clinics

Psychiatric Morbidities	Present		Absent		Total	
	Frequency	%	Frequency	%	Frequency	%
Major Depressive Disorder	82	73	31	27	113	100
Generalized Anxiety Disorder	56	50	57	50	113	100
Social Anxiety Disorder (SAD)	41	36	72	64	113	100
Panic Disorder	43	38	70	62	113	100
Hypomania	12	11	101	89	113	100
Mania	49	43	64	57	113	100
Psychotic Disorder only	14	12	99	88	113	100
Mood Disorder with psychotic features	38	34	75	66	113	100
Suicidality	27	24	86	76	113	100

On the prevalence of Major Depressive Disorder, 73% (82) of the respondents reported that it was present against 27% (31) that reported absent. At the same time, 50% (56) indicated that Generalized Anxiety Disorder was present while 50% (57) reported absent. Thirty six percent (n=41) of the respondents reported that Social Anxiety Disorder (SAD) was present while 64% (72) said that this was absent. On Panic Disorder, 38% (43) of the respondents had

experienced the morbidity while 62% (70) said they did not have the problem. Eleven percent (n=12) indicated they had Hypomania while 89% (101) did not experience the same. On mania, 43% (49) of the respondents reported present while 57% (64) indicated they did not experience this.

The findings also showed that 54% (61) of the respondents reported to have experienced Mood Disorder while 46% (52) said they did not. It also emerged that 12% (14) of the respondents reported Psychotic Disorder only as present while 88% (99) said they did not experience the morbidity. On Mood Disorder with psychotic features, 34% (38) had experienced the morbidity while 66% (75) said they did not. The study also revealed that 46% (52) of the respondents had experienced No Psychotic Disorder whereas 54% (61) had. Finally, 24% (27) reported Suicidality whereas 76% (86) said they did not experience the problem. Overall, the average of the respondents that reported the psychiatric morbidities was 49% (56), against 51% (57) that did not report to have experienced them.

4.5 Correlation between Socio-demographic Characteristics and Psychiatric Disorders

In order to establish the relationship between socio-demographic characteristics of the respondents and psychiatric comorbidities, the Pearson chi square was used. At the same time, the crammer's phi coefficient was used to establish the correlation between non-binominal categorical variables, measuring the strength of the influence of the independent or predictor variables on the dependent variable or outcome of the study.

Table 4.3 Association between Socio-demographic Characteristics and Psychiatric Disorders

Variable		Presence of psychiatric disorder		Pearson's chi square (p-value)	Phi-coefficient (φ)	Correlation statistics (Crammer's V)
		Yes	No			
Gender	Male	43 (38%)	44 (39%)	X^2=10.401 Df=1 P=0.001	-0.253	
	Female	13 (11%)	13 (12%)			
Age	18-24	24 (21%)	25 (22%)	X^2=3.107 Df=1 P=0.014	-0.128	
	25-35	32 (28%)	32 (29%)			
Level of Education	Primary	24 (21%)	24 (21.4%)	X^2=12.17 3 Df=2 P=0.005		0.271
	Secondary	11 (10%)	11 (10%)			
	College	6 (5%)	6 (5%)			
	University	0 (0%)	1 (0.4%)			
	Dropout	15 (13%)	15 (13.4%)			
Marital Status	Single	30 (26%)	30 (27%)	X^2=7.612 Df=3 P=0.017		
	Married	8 (7%)	8 (7%)			
	Divorced	16 (14%)	17 (15%)			
	Widowed	2 (2%)	2 (2%)			
Religion	Christianity	42 (37%)	43 (38%)	X^2=11.17 3 Df=2 P=0.007		
	Islam	12 (11%)	13 (12%)			
	Others	1 (1%)	2 (1%)			
Occupation Status	Employed	11 (10%)	12 (11%)	X^2=8.205 Df=1 P=0.009	0.218	
	Unemployed	45 (39%	45 (40%)			
Family History of Mental Illness	Yes	36 (32%)	36 (32%)	X^2=3.356 Df=1 P=0.012	-0.131	
	No	20 (18%)	21 (19%)			

As documented in table 4.3, gender (P=0.001<0.05), age (P=0.014<0.05), level of education (P=0.005<0.05), marital status (P=0.017<0.05), religion ((P=0.007<0.05), occupation or employment status (P=0.009<0.05), and family history (P=0.012<0.05), each had a significant statistical relationship with psychiatric comorbidities. In the terms of the absolute numbers and percentages, more women (43%) than men (13%) seemed to be suffering from psychiatric comorbidities. Regarding the ages of the respondents, those aged 18-24 years

appeared to be affected less than those of the age categories of 25-35 years, accounting for 21% and 28% respectively.

At the same time, the findings showed that the more educated an individual was, the less likely it was that they would report comorbidity, with those having university education accounting only for 0% against those with primary education (21%) and dropouts (13%), who were relatively higher. It also emerged that there was disparity related to marital status, with those who were single and divorced reporting highest incidences of psychiatric comorbidity of 26% and 14% respectively, against those who were married (7%) and widowed (2%). On religion, a greater number of Christians (37%) had experienced psychiatric disorder compared to 11% of those belonging to Islam and 1% in other religions. Employment status of an individual also seemed to contribute to psychiatric disorder, with 39% of those who suffered a mental comorbidity being unemployed as opposed to just 10% of those who were employed. The findings also showed that individuals whose families had history of mental illness had higher chances of psychiatric disorder, with 32% confirming to have been affected as opposed to 18% of the individuals whose families did not have history of mental illness.

4.6 Binary Logistic Regression to Determine Predictors of Psychiatric comorbidities

Multiple binominal/binary logistic regression was carried out to measure the effect of socio-demographic characteristics on the probability of the respondents developing mental comorbidities. The Wald chi square test was applied to establish statistical significance for each of the predictor variables.

Table 4.4 Binary Logistic Regression to Determine the Predictors of Psychiatric Comorbidities

Variables	β	S.E	Wald	df	Sig.	Exp(β)
Gender	0. 439	1.021	1.21	112	0.005	1.212
Age2	-0. 892	.087	0.211	112	0.034	0.995
Level of education	1. 327	.687	0.201	112	0.023	6.213
Marital Status	0. 344	.881	0.243	112	0.041	1.112
Religion	0. 343	2312.011	0.000	112	0.007	0.776
Occupation Status	0. 202	120.122	0.000	112	0.012	0.623
Family History of Mental Illness	0. 429	1221.121	0.000	112	0.009	0.123

Constant	-34.053	1121.021	0.000	112	0.956	0.000
Variables: Gender, Age2, Level of education, Marital Status, Religion, Occupation Status, Family History of Mental Illness						

Based on the findings of binary logistic regression in table 4.4, gender (P=0.005<0.05), age (P=0.034<0.05), level of education, (P=0.023<0.05), marital status (P=0.041<0.05), religion (P=0.007<0.05), occupation or employment status (P=0.012<0.05), and family history of mental illness (P=0.009<0.05), all significantly influenced the model or prediction. This implied that each of the predictor variables in terms of the respondents' socio-demographic characteristics can significantly contribute to prevalence of psychiatric morbidities of youth enrolled in MAT clinics.

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CHAPTER FIVE
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The chapter presents discussion, conclusions and recommendations of the study. The study set out to determine the prevalence of psychiatric morbidities among young adults enrolled in MAT clinics in Mombasa. The study specifically addressed the following mental disorders: Major depressive disorder, Generalized Anxiety Disorder, Social Phobia, Panic Disorder, Mood Disorder, and Psychotic Disorder. Also, the study sought to determine the relationship between socio-demographic characteristics of the MAT patients and prevalence of psychiatric disorders.

5.2 Discussion

5.2.1 Significance of the Respondents' Socio-demographic Characteristics

The study considered socio-demographic characteristics of the respondents in terms of gender, age, level of education, marital status, religion, employment or occupation status, and family history of mental health illness. The study revealed that a greater majority of the respondents were male, accounting for 77% compared to 23% female. These findings were in agreement with a previous study by Matandika et al (2022) conducted to examine prevalence of factors and their association with mental disorders among children and adolescents in Malawi where it was noted that male children and adolescents showed higher prevalence of 7.1% while their female counterparts had 4.7% prevalence level of mental disorders.

In terms of age, the findings indicated that majority of the respondents were aged 25-35 years which accounted for 57% (64), against 43% (49) that were aged 18-24 years. However, the difference in percentage of the age categories was not very significant, thus implying that almost all young adults of 18-35 years attending MAT clinics were likely to be affected by psychiatric disorders in similar ways. Yet, in concurrence with the findings of current study, research by Bagley et al, 2021) noted that Opioid use disorder (OUD) which is a complex mental health problem that most commonly originates during the adolescent and young adult

period, mostly affected young adults aged 25 years. The previous research had also noted that prevalence of Opioid Use Disorders (OUD) increased by ascending age groups.

It was also evident from the current study that prevalence of psychiatric disorders was highest among respondents least educated, with majority of school dropouts (27%) and those with primary level of education (42%) reporting psychiatric disorder. These statistics were buttressed by multiple regression analysis, which indicated that level of education significantly predicted psychiatric comorbidities. This may also explain why majority (80%; n=90) of the respondents did not have gainful employment. These findings were a reflection of an earlier research by Sane (2019) done in Kenya which noted that 74.3% (107) of epileptic respondents were unemployed.

Other socio-demographic factors that significantly featured in this study were related to marital status of the respondents, with the findings indicating that 53% of them were single while just 14% were married. These findings reflected similar sentiments in a previous study carried out by Ngarachu et al (2022) on the prevalence and use of cannabis among adult patients attending MAT clinic in Nairobi where it was established that 49% of the patients were not in a marriage relationship. The study also established a correlation between gender, level of education, and employment status, and use of cannabis, with a greater majority being male, 76% unemployed, and 51% had primary level education. It was also established that individuals with university education stood the lowest risk for cannabis use, thus indicating that socio-demographic factors played a significant role when it came to being hooked into drug use, or subsequently suffering from a mental health disorder.

Several other previous studies reflected similar sentiments as noted in the current study. A nationwide survey by Mohammadi et al (2020) in Iran on social anxiety disorder (SAD) among children and adolescents where 29,878 participants were involved, the findings noted that there were various demographic factors influencing the rate of prevalence of different mental health disorders among the children. Like the current research, this previous research adopted quantitative approach where out of the 585 people diagnosed with SAD, older adolescents exhibited higher odds of this disorder. Similarly, individuals who had past paternal psychiatric hospitalization were more highly disposed to SAD compared to those without paternal history of psychiatric problems. The study further indicated that persistent depression disorder and melancholic personal trait in mothers were associated with SAD in children. Despite the difference of age of the participants used in the two researches where

each of them was conducted in a different social setting, both of them revealed that paternal history of schizophrenia and anxiety to social anxiety disorder had a relationship with the disorder in their children.

Furthermore, in a past study by Jystad et al (2021) which was carried out on the relationship between socio-demographic characteristics and mental health co-morbidities among adolescents experiencing social anxiety in Norway, like the current research, the study revealed that social anxiety affected the patients largely. However, unlike the past study that involved adolescents, research participants in the current study used young adults aged 18-35 years. Both of the studies established that psychiatric co-morbidity played a significant role in heightening the burden of mental health conditions. Involving 388 adolescents positively associated with SAD where professional nurses conducted the interviews using Anxiety Disorders Interview Schedule, Jystad et al (2021) noted that more than two-thirds of the respondents diagnosed with SAD were reported to have at least one comorbid psychiatric disorder. Self-reported social anxiety symptoms, sleep challenges, poor family financial status, and low physical activity were some of the factors commonly linked to individuals diagnosed with SAD.

5.2.2 Psychiatric Disorders among Young MAT Patients

The findings of the study indicated that there were different prevalence levels of the various psychiatric disorders reported by the MAT young adult patients attending clinics in Kisauni sub-county in Mombasa County. The prevalence of Major Depressive Disorder was 73%, 50% for Generalized Anxiety Disorder, 30% for Social Anxiety Disorder (SAD), 38% for Panic Disorder, 11% for Hypomania, and 43% for mania. At the same time, 46% of the respondents had no Mood Disorder, 12% reported Psychotic Disorder, while 34% had Mood Disorder with psychotic features. The study also revealed that 54% of the MAT patients experienced No Psychotic Disorder 24% (27) reported Suicidality. Overall, the average of the respondents that reported the psychiatric morbidities was 49%. The prevalence of psychiatric disorders among young adult population has also been found by different previous studies. For instance, Sane (2019) found out that 79.2% of adult epileptic patients that attended Mathari outreach clinic had experienced psychiatric comorbidities.

Although the current study established a relatively low prevalence of psychiatric disorders, the findings of the current research generally reflected what has been found by several studies

on this subject. For example, Josephson (2017) noted that psychiatric comorbidities such as mood anxiety disorders were prevalent among young adult patients. Similarly, Chun et al, (2016) established that prevalence of depression and anxiety among children and adolescents has increased over time while Kumar and Gleason (2019) noted that overall, 48% of Irish adolescents with Substance Use Disorders had a lifetime history of psychiatric disorders. Bagley et al (2021) also found out that substance use disorder and mental health disorders were very high in youth with Opioid use disorder (OUD), particularly for those aged 16–17 years.

The current study used the Pearson chi square to establish the relationship between socio-demographic characteristics of the respondents and psychiatric comorbidities. The current study further noted that gender with a p-value of ($P=0.001<0.05$), age ($P=0.014<0.05$), level of education ($P=0.005<0.05$), marital status ($P=0.017<0.05$), religion ($P=0.007<0.05$), occupation or employment status ($P=0.009<0.05$), and family history ($P=0.012<0.05$), each had statistically significant influence on psychiatric comorbidities. In the terms of the absolute numbers and percentages, more women than men seemed to be suffering from comorbidities, accounting for 55% and 20% respectively. These findings corroborated those by Ngarachu et al (2022) in their research on the prevalence and use of cannabis among adult patients attending methadone clinic in Nairobi, which noted a significant correlation between socio-demographic characteristics (gender, level of education, employment status, and marital status) and use of cannabis that subsequently contributed to the prevalence of mental health disorders.

Like other studies previously done on the psychiatric disorder among different social groups in different social settings, the current study noted that MAT patients were variedly affected by mental disorders. According to Khanal et al (2022) in a study to examine a nationwide Finnish children and adolescents experiencing mental disorders within different social and healthcare settings, the findings indicated that individuals' born environment had some influence on social anxiety disorder. This finding was also confirmed by the current research. The past study further showed that individuals born in rural or semi-rural showing lower risk of anxiety disorder compared to those born in urban areas. As a conclusion, the study by Khanal et al (2022) noted that adolescents in Finland were increasingly experiencing overall anxiety disorders and/or decreasing treatment seeking habits. Both the current research and that by Khanal et al (2022) further noted that generally, environmental risk factors were

progressively occupying a central debate with respect to issues of anxiety disorders among children and young people in general.

In a previous study by Ogachi et al (2019) on the relationship between depression and irrational use of the internet among university students in Kenya where correlational design was used to conveniently sample 400 respondents, the findings noted a prevalence of 17% of pathological internet use against a prevalence of 24% of depression among the Kenyan university students in general. Despite the current study' using MAT patients as opposed to the study by Ogachi et al (2019), both of them noted that gender played a significant role in contributing to prevalence of psychiatric morbidities of young people. The findings of the current research further noted that individuals' socio-demographic characteristics, such as gender age, level of education, marital status, religion, occupation or employment status, and family history of mental illness, all significantly contributed to prevalence of psychiatric morbidities among the youth enrolled in MAT clinics. These findings further concurred with Ogachi et al (2019) which indicated that female students were more likely to be negatively affected by pathological internet use compared to their male counterparts, this causing them mental issues. Ogachi et al (2019) concluded that there was need to proactively identify and help affected students to observe moderation and self-control when using the internet to avoid wasting too much time at the expense of their academic and life goals and objectives.

5.3 Conclusions

Based on the findings of this study, it was evident that there is high prevalence of psychiatric comorbidities among young adults enrolled in MAT clinics in Kenya. As noted within the scope of this study, these mental health conditions included major depressive disorder, Generalized Anxiety Disorder, Social Phobia, Panic Disorder, Mood Disorder, and Psychotic Disorder, which all could significantly aggravate deterioration of the health conditions of MAT patients. These psychiatric conditions, if not properly addressed in a timely manner, could cause more harm to the MAT patients. Additionally, socio-demographic characteristics such as occupation or employment status, religion, level of education, and gender, significantly impacted prevalence of mental health disorders among young adults enrolled in methadone assisted clinics in Kenya. This implied that mental health disorder among young people is a complex issue which should be approached from a holistic angle where different considerations are put into question.

5.4 Recommendations

The following recommendations were made by the study:

i. Regular clinical assessments should be conducted among young adult MAT patients for easier and more effective management of their situations.
ii. Proper management of psychiatric morbidities is important in order to ensure quality of life for MAT patients.
iii. Socio-demographic characteristics of patients of mental health disorders should be carefully considered when addressing this issue.

5.5 Suggestions for Further Studies

Further studies should be conducted on more predictive factors of comorbidities among young adult MAT patients in Kenya.

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APPENDICES

Appendix I: Informed Consent Explanation

TITLE OF STUDY: Prevalence of psychiatric morbidities among young adults ages 18 to 35 years enrolled in methadone assisted clinics in Kisauni subcounty, Mombasa County

PRINCIPAL INVESTIGATOR AND INSTITUTIONAL AFFILIATION: Dr. Nafisa Ahmed Seif MMED Psychiatry, University of Nairobi.

INTRODUCTION:

The researcher is undertaking a study on the above topic. The purpose of this consent form is to give you the information you will need to help you decide whether to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions to your satisfaction, you may decide to be in the study or not. This process is called "informed consent‖". Once you understand and agree to be in the study, I will request you to sign your name on this form. You should understand the general principles which apply to all participants in medical research:

i) Your decision to participate is entirely voluntary
ii) You may withdraw from the study at any time without necessarily giving a reason for your withdrawal
iii) Refusal to participate in the research will not affect the services you are entitled to in this health facility or other facilities. We will give you a copy of this form for your records.

May I continue? YES/ NO

This study has approval by The Kenyatta National Hospital–University of Nairobi Ethics and Research Committee protocol **Yes/No.**

WHAT IS THIS STUDY ABOUT?

The researcher listed above is interviewing youth aged 18-35 years enrolled in MAT clinics to understand prevalence of psychiatric morbidities. Participants in this research study will be asked questions about their psychological wellness among other questions that will focus on the demographic factors.

There will be approximately 128 participants in this study. We are asking for your consent to consider participating in this study.

WHAT WILL HAPPEN IF YOU DECIDE TO BE IN THIS RESEARCH STUDY?

If you agree to participate in this study, the following things will happen:

You will be interviewed by the researcher who is a Doctor in a private designated office at the hospital where you feel comfortable answering questions. The interview will last approximately 30 minutes.

After the interview is done, the psycho education and probably treatment will be accorded as per diagnosis. Referral for psychotherapy could be done.

We will ask for a telephone number where we can contact you if necessary. If you agree to provide your contact information, it will be used only by people working for this study and will never be shared with others. The reasons why we may contact you may be to get clarification of information given.

ARE THERE ANY RISKS, HARMS, DISCOMFORT ASSOCIATED WITHTHIS STUDY?

Medical research has the potential to introduce psychological, social, emotional and physical risks. Efforts will always be put in place to minimize the risks. One potential risk of being in the study is loss of privacy. We will keep everything you tell us as confidential as possible. We will use a code number to identify you in a password protected computer database and will keep all our paper records in a locked file cabinet. However, no system of protecting your confidentiality can be absolutely secure, so it is still possible that someone could find out you were in this study and could find out information about you.

Also, answering questions in the interview may be uncomfortable for you. If there are any questions you do not want to answer, you can skip them. You have the right to refuse the interview, or any question asked during the interview.

It may be embarrassing for you to have to give details of your personal life. We will do everything we can to ensure that this is done in private. Furthermore, the researcher is a professional with special training in these examinations/interviews. Also, discussing your condition may be stressful leading to emotional distress. Referrals for psychological review (counselling) will be done for emotional distress after treatment (for moderate to severe cases).

In case of any injury, illness or complications related to this study, contact the researcher right away at the number provided at the end of this document.

ARE THERE ANY BENEFITS BEING IN THIS STUDY?

Determining if you have a psychiatric illness will be helpful especially in improving your treatment plan hence better outcome and quality of life

The information you will provide will be contribution to science and knowledge in understanding psychiatric morbidities among outpatients and hence improve their level of care

WILL BEING IN THIS STUDY COST YOU ANYTHING?

There will be no financial cost to you as the data collection will be carried out during your clinic visit.

WILL YOU GET REFUND FOR ANY MONEY SPENT AS PART OF THIS STUDY?

As indicated above, you will not spend any money to take part in this study. Hence there will be no compensation.

WHAT IF YOU HAVE QUESTIONS IN FUTURE?

If you have further questions or concerns about participating in this study, please call or send a text message to the researcher at the number provided at the bottom of this page.

For more information about your rights as a research participant you may contact the:

KENYATTA NATIONAL HOSPITAL-UNIVERSITY OF NAIROBI ETHICS AND RESEARCH COMMITTEE

SECRETARY/ CHAIRPERSON,

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WHAT ARE YOUR OTHER CHOICES?

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

Appendix II: Ridhaa Ya Kushiriki Kwa Utafiti

UTANGULIZI

Majina yangu ni Dkt Nafisa Ahmed Seif, mimi ni mwanafunzi wa chuo kikuu cha Nairobi na waania shahada ya uzamili ya Psykiatri. Mada ya utafiti ni Prevalence of psychiatric morbidities among young adults between ages 18-35 enrolled in methadone assisted clinics in Kisauni subcounty, Mombasa County.

MADHUMUNI YA UTAFITI

Kuchunguza idadi au ujumla wa wangonjwa wanao ugonjwa wa akili baina ya vijana wa umri wa miaka 18-35 wanaotibiwa katika hospitali za ugojwa wakusongwa na mawazo katika Kisauni, kaunti ya Mombasa.

MAELEZO YA UTARATIBU WA UTAFITI

Umechaguliwa kama mshiriki mdhaniwa wa utafiti huu kwa sababu unakidhi vigezo vya kuingizwa vya utafiti huu yale yalikuwa. Nakuhimiza usome fomu hii na uulize maswali yoyote ambayo unaweza kuwa nayo kabla ya kukubali kuingia kwenye utafiti huu. Ni ya muhimu kutambua kuwa utafiti huu utachapishwa baada ya kukamilika. Ikiwa unakubali kuwa katika utafiti huu, utaombwa kusaini fomu ya kibali kama uthibitisho ya hiari ya ushiriki. Baada ya kutia sahihi kwenye ridhaa, basi utaendelea kama mshiriki na kujaza orodha ya maswali yatayo andikwa kwenye karatasi tatu tofauti. Kujibu maswali hayo yote yatachukuwa kama muda wa dakika thelathini.

HATARI, MADHARA NA USUMBUFU INAYOHUSISHWA NA UTAFITI HUU

Hakuna hatari, madhara na usumbufu wowote inayohusishwa na utafiti huu.

FAIDA YANAYOHUSISHWA NA UTAFITI HUU

Faida inayohusishwa na utafiti huu ni kuwa mshiriki atapata kujua kama ana ugonjwa wa kiakili. Hivyo basi matibabu kikamilifu yataanzishwa.

SIRI YAKO KAMA MSHIRIKI

Tutahakikisha kuwa unachotueleza kama mshriki itakuwa siri. Tutatumia msimbo kukujua kwenye data itakayokuwa kwa kompyuta ambayo imelindwa na neno fiche. Isitoshe, makaratasi yetu yote yatawekwa na kufungiwa ndani ya kabati ya faili.

NITAREGESHEWA PESA AMBAYO NITATUMIA KAMA MSHIRIKI WA UTAFITI HUU?

LA, kama ilivyoelezwa, hautahitaji pesa kuhusishwa kwa utafiti huu.

HAKI YA KUULIZA MASWALI AMA KURIPOTI WASIWASI

Kama una maswali zaidi ama wasiwasi wowote kama bado utafiti unaendelea au baada ya kushiriki kwenye utafiti, tafadhali wasiliana nami kwa simu au unaweza tuma ujumbe kwenye nambari hii ya mtafiti au, unaweza wasiliana na karani/ Mwenya kiti, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee.

KENYATTA NATIONAL HOSPITAL-UNIVERSITY OF NAIROBI ETHICS AND RESEARCH COMMITTEE
SECRETARY/ CHAIRPERSON,
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HAKI YA KUJITOA KWENYE UTAFITI
Uamuzi wako kushiriki ni kwa hiari yako. Uko na huru kukataa kuwa mshiriki wa utafiti huu. Unaweza kujitoa kama mshiriki wa utafiti huu wakati wowote bila udhalimu au upungufu wa faida yoyote kwako. Una ruhusa kutojibu swala lolote ama kujitoa kabisa kwenye utafiti wakati wowote ukiendelea na unaweza pia kataa majibu yako kutumika.

Appendix III: Statement of Consent

Participant's statement

I have read this consent form or had the information read to me. I have had the chance to discuss this research study with the researcher. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study: Yes No. I agree to have the questionnaire preserved for later study: Yes No. I agree to provide contact information for follow up: Yes No

Participant printed name: ……

Participant signature / Thumb stamp …….

Date ……..

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/ her consent.

Researcher's Name: …….

Date ……

Signature ……..

Role in the study: ……..

Appendix IV: Fomu Ya Ridhaa Ya Mshiriki

KAULI YA MSHIRIKI

Nimesoma fomu ya ridhaa hii ama nimesikiza maneno ambayo nimesomewa. Nimepata muda wa kujadiliana juu ya utafati huu na mshauri wa utafiti. Maswali yangu yamejibiwa kwa lugha ambayo ninaelewa. Nimeelezewa juu ya madhara na faida na ninaelewa kuwa kushiriki kwenye utafiti huu ni kwa hiari yangu na ninaweza kujitoa wakati wowote kama mshiriki. Ninakubali kuhisika na utafiti huu.

Ninaelewa kuwa watafiti watafanya juhudi na mikakati ambayo yatahakikisha kuwamambo yangu(utambulisho) yatabaki kuwa siri.

Kwa kutia saini kwenye fomu hii, sijawapa au kukana haki zangu za kisheria ambazo ninazo kama mshiriki wa utafiti huu.

Nakubali kuwa mshiriki wa utafiti huu Ndio La

Nakubali kuwa dodoso yangu inaweza wekwa na kutumika Ndio La

Katika utafiti mwingine Ndio La

Nakubali kuwapa nambari yangu ya mawasiliano iliniweze

Fuatiliwa virahisi Ndio La

Jina la Mshiriki: …….

Saini la Mshiriki / Kidole Tarehe Mtafiti……

Mimi niliyepiga saini yangu hapa, nimemweleza mshiriki maneno yote muhimu juu ya utafiti huu na nina amini kuwa ameelewa na kuamua kwa hiari yake kuwa mshiriki wa utafiti huu.

Jina la Mtafiti: Tarehe Saini …….

Jukumu langu kwa utafiti huu: …….

Kwa maelezo zaidi, tafadhali wasiliana na Dkt. Nafisa Ahmed Seif kutoka saa mbili asubuhi hadi saa kumi na moja na nusu jioni (Jumatatu hadi Ijumaa).

Appendix V: Socio-Demographic Questionnaire

PREVALENCE OF PSYCHIATRIC MORBIDITIES MAINLY MAJOR DEPRESSIVE DISORDER, GENERALIZED ANXIETY DISORDER, SOCIAL PHOBIA, PANIC

DISORDER, MOOD AND PSYCHOTIC DISORDER AMONG YOUNG ADULTS AGES 18 TO 35 YEARS OLD ENROLLED IN METHADONE ASSISTED CLINICS IN KISAUNI SUBCOUNTY, MOMBASA COUNTY

1) **Study Participant unique ID: …….**
2) Age in years _____
3) Gender
4) Male [ ]
5) Female [ ]
6) What is your highest level of education?

a) No school [ ]
b) Primary [ ]
c) Secondary [ ]
d) College [ ]
e) Bachelor's degree [ ]
f) Master's degree [ ]
g) Doctorate degree [ ]
h) Other, Specify……

7) What is your marital status?

a) Single [ ]
b) Married [ ]
c) Separated [ ]
d) Divorced [ ]
e) Widowed [ ]
f) Cohabitating [ ]

8) What is your occupation status?

a. Employed [ ]
b. Unemployed [ ]
c. Self-employed [ ]
d. Non- paid worker, such as volunteer/ charity [ ]
e. Student [ ]
f. Unemployed for health reasons [ ]
g. Other, Specify……

9) What is your religion?
10) Roman Catholic [ ]

11) Protestant [ ]

12) Muslim [ ]

13) Buddhist [ ]

14) Hindu [ ]

15) None [ ]

16) Other, Specify……

17) What is your monthly income?

- **a. 0 – 10,000 [ ]**
- **b. 10,001-30,000 [ ]**
- **c. 30,001 – 60,000 [ ]**
- **d. 60,001 – 90,000 [ ]**
- **e. 90,001 – 120,000 [ ]**
- f. **Over 120,000** [ ]

18) 9. Family history of substance use

a. 1) Yes [ ]

b. 2) No [ ]

19) 10. Family history of mental illness

a. 1) Yes [ ]

b. 2) No [ ]

i. What caused you to start using substances?

c. a) Self-medication [ ]

d. b) Peer pressure [ ]

e. c) Curiosity [ ]

f. d) Poor relationship i.e. physical/psychological abuse [ ]

g. e) Escape problems (home, work place, school) [ ]

h. f) Poverty [ ]

i. Other, Specify……

Appendix VI: Maneno ya Kijamii na Idadi

1. Umri katika miaka _____
2. Jinsia

Kiume [ ]

Kike [ ]

3. Kiwango cha juu cha masomo?

Hakuna masomo [ ]

Msingi [ ]

Secondari [ ]

College [ ]

Shahada ya kwanza [ ]

Shahada ya pili [ ]

Uzamivu [ ]

Mengine, fafanua……

4. Hali ya ndoa?

Bado kuolewa/oa [ ]

Umeolewa/oa [ ]

Tengana [ ]

Talakia [ ]

Mjane [ ]

Kuishi tu [ ]

5. Hali ya kikazi?

Ajiliwa [ ]

Sijaajilia [ ]

Nimejiajili [ ]

Kujitolea [ ]

Mwanafunzi [ ]

Kutoajiliwa kwa sababu ya kiafya [ ]

Mengine, Fafanua……

6. Dini yako ni gani?

Katoliki [ ]

Protestanti [ ]

Uislamu [ ]

Wa Budha [ ]

Kihindu [ ]

Hakuna [ ]

Mengine, fafanua……

7. Mapato ya kila mwezi?

0 – 10,000 [ ]

10,001-30,000 [ ]

30,001 – 60,000 [ ]

60,001 – 90,000 [ ]

90,001 – 120,000 [ ]

Over 120,000 [ ]

9. Historia ya familia ya utumizi wa madawa ya kulevya

1) Ndio [ ]

2) La [ ]

10. Historia ya familia ya ugonjwa wa akili

1) Ndio [ ]

2) La [ ]

11. Nini ilisababisha uanze kutumia madawa ya kulevya?

a) Kujitibu [ ]

b) Msukumo wa marafiki [ ]

c) Udadisi [ ]

d) Uhusiano mbaya/msongo wa mawazo [ ]

e) Kwa kuhepa shida [ ]

f) Umaskini [ ]

Mengine, fafanua……

Appendix VII: The Mini International Neuropsychiatric Interview (MINI)

STUDY PARTICIPANT UNIQUE ID: *……*
DATE OF BIRTH : TAREHE YA KUZALIWA: ……
PROTOCOL NUMBER : NAMBA YA PROTOKALI……

DATE OF INTERVIEW: Muda wa Kuanza Usaili……..

Time Interview Ended: Muda wa Kumaliza Usaili……

INTERVIEWER'S NAME JINA LA MSAILI: ……

M.I.N.I.

Mini International Neuropsychiatric Interview

English Version 5.0.0

DSM-IV

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DISCLAIMER

Our aim is to assist in the assessment and tracking of patients with greater efficiency and accuracy. Before action is taken onany data collected and processed by this program, it should be reviewed and interpreted by a licensed clinician. This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician – psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel.

M.I.N.I. 5.0.0 (July 1, 2006)

STUDY PARTICIPANT UNIQUE ID *: _____ : _____ DATE OF BIRTH : _____ TAREHE YA KUZALIWA: _____*

INTERVIEWER'S NAME : _____ *JINA LA MSAILI :* _____

DATE OF INTERVIEW : _____ *TAREHE YA USAILI :* _____

MODULES **VIHUNZI HURU**	**TIME FRAME** **MUDA**
A. MAJOR DEPRESSIVE EPISODE TUKIO LA SONONA MDE with melancholic features (optional) TUKIO LA SONONA lenye uzito wa moyo(hiari)	Current (2 weeks) Recurrent Current (2 weeks)
B. DYSTHYMIA DISTHIMIA	Current (Past 2 years)
C. SUICIDALITY HALI YA KUTAKA KUJIUA	Current (Past Month) Risk: low medium high
D. (HYPO) MANIC EPISODE TUKIO LA MANIA (KICHAA KIDOGO)	Current Past
E. PANIC DISORDER UGONJWA WA KUHOFIA KILA WAKATI	Current (Past Month) Lifetime
F. AGORAPHOBIA\ UOGA WA NAFASI ZA WAZI	Current
G. SOCIAL PHOBIA UOGA WA MKUSANYIKO WA WATU	Current (Past Month)
H. OBSESSIVE-COMPULSIVE DISORDER UGONJWA WA MAJINUNI LAZIMISHO	Current (Past Month)
I. POSTTRAUMATIC STRESS DISORDER UGONJWA WA SHIDA YA MAFIKIRA/ MKAZO YANATOKEA BAADA YA MATUKIO MABAYA	Current (Past Month)
J. ALCOHOL DEPENDENCE /ABUSE KUTAWALIWA NA POMBE / MATUMIZI MABAYA YA POMBE	Past 12 Months
K. DRUG DEPENDENCE / ABUSE (Non-alcohol) KUTAWALIWA / MATUMIZI MABAYA YA MADAWA YA KULEVYA (isiyo pombe)	Past 12 Months
L. PSYCHOTIC DISODERS MAGONJWA YA SAIKOSIS	Lifetime Current
M. ANOREXIA NERVOSA UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA	Current (Past 3 Months)
N. BULIMIA NERVOSA	Current (Past 3 Months)

UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO NA KUJILAZIMISHA KUTAPIKA

O. GENERALIZED ANXIETY DISORDER — Current (Past 6 Months)
UGONJWA WA WASIWASI MKUBWA ISIYO HUSISHWA NA CHOCHOTE HASWA

P. ANTISOCIAL PERSONALITY DISORDER (optional) — Lifetime
UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P and the CIDI. The results of these studies show that the M.I.N.I. has acceptably high validation and reliability score median 15 min.) than the above referenced instruments. It can be used by clinicians, after a brief training session. Lay interviewers require more extensive training.

Interview:

In order to keep the interview as brief as possible, inform the patient that you will conduct a clinical interview that is more structured than usual, with very precise questions about psychological problems which requires a yes or no answer.

General format:

The M.I.N.I. is divided into modules identified by letters, each corresponding to a diagnostic category. At the beginning of each module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a gray box. At the end of each module, diagnostic box (es) permit(s) the clinician to indicate whether the diagnostic criteria are met.

Conventions:

Sentences written in « normal font » should be read exactly as written to the patient in order to standardize the assessment of diagnostic criteria. Sentences written in « CAPITALS » should not to be read to the patient. They are instructions for the interviewer to assist in the scoring of the diagnostic algorithms.

Sentences written in « bold » indicate the time frame being investigated. The interviewer should read them as often as necessary. Only symptoms occurring during the time frame indicated should be considered in scoring the responses.

Sentences (in parentheses) are clinical examples of the symptom.These may be read to the patient to clarify the question.

Answers with an arrow above them (es) are not met. In this case, the interviewer should go to the end of the module, to circle « NO » in all the diagnostic boxes and move to the next module.

When terms are separated by a slash (/), the interviewer should read only those symptoms known to be present in the patient (for example, question A3).

Rating instructions:

All questions read must be rated. The rating is done at the right of each question by circling either YES or NO.

The clinician should be sure that each dimension of the question is taken into account by the patient (i.e.: time frame, frequency, severity, « and/or »alternatives).

Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I.. The M.I.N.I. Plus has questions that investigate these issues.

For any questions, suggestions, need for a training session, or information about updates of the M.I.N.I., please contact:

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A. MAJOR DEPRESSIVE EPISODE

TUKIO LA SONONA

A1 Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? Je, ulishawahi kukosa raha muda mwingi wa siku, karibu kila siku, kwa muda wa wiki mbili zilizopita?	NO HAPANA	YES 1 NDIYO 1
A2 In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time ? Katika wiki mbili zilizopita, je, umekosa hamu/ari katika vitu vingi au kukosa raha kwa muda mwingi katika vitu vilivyokuwa vikikufurahisha?	NO HAPANA	YES 2 NDIYO 2
	→	
IS A1 OR A2 CODED YES? JE, KIPENGELE A1 AU A2 KIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO

A3 Over the past two weeks, when you felt depressed and/or uninterested:

Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha na / au kutokuwa na ari:

A. Was your appetite decreased or increased nearly every day or did your weight decrease or increase without trying intentionally? (i.e., ± 5 % of body weight or ± 3,5 kg or ± 8 lbs., for a 70 kg / 120 lbs. person in a month)? Je, hamu yako ya kula ilipungua au kuongezeka, karibu kila siku? Uzito wako ulipungua au uliongezeka bila wewe kukusudia? (yaani ± 5 % ya uzito wako au kg. 3.5 katika mwezi)? IF YES TO EITHER, CODE YES IWAPO JIBU NI NDIYO KWA LOLOTE,JAZA NDIYO	NO HAPANA	YES 3 NDIYO 3
B. Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? Je, ulipata shida ya usingizi karibu kila siku? (tabu ya kupata usingizi, kukatika usingizi katikati ya usiku, kuamka mapema sana, au kulala mno)?	NO HAPANA	YES 4 NDIYO 4
C. Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still, almost every day? Je, ulikuwa ukiongea au kutembea pole pole zaidi kuliko kawaida yako, au ulikuwa na hali ya kutotulia, au kuwa na tatizo la kukaa kwa utulivu karibukila siku?	NO HAPANA	YES 5 NDIYO 5

D. Did you feel tired or without energy, almost every day? Je, ulijisikia mchovu au kutokuwa na nguvu karibu kila siku?	NO HAPANA	YES 6 NDIYO 6
E. Did you feel worthless or guilty, almost every day? Je, ulijisikia huna thamani au kuwa na hali ya kujilaumu karibu kila siku?	NO HAPANA	YES 7 NDIYO 7
F. Did you have difficulty concentrating or making decisions, almost every day? Je, ulikuwa na matatizo ya kuwa makini au kufanya maamuzi karibu kila siku?	NO HAPANA	YES 8 NDIYO 8
G. Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? Je, mara kwa mara ulifikiria kuhusu kujiumiza, au kutaka kujiua, au bora ufe?	NO HAPANA	YES 9 NDIYO 9

A4 ARE 3 OR MORE A3 ANSWERS CODED YES?

(OR 4 A3 ANSWERS IF A1 OR A2 ARE CODED NO)

JE, VIPENGELE 3 AU ZAIDI VYA A3 VIMEJIBIWA NDIYO?

(AU MAJIBU 4 YA A3 IKIWA AI AU A2 VIMEJIBIWA HAPANA)

NO	YES
HAPANA	NDIYO
MAJOR DEPRESSIVE EPISODE CURRENT	
TUKIO LA SONONA KWA SASA	

IF PATIENT MEETS CRITERIA FOR MAJOR DEPRESSIVE EPISODE CURRENT:

IKIWA MGONJWA ATAFIKIA VIGEZO VYA TUKIO LA SONONA KWA SASA

→

A5 a) During your lifetime, did you have other periods of two weeks or more when you felt depressed or uninterested in most things, and had most of the problems we just talked about? Katika maisha yako, uliwahi kuwa na kipindi kingine cha wiki mbili au zaidi ambapo ulikosa raha au kukosa ari katika mambo mengi na kwamba umekuwana shida kama zile tulizokwishazizungumza?	NO → HAPANA	YES 10 NDIYO 10
b) Was there an interval of at least 2 months without depression and/or loss of interest between your current episode and your last episode of depression? Je, kulikuwa na kipindi cha angalau miezi 2 bila hali ya kukosa raha na /aukupoteza ari kati ya wakati huu na ulipokuwa na hali hii siku za nyuma?	NO HAPANA	YES 11 NDIYO 11

NO	YES
HAPANA	NDIYO
MAJOR DEPRESSIVE	
EPISODE PAST	
TUKIO LA SONONA	
WAKATI ULIOPITA	

IS A5b CODED YES?

JE, KIPENGELE A5b KIMEJIBIWA NDIYO?

A. MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIC F

A. TUKIO LA SONONA LILILOAMBATANA NA UZITO WA

IF THE PATIENT CODES POSITIVE FOR A MAJOR DEPI

YES), EXPLORE THE FOLLOWING:

KAMA MGONJWA ATADHIHIRISHA KUWA NA SONONA KWA SASA (A4 = NDIYO), CHUNGUZA YAFUATAYO:

A6 a) IS A2 CODED YES? JE KIPENGELE A2 KIMEJIBIWA NDIYO?	NO → HAPANA	YES 12 NDIYO 12
b) During the most severe period of the current depressive episode, did you lose your ability to respond to things that previously gave you pleasure, or cheered you up? Wakati wa hali mbaya zaidi ya sonona ya sasa, uliwahi kupoteza uwezo wa kufanya vitu ambavyo mwanzoni vilikuwa vikikupa furaha au kukuchangamsha? IF NO: When something good happens does it fail to make you feel better, even temporarily? KAMA JIBU NI HAPANA:Wakati jambo zuri linatokea, je, jambo hilo hukufanya kujisikia vizuri, hata kama kwa muda.	NO HAPANA	YES 13 NDIYO 13
IS EITHER A6a OR A6b CODED YES? JE, KIPENGELE A6a AU A6b KIMEJIBIWA NDIYO?	→ NO HAPANA	 YES NDIYO

Over the past two weeks period, when you felt depressed and uninterested:

Katika kipindi cha wiki mbili zilizopita, ulipojisikia kukosa raha au kukosa ari:

A7

a. Did you feel depressed in a way that is different from the kind of feeling you experience when someone close to you dies? Je, ulikosa raha tofauti na vile unavyojisikia wakati unapofiwa na mtu wako wa karibu?	NO HAPANA	YES 14 NDIYO 14
b. Did you feel regularly worse in the morning, almost every day? Je, ulijisikia kuwa na hali mbaya zaidi kwa kila asubuhi karibu kila siku?	NO HAPANA	YES 15 NDIYO 15

c. Did you wake up at least 2 hours before the usual time of awakening and have difficulty getting back to sleep, almost every day?
Je, ulikuwa ukiamka angalau masaa mawili kabla ya muda wako wa kawaida wa kuamka na kupata tabu ya kulala tena karibu kila siku?

NO YES 16
HAPANA NDIYO 16

d. IS A3c CODED YES?
JE, KIPENGELE A3c KIMEJIBIWA NDIYO?

NO YES 17
HAPANA NDIYO 17

e. IS A3a CODED YES (ANOREXIA OR WEIGHT LOSS ONLY)?
JE, KIPENGELE A3a KIMEJIBIWA NDIYO (KUKOSA HAMU YA CHAKULA AU KUPUNGUA MWILI)?

NO YES 18
HAPANA NDIYO 18

f. Did you feel excessive guilt or out of proportion to the reality of the situation?
JE, A3e IMEJIBIWA NDIYO (KUJILAUMU KUPITA KIASI, AU KUJILAUMU KUSIVYOSTAHILI)?

NO YES 19
HAPANA NDIYO 19

NO YES
HAPANA NDIYO
MAJOR DEPRESSIVE EPISODE with melancholic features CURRENT
TUKIO LA SONONA lililoambatana na uzito wa moyo KWA SASA

ARE 3 OR MORE A7 ANSWERS CODED YES?

JE, VIPENGELE VITATU AU ZAIDI VYA A7 VIMEJIBIWA NDIYO?

B. DYSTHYMIA

➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

IF PATIENT'S SYMPTOMS CURRENTLY MEET CRITERIA FOR MAJOR DEPRESSIVE EPISODE, DO NOT EXPLORE THIS MODULE

B1 Have you felt sad, low or depressed most of the time for the last two years? Je, umewahi kujisikia kutokuwa na furaha au kusononeka kwa miaka miwili iliyopita?	→ NO HAPANA	YES 20 NDIYO 20 →
B2 Was this period interrupted by your feeling OK for two months or more? Je, hikikipindi kilikatizwa na kujiskia vizuri kwa mwezi mmoja au zaidi	NO HAPANA	→ YES 21 → NDIYO 21

B3 During this period of feeling depressed most of the time?

a. Did your appetite change significantly? Je, hamu ya chakula ilibadilika kwa kiwango kikubwa?	NO HAPANA	YES 22 NDIYO 22
b. Did you have trouble sleeping or sleep excessively? Je, ulikuwa na wakati mgumu wa kulala, au kulala sana?	NO HAPANA	YES 23 NDIYO 23
c. Did you feel tired or without energy? Je, ulisikia kuchoka au kukosa nguvu?	NO HAPANA	YES 24 NDIYO 24
d. Did you lose your self-confidence? Je, ulipoteza Uwezo wa kujiamini?	NO HAPANA	YES 25 NDIYO 25
e. Did you have trouble concentrating or making decisions? Je, ulikuwa na shida kuwa makini au kufanya maamuzi?	NO HAPANA	YES 26 NDIYO 26
f. Did you feel hopeless? Je, ulijisikia kukosa matumaini?	NO HAPANA	YES 27 NDIYO 27
ARE 2 OR MORE B3 ANSWERS CODED YES? JE, VIPENGELE 2 AU ZAIDI VYA B3 VIMEJIBIWA NDIYO?	→ NO → HAPANA	YES 27 NDIYO 27

B4 Did the symptoms of depression cause you significant distress or impair your ability to function at work, socially, or in some other important way?

Je, dalili za kukosa raha zilikupa shida nyingi na hata kukutoofisha au kukufanya udhoofike katika ufanisi wako?

NO	YES
HAPANA	NDIYO
DYSTHYMIA CURRENT	
DYSTHYMIA KWA SASA	

C. SUICIDALITY

HALI YA KUTAKA KUJIUA

In the past month did you:

Katika mwezi uliopita, je:

C1 Think that you would be better off dead or wish you were dead? Ulifikiria kwamba ni bora ungekufa?	NO HAPANA	YES 1 NDIYO 1
C2 Want to harm yourself? Ulitaka kujidhuru?	NO HAPANA	YES 2 NDIYO 2
C3 Think about suicide? Ulifikiria kujiua?	NO HAPANA	YES 3 NDIYO 3
C4 Have a suicide plan? Ulikuwa na mpango wa kujiua?	NO HAPANA	YES 4 NDIYO 4
C5 Attempt suicide? Ulijaribu kujiua?	NO HAPANA	YES 5 NDIYO 5
C6 In your lifetime, did you ever make a suicide attaempt? Katika maisha yako yote, umewahi jaribu kujiua?	NO HAPANA	YES 6 NDIYO 6

IS AT LEAST 1 OF THE ABOVE CODED YES?

JE, ANGALAU KIPENGELE 1 KATI YA HIVYO JUU KIMEJIBIWA NDIYO?

NO HAPANA	YES NDIYO
SUICIDE RISK CURRENT HATARI YA KUJIUA KWA SASA	
LOW HATARI KIDOGO	
MODERATE HATARI YA WASITANI	
HIGH HATARI KUBWA	

IF YES, SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

KAMA NDIYO, ELEZA KIWANGO CHA KUTAKA KUJIUA KAMA IFUATAVYO:

C1 or C2 or C6 = YES: LOW
C1 or C2 or C6 = NDIYO: HATARI KIDOGO

C3 or (C2 + C6) = YES: MODERATE
C3 or (C2 + C6) = YES: HATARI YA WASITANI

C4 or C5 or (C3 + C6) = YES: HIGH
C4 or C5 or (C3 + C6) = NDIYO: HATARI KUBWA

:

D. (HYPO) MANIC EPISODE

TUKIO LA MANIA (MANIA NDOGO)

In the past month did you:

Katika mwezi uliopita, je:

D1 a Have you ever had a period of time when you were feeling 'up' or 'high' or ‘hyper’or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	NO	YES 1
Je, ulishawahi kwa kipindi Fulani kujisikia una hali ya juu, au umejawa na nguvu au umesongwa kiasi cha kupatashida, au kwamba watu kukudhania kuwa sio mtu wa kawaida? (usichukulie muda ambao ulikuwa umedhurika kwa madawa au pombe)	HAPANA	NDIYO 1
IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN BY 'UP' OR 'HIGH' OR ‘HYPER’, CLARIFY AS FOLLOWS: By 'up' or 'high' or ‘hyper’ I mean: having elated mood; increased energy; needing less sleep; having rapid thoughts; being full of ideas; having an increase in productivity, motivation, creativity, or impulsive behaviour KAMA MGONJWA ANAONEKANA KUTOELEWA MAANA YA “HALI YA JUU”, FAFANUA KAMA IFUATAVYO : Hali ya juu ina maana ya kuwa na hali ya furaha; kuhitaji usingizi mchache;kuwa na fikra za haraka; kusongwa na mawazo; kuongezeka katika tija, ubunifu, motisha au tabia ya kuamua ghafla		
IF YES ASK:		
b Are you currently feeling "up" or "high" or full of energy?	NO	YES 2
Je, sasa hivi unajisikia kuwa na hali ya juu au kujawa na nguvu?	HAPANA	NDIYO 2

D2 a Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? (Do not consider times when you were intoxicated on drugs or alcohol). Je, umeshawahi kuwa mwenye kuudhika upesi kwa muda mrefu, kwa siku nyingi, kiasi kwamba ukawa na mabishano, au mapigano kwa maneno au vitendo, au kuwapigia kelele watu wasiokuwa wa familia yako?	NO HAPANA	YES 3 NDIYO 3
IF YES ASK: b Are you currently feeling persistently irritable? Je, kwa sasa unajisikia kuwa mwepesi wa kuudhika kwa muda mrefu?	NO HAPANA	YES 4 NDIYO 4
ARE D1a OR D2a CODED YES? JE, KIPENGELE D1a AU D2a KIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO

D3 IF D1b OR D2b = YES : EXPLORE ONLY CURRENT EPISODE
IF D1b AND D2b = NO : EXPLORE THE MOST SYMPTOMATIC PAST EPISODE
KAMA D1B AU D2B = NDIYO: CHUNGUZA TUKIO LA SASA TU
KAMA D1B NA D2B = HAPANA: CHUNGUZA TUKIO LILILOPITA AMBALO LILIKUWA NA DALILI NYINGI ZAIDI?

During the times when you felt high, full of energy, or irritable did you:
Kwa muda ambao ulijisikia hali ya juu, kujawa na nguvu, au mwenyekuudhika upesi, je:

a. Feel that you could do things others couldn't do, or that you were an especially important person? Ulijisikiakuweza kufanya vitu ambavyo wengine hawawezi au kujiona kuwa mtu pekee muhimu?	NO HAPANA	YES 5 NDIYO 5
b. Need less sleep (e.g., feel rested after only a few hours sleep)? Ulihitaji usingizi mchache (kwa mfano, kujisikisa mapumziko baada ya muda mdogo tu wa kulala)?	NO HAPANA	YES 6 NDIYO 6

c. Talk too much without stopping, or so fast that people had difficulty understanding? Uliongea sana bila kunyamaza, au kwa haraka zaidi kiasi kwamba watu wakapata tabu ya kukuelewa?	NO HAPANA	YES 7 NDIYO 7
d. Have racing thoughts? Umekua na mawazo mengi akilini?	NO HAPANA	YES 8 NDIYO 8
e. Become easily distracted so that any little interruption could distract you? Ulikua mtu wa kuporezewa umakinifu hata mambo madogo madogo?	NO HAPANA	YES 9 NDIYO 9
f. Become so active or physically restless that others were worried about you? Ulikuwa sio mtu wa subra, hadi wenzako wakawa na wasiwasi?	NO HAPANA	YES 10 NDIYO 10
g. Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)? Ukataka sana kujiingiza kwa mambo ya kiholela holela, kama vile kuendesha gari kwa njia ya kihatari, au mambo ya ngono.	NO HAPANA	YES 11 NDIYO 11
ARE 3 OR MORE D3 ANSWERS CODED YES (OR 4 OR MORE IF D1a IS NO (IN RATING PAST EPISODE) AND D1b IS NO (IN RATING CURRENT EPISODE)? RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE D3 SYMPTOMS WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE D3 SYMPTOMS	NO HAPANA	YES NDIYO
D4. Did these symptoms last at least a week and cause significant problems at home, at work, socially, or at school, or were you hospitalized for these problems? Je, hizo dalaili zidumu kwa wiki moja au zidi na kusababisha taharuki yoyote nyumbani?	NO HAPANA	YES 12 NDIYO 12

IF YES TO EITHER, CODE YES

KAMA JIBU NI NDIYO KWA LOLOTE, JAZA NDIYO

IS D4 CODED NO?

JE, KIPENGELE D4 KIMEJIBIWA HAPANA?

NO	YES
HAPANA	NDIYO
HYPOMANIC EPISODE	
TUKIO LA MANIA NDOGO	
CUURENT KWA SASA	
PAST	
LILILOPITA	

IF YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST

KAMA JIBU NI NDIYO, ELEZA KAMA TUKIO NI SASA AU LILOPITA

NO	YES
HAPANA	NDIYO
HYPOMANIC EPISODE	
TUKIO LA MANIA NDOGO	
CUURENT	
KWA SASA	
PAST	
LILILOPITA	

IS D4 CODED YES?

JE, KIPENGELE D4 KIMEJIBIWA NDIYO?

IF YES, SPECIFY IF THE EPISODE EXPLORED IS CURRENT OR PAST

KAMA JIBU NI NDIYO, ELEZA KAMA TUKIO NI SASA AU LILOPITA

E. PANIC DISORDER

UGONJWA WA HOFU KUBWA

In the past month did you:

Katika mwezi uliopita, je:

E1:

Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?

Je, kwa mara zaidi ya moja, umekuwa na vipindi vya kujisikia au kupatwa na wasiwasi wa ghafla, hofu, kutotulia au mashaka, hata katika mazingira ambayo watu wengi hawajisikii hivyo? Je, mshituko huo uliisha ndani ya

NO	YES 1
HAPANA	NDIYO 1

CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES.
JAZA NDIYO IKIWA TU IKIWA MSHITUKO HUO ULIISHA NDANI YA DAKIKA KUMI

IF E1 = NO, CIRCLE NO IN E5 AND SKIP TO F1

KAMA E1 = HAPANA, JAZA HAPANA KATIKA E5 NA NENDA KIPENGELE F1

At any time in the past, did any of those spells or attacks come on

E2:

Unexpectedly or spontaneously, or occur in an unpredictable or unprovoked manner?	NO	YES 2
Katika wakati wowote uliopita, je, vipindi hivi au mishituko hiyo ilikuja bilakutegemea au kutokea katika namna isiyobashirika au kuchochewa?	HAPANA	NDIYO 2

IF E2 = NO, CIRCLE NO IN E5 AND SKIP TO F1
KAMA E2 = HAPANA, JAZA HAPANA KATIKA E5 NA NENDA KIPENGELE F1

Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack?	NO	YES 3
Je, ulishawahi kupata tukio moja kama hilo lililofuatiwa na kipindi cha mwezi mmoja au zaidi cha kujisikia hofu ya tukio jingine au woga wamadhara ya tukio hilo?	HAPANA	NDIYO 3

IF E3 = NO, CIRCLE NO IN E5 AND SKIP TO F1
KAMA E3 = HAPANA, ZUNGUSHIA HAPANA NA NENDA KIPENGELE F1

E4 During the worst spell that you can remember:
Katika kipindi kibaya zaidi ambacho unakumbuka:

a. Did you have skipping, racing or pounding of your heart? Je, moyo wako ulidundadunda, kwenda mbio, au kupiga kwa kasi?	NO HAPANA	YES 4 NDIYO 4
b. Did you have sweating or clammy hands? Je, ulitokwa na jasho au mikono kuwa na kijasho?	NO HAPANA	YES 5 NDIYO 5

c. Were you trembling or shaking? Je, ulitetemeka au kutikisika?	NO HAPANA	YES 6 NDIYO 6
d. Did you have shortness of breath or difficulty breathing? Je, ulipata kutapia hewa au tabu ya kupumua?	NO HAPANA	YES 7 NDIYO 7
e. Did you have a choking sensation or a lump in your throat? Je, ulihisi ni kama kunyongwa au donge kifuani kwako?	NO HAPANA	YES 8 NDIYO 8
f. Did you have chest pain, pressure or discomfort? Je, ulipata maumivu ya kifua, shinikizo au usumbufu?	NO HAPANA	YES 9 NDIYO 9
g. Did you have nausea, stomach problems or sudden diarrhea? Je, ulipata kichefuchefu, matatizo ya tumbo au kuharisha kwa ghafla?	NO HAPANA	YES 10 NDIYO 10
h. Did you feel dizzy, unsteady, lightheaded or faint? Je, ulijisikia kizunguzungu, kutetereka, kichwa chepesi, au kuzirai?	NO HAPANA	YES 11 NDIYO 11
i. Did things around you feel strange, unreal, detached or unfamiliar, or didyou feel outside of or detached from part or all of your body? Je, vitu vilivyokuzunguka uliviona ni vya ajabu, sio halisi, upweke au vya kigeni, au je, ulijisikia upo kando ya, au kujitenga kutoka katika sehemu au mwili wako wote ?	NO HAPANA	YES 12 NDIYO 12
j. Did you fear that you were losing control or going crazy? Je, ulihofia kwamba nikama hauwezi dhibiti kila kitu juu yako au umepata wazimu?	NO HAPANA	YES 13 NDIYO 13
k. Did you fear that you were dying? Je, ulihofia kwamba unakufa?	NO HAPANA	YES 14 NDIYO 14
l. Did you have tingling or numbness in parts of your body? Je, ulipatwa na msisimko au ganzi katika sehemu za mwili wako?	NO HAPANA	YES 15 NDIYO 15
m. Did you have hot flashes or chills? Je, ulipatwa na wekundu usoni(kuiva uso) u mzizimo wa baridi?	NO HAPANA	YES 16 NDIYO 16
E5 ARE 4 OR MORE E4 ANSWERS CODED YES? JE, VIPENGELE 4 AU ZAIDI VYA E4 VIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO
IF E5 = NO, SKIP TO E7 KAMA E5 = HAPANA, NENDA KIPENGELE E7	*Panic disorder current* *Hofu kubwa kwa sasa*	

E6 In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack? Katika mwezi mmoja uliopita, ulipatwa na matukio hayo kwa kujirudiarudia(mara 2 au zaidi) kufuatiwa na hofu ya kupata tukio jingine? IF E6 = YES, SKIP TO F1 KAMA E6 = NDIYO, NENDA F1	NO HAPANA *Panic disorder current* *Hofu kubwa kwa sasa*	YES 17 NDIYO 17
E7 ARE 1, 2 OR 3 E4 ANSWERS CODED YES? JE, VIPENGELE 1, 2 AU 3 E4 VILIJIBIWA NDIYO?	NO HAPANA *Limited Symptom Attacks Lifetime*	YES 18 NDIYO 18

F. AGORAPHOBIA

WOGA WA NAFASI ZA WAZI

F1: Do you feel anxious or particularly uneasy in places or situations from which escape might be difficult, and where help might not be available in case ofpanic attack, like being in a crowd, standing in a line (queue), when you are alone away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car? Je, unajisikia wasiwasi au mashaka katika sehemu au mazingira ambapo unaweza kupata mshituko wa hofu kubwa au dalili zinazofanana na hofu kubwa tulizozizungumza hivi punde, na ambapo msaada unaweza usiwepo, au ambapo kukwepa kunaweza kuwa kugumu: kama kuwa kwenye kundi la watu wengi, kusimama kwenye foleni, ukiwa peke yako mbali na nyumbani, au upo nyumbani peke yako, au ukiwa unavuka daraja, kusafiri ndani ya basi, treni, au gari?	NO HAPANA	YES 19 NDIYO 19

IF F1 = NO, CIRCLE NO IN F2

KAMA F1 = HAPANA, ZUNGUSHIA HAPANA KATIKA F2

F2 Do you fear these situations so much that you avoid them, or suffer through them, or need a companion to face them? Je, unahofia sana mazingira haya kiasi cha kujitenga nayo, au kuteseka kwa ajili ya mazingira hayo auunahitaji mwenzi kukabiliana nayo?	NO HAPANA *Agoraphoba Current* *Woga wa nafasi zawazi kwa sasa*	YES NDIYO

IS F2 (CURRENT AGORAPHOBIA) CODED NO

and

IS E6 (CURRENT PANIC DISORDER) CODED YES?

JE F2 (WOGA WA NAFASI ZA WAZI KWA SASA)

NO YES

PANIC DISORDER without Agoraphobia CURRENT

IS F2 (CURRENT AGORAPHOBIA) CODED YES

and

IS E6 (CURRENT PANIC DISORDER) CODED YES?

NO YES

PANIC DISORDER with Agoraphobia CURRENT

IS F2 (CURRENT AGORAPHOBIA) CODED YES

and

IS E5 (PANIC DISORDER LIFETIME) CODED NO?

NO YES

AGORAPHOBIA without history of panic disorder CURRENT

G. SOCIAL PHOBIA

WOGA WA MKUSANYIKO WA WATU

G1: In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations. Katika mwezi uliopita, je ulipata hofu au shida ukiwa uanaangaliwa, ukiwa mlengwa, au hofu ya kufedheheshwa? Hii ni pamoja na mambo kama kuongea hadharani; kula hadharani au kula na watu, kuandika wakati mtu anakuangalia au kuwa katika mikusanyiko ya watu?	NO HAPANA	YES 1 NDIYO 1
G2 Is this social fear excessive or unreasonable? Je hofu hii ni kubwa mno au yenye kuzidi?	NO HAPANA	YES 2 NDIYO 2

G3 Do you fear these situations so much that you avoid them or suffer through them? NO YES 3
Je unahofia sana mazingira haya kiasi cha kujitenga nayo au kuteseka kwaajili ya mazingira hayo. HAPANA NDIYO 3

G4 Does this fear disrupt your normal work or social functioning or cause you significant distress? NO YES 4
Je hofu hizi zinavuruga shughuli zako za kawaida au shughuli za kijamii au NO zinakusababishia shida kubwa? HAPANA NDIYO 4

IS G4 CODED YES?
Je kipengele G4 kimejibiwa ndiyo?

NO	YES
SOCIAL PHOBIA	

H. OBSESSIVE-COMPULSIVE DISORDER
SHAUKU LAZIMISHO

H1 In the past month, have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (e.g., the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though youdidn't want to, or fearing you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting,or religious obsessions.)? NO YES

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.

H1 Katika mwezi ulioputa, je ulishawahi kukerwa na mawazo yenye kujirudiarudia, misukumo, au fikra ambazo hazihitajiki, za maudhi, zisizostahili, zenye kuingilia, au zenye kuleta shida? (mf: mawazo ya kwamba umchafu, umechafuliwa na vijidudu, au hofu ya kuwachafua wengine, au hofu ya kumdhuru mtu hata kama hukutaka kufanya hivyo, au kuhofia kutenda kwa msukumo, au hofu au imani za kichawi kwamba ungewajibika kwa mambo mabaya, au shauku yenye mawazo ya ngono, fikra au misukumo,au shauku ya kuhodhi, kukusanya au ya kidini). HAPANA NDIYO

(Usichanganye na wasiwasi juu ya matatizo halisi ya maisha, usichanganye na shauku zinazoendana moja kwa moja na magonjwa ya kula chakula, tabia za uasherati, kamari, au pombe au madawa ya kulevya kwa sababu, mgonjwa anaweza kupata starehe kutokana na

tendo hilo na kutaka kujizuia kwa sababu tu ya matokeo hasi ya jambo hilo.

F H1 = NO, SKIP TO H4

H2 Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO	YES 2
IF H2 = NO, SKIP TO H4		
Je, yanaendelea kukurudia ndani ya mawazo yako hata wakati unapojaribu kuyasahau au kuyaondoa?	HAPANA	NDIYO 2
H3 Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?	NO	YES 3
Je, unadhani kwamba shauku hizi zinatokana na mawazo yako mwenyewena kwamba hazijalazimishwa kutoka nje?	HAPANA	NDIYO 3
H4 In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?	NO	YES 4
Katika mwezi uliopita, je ulifanya kitu kwa kurudiarudia bila kuwa na uwezo wa kujizuia kufanya hivyo, kama vile kuosha au kusafisha sana, kuhesabu, kukagua vitu mara kwa mara, au kurudia, kukusanya, kupanga vitu, au matambiko mangine ya kishirikina?	HAPANA	NDIYO 4
ARE H3 OR H4 CODED YES? JE KIPENDELE H3 AU H4 KIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO
H5 Did you recognize that either these obsessive thoughts and/or these compulsive behaviors you can not resist doing them, were excessive orunreasonable?	NO	YES 5
Je ulitambua kwamba kujiwa na mawazo haya au hizi tabia zisizodhibitika zimekuwa ni nyingi mno au zimezidi?	HAPANA	NDIYO 5
Did these obsessive thoughts and / or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day?	NO	YES 6
Je kujawa na mawazo haya na/au tabia zisizodhibitika kwa kiasi kikubwa kunaingilia zako za kawaida, shughuli za kikazi, kazi za kawaida za kijamii, au mahusiano, au yamechukua zaidi ya saa nzima kwa siku?	HAPANA	NDIYO 6

IS H6 CODED YES?

NO	YES
OBSESSIVE-COMPULSIVE DISORDER CURRENT	

I. POSTTRAUMATIC STRESS DISORDER (optional)
UGONGWA WA MSONGO BAADA YA MATUKIO MABAYA (Hiari)

11. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Je, umewahi kupata au kushuhudia au kushughulika na matukio mabayaikiwepo kifo au tishio la kifo au ajali mbaya kwako au mtu mwingine?	NO HAPANA	YES 1 NDIYO 1
12. During the past month, have you re-experienced the event in a distressing way (i.e., dreams, intense recollections, flashbacks or physical? Kwa mwezi uliopita je umewahi kupata tena tukio hilo katika namna ya mashaka (Kama vile, ndoto, mkusanyiko mkali, kumbukumbu za ghafla, au kujibu kwa matendo)?	NO HAPANA	YES 2 NDIYO 2

13. In the past month:

    Katika mwezi uliopita:

a. Have you avoided thinking about the event, or have you avoided things that remind you of the event? Je, moyo wako ulidundadunda, kwenda mbio, au kupiga kwa kasi? Je, umewahi kujizuia kufikiria juu ya tukio hilo, au kujiepusha na vitu vinavyokukumbusha tukio hilo?	NO HAPANA	YES 3 NDIYO 3

b.	Have you had trouble recalling some important part of what happened? Je, umepata tabu ya kukumbuka baadhi ya sehemu muhimu juu ya kilichotokea?	NO HAPANA	YES 4 NDIYO 4
c.	Were you trembling or shaking? Je, ulitetemeka au kutikisika?	NO HAPANA	YES 5 NDIYO 5
d.	Have you felt detached or estranged from others? Je, ulijisikia umejitenga au kutenganisha na wengine?	NO HAPANA	YES 6 NDIYO 6
e.	Have you noticed that your feelings are numbed? Je, ulitambua kwamba mawazo yako ni mazito?	NO HAPANA	YES 7 NDIYO 7
f.	Have you felt that your life would be shortened because of this trauma? Je, ulijisikia kwamba maisha yako yangekuwa mafupi kutokana na tukio hili?	NO HAPANA	YES 8 NDIYO 8
	ARE 3 OR MORE I3 ANSWERS CODED YES? JE, VIPENGELE VITATU AU ZAIDI VYA I3 VIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO

14. In the past month:

Katika mwezi uliopita:

a.	Have you had difficulty sleeping? Je ulipata tabu ya usingizi?	NO HAPANA	YES 9 NDIYO 9
b.	Were you especially irritable or did you have outbursts of anger Je ulikuwa mwenye kuudhika upesi, au ulipatwa na milipuko ya hasira?	NO HAPANA	YES 10 NDIYO 10
c.	Have you had difficulty concentrating? Je, umepata tabu ya kuwa makini?	NO HAPANA	YES 11 NDIYO 11
d.	Were you nervous or constantly on your guard? Je, ulikuwa na wahaka/wasiwasi au muda wote kujilinda	NO HAPANA	YES 12 NDIYO 12
e.	Were you easily startled? Je, ulikuwa mwepesi wa kushtushwa?	NO HAPANA	YES 13 NDIYO 13

ARE 2 OR MORE I4 ANSWERS CODED YES? JE VIPENGELE 2 AU ZAIDI YA I4 VIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO
15. During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?	NO	YES 14
Katika mwezi uliopita, je matatizo haya kwa kiasi kikubwa yalivurugautendaji wa kazi yako au shughuli za kijamii au kusababisha mashaka makubwa?	HAPANA	NDIYO 14

IS I5 CODED YES?

JE I5 IMEJIBIWA NDIYO?

NO	YES
POSTTRAUMATIC STRESS DISORDER CURRENT	

J. ALCOHOL ABUSE AND DEPENDENCE

MATUMIZI MABAYA NA KUTAWALIWA NA POMBE

J1 In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?	NO	YES 1
Katika miezi 12 iliyopita, ulishawahi kuwa na vinywaji vitatu au zaidi vya pombe ndani ya kipindi cha masaa matatu katika matukio m atatu au zaidi?	HAPANA	NDIYO 1

J2 In the past 12 months:

J2 Katika miezi 12 iliyopita:

a. Did you need to drink more in order to get the same effect that you did when you first started drinking? Je, ulihitaji kunywa zaidi ili upate matokeo sawa nay ale uliyokunywa mara ya kwanza?	NO HAPANA	YES 2 NDIYO 2
b. When you cut down on drinking did your hands shake, did you sweat, or feel agitated? Or, did you drink to avoid these symptoms or to avoid being hangover, e.g. “the shakes", sweating or agitation?	NO HAPANA	YES 13 NDIYO 3

Je, wakati ulipoacha kunywa mikono yako ilitetemeka ulitokwa na majasho au kujisikia wasiwasi? Je, ulikunywa ili kuondoa dalili hizi au kuepuka kuwa mchovu, mfano mtetemeko, kutokwa majasho au wasiwasi?

IF YES TO EITHER, CODE YES
KAMA NI NDIYO KWA CHOCHOTE, JIBU NDIYO

c. During the times when you drank alcohol, did you end up drinking morethan you planned when you started?
Wakati ambapo umelewa pombe, je uliishia kunywa zaidi kulikoc ulivyopanga mwanzoni?

NO HAPANA — YES 4 NDIYO 4

d. Have you tried to reduce or stop drinking alcohol but failed?
Je ulijaribu kupunguza au kuacha ulevi ikashindikana?

NO HAPANA — YES 5 NDIYO 5

NO	YES
ALCOHOL DEPENDENCE CURRENT	

ARE 3 OR MORE J2 ANSWERS CODED YES?
JE VIPENGELE VITATU AU ZAIDI VYA J2 VIMEJIBIWA NDIYO

DOES THE PATIENT CODES POSITIVES FOR ALCOHOL DEPENDENCE?

NO — YES

J3 In the past 12 months:

J3 Katika miezi 12 iliyopita:

a. Have you been intoxicated, high, or hangover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems ??
Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa pombe zaidi ya mara moja wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili litaleta matatizo yeyote??

NO HAPANA — YES 2 NDIYO 2

CODE YES ONLY IF THIS CAUSED PROBLEMS
(JIBU NDIYO IKIWA TU HILI LILILETA MATATIZO)

b. When you cut down on drinking did your hands shake, did you Were you intoxicated in any situation where you were physically at risk, e.g., driving a car, riding a motor bike, using machinery, boating, etc?
Je, ulirukwa akili katika mazingira yeyote ambapo ulikuwa hatarini mf. Kuendesha gari, kuendesha pikipiki, kutumia mashine, kusafiri kwa mashua, etc.?

NO HAPANA YES 3 NDIYO 3

c. Did you have any legal problems because of your drinking, e.g., an arrest or disorderly conduct?
Je ulipata matatizo yeyote ya kisheria kwa sababu ya ulevi wakomfa. Kutiwa mbaroni au kufanya vurugu??

NO HAPANA YES 4 NDIYO 4

d. Did you continue to drink even though your drinking caused problems with your family or other people?
Je, uliendelea kulewa japokuwa ulevi wako ulisababisha matatizo kwad familia yako au watu wengine?

NO HAPANA YES 5 NDIYO 5

NO	YES
ALCOHOL ABUSE CURRENT	

ARE 1 OR MORE J3 ANSWERS CODED YES ?

JE KIPENGELE KIMOJA AU ZAIDI CHA J3 KIMEJIBIWA NDIYO?

CARD OF SUBSTANCES

AMPHETAMINE	GASOLINE	MORPHINE
CANNABIS	GLUE	OPIUM
COCAINE	GRASS	PALFIUM
CODEINE	HASHISH	PCP
CRACK	HEROIN	RITALIN
DICONAL	LSD	TEMGESIC
ECSTASY	MARIJUANA	THC

ETHER	MESCALINE	TOLUENE
FREEBASE	METHADONE	TRICHLORETHYLE

K. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS UGONJWA WA MATUMIZI YA MADAWA YA KULEVYA AMBAYO SI POMBE

K1 a: Now, I am going to show you (SHOW THE CARD OF SUBSTANCES) / to read to you, a list (READ THE LIST BELOW) of street drugs or medicines. In the past 12 months, did you take any of these drugs, more than once, to get high, to feel better or to change your mood? Sasa ninakuonyesha (ONYESHA KADI YA MADAWA) / ninakusomea orodha ya madawa ya mitaani. Katika miezi 12 iliyopita, je ulitumia dawa yeyote katika hizi zaidi ya mara moja, ili uwe na hali ya juu, kujisikia mborazaidi, au kubadilisha hali yako?	NO HAPANA	YES 1 NDIYO 1

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, « speed », crystal meth, « rush », Dexedrine, Ritalin, diet pills.Cocaine: snorting, IV,
freebase, crack, « speedball ».
Narcotics: heroin, morphine, dilaudid, opium, demerol, methadone, codeine, percodan, darvon.Hallucinogens:
LSD (« acid »), mescaline, peyote, PCP (« angel dust », « peace pill »), psilocybin, STP, « mushrooms », ecstasy, MDA, or MDMA.
Inhalants: « glue », ethyl chloride, nitrous oxide, (« laughing gas »), amyl or butyl nitrate(« poppers »).
Marijuana: hashish (« hash »), THC, « pot », « grass », « weed », « reefer ».
Tranquilizers: quaalude, Seconal (« reds »), Valium, Xanax, Librium, Ativan, Dalmane, Halcion,barbiturates,
Miltown.

Miscellaneous: steroids, nonprescription sleep or diet pills. Any others?

SPECIFY MOST USED DRUG(S): _____

ZUNGUSHIA KILA DAWA ULIYOTUMIA:

Vichangamsho:AmphetaminiCokein:

Nakotiks:

Hallucinogens:

Inhalants:

Marijuana:

Tranquilizers:

Nyinginezo:

ELEZA DAWA / MADAWA UTUMIAYO ZAIDI _____

b. SPECIFY WHICH WILL BE EXPLORED IN CRITERIA BELOW: IF CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE:

EACH DRUG (OR DRUG CLASS) USED INDIVIDUALLY •

MOST USED DRUG (OR DRUG CLASS) ONLY •

IF ONE DRUG (OR DRUG CLASS) USED:

SINGLE DRUG (OR DRUG CLASS) ONLY •

ELEZA NI DAWA IPI IPO NDANI YA VIGEZO HAPA CHINI:

b. KAMA NI MATUMIZI YA PAMOJA AU YENYE KUFUATANA YADAWA ZAIDI YA:

MOJA: •

KILA KUNDI LA DAWA KUTUMIKA PEKE YAKE•

KUNDI LA DAWA LINALOTUMIKA ZAIDI TU •

NI DAWA MOJA TU / KUNDI LA DAWA IMETUMIKA

K2 Considering your use of [NAME THE SELECTED DRUG / DRUG CLASS] in thepast 12 months: Fikiria matumizi yako ya madawa (TAJA JINA LA DAWA / KUNDI LADAWA LILILOCHAGULIWA), katika miezi 12 iliyopita:

a. Have you found that you needed to use more of [NAME OF SELECTED DRUG /DRUG CLASS] to get the same effect that you did when you first started taking it? Je, uliona kwamba unahitaji kutumia zaidi (Jina la dawa au kundi la dawa lililochaguliwa) ili kupata athari sawa na ile ulipotumia mara ya kwanza?	NO HAPANA	YES 1 NDIYO 1

b.	When you reduced or stopped using [NAME OF SELECTED DRUG / DRUG CLASS] did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable or depressed)? Or did you use any drug(s) to keep yourself from getting sick (WITHDRAWAL SYMPTOMS) or so that you would feel better? Je, ulirukwa akili katika mazingira yeyote ambapo ulikuwa hatarini mf. Kuendesha gari, kuendesha pikipiki, kutumia mashine, kusafiri kwa mashua, etc.? IF YES TO EITHER, CODE YES Wakati ulipopunguza au kutotumia (JINA LA DAWA / KUNDI LA DAWA LILILOCHAGULIWA) Je, ulipatwa na dalili zinazotokana na kuacha madawa? (Maumivu, kutetemeka, homa, udhaifu, kuharisha, kichefuchefu, kutokwa jacho, moyo kudunda, tabu ya usingizi, kujisikia wasiwasi, dukuduku, mwenye kuudhika upesi, au mwenye huzuni). Je ulitumia dawa/madawa yeyote ili kukufanya usiumwe (dalili za kuacha dawa) au kukufanya ujisikie vizuri zaidi? IKIWA JIBU NI NDIYO KWA SWALI LOLOTE, JAZA NDIYO	NO HAPANA	YES 2 NDIYO 2
c.	Have you often found that when you used [NAME OF SELECTED DRUG / DRUG CLASS], you ended up taking more than you thought you would? Je, mara kwa mara ulijiona kwamba wakati unatumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), uliishia kutumia nyingi zaidikuliko Uwezo wako?	NO HAPANA	YES 3 NDIYO 3
d.	Have you tried to reduce or stop taking [NAME OF SELECTED DRUG / DRUG/CLASS] but failed? Je, ulijaribu kupunguza/kuacha kutumia (JINA LA DAWA/ KUNDI LADAWA LILILOCHAGULIWA) lakini ukashindwa?	NO HAPANA	YES 4 NDIYO 4
e.	On the days that you used [NAME OF SELECTED DRUG / DRUG CLASS], did you spend substantial time (>2 hours), obtaining, using or recovering from the effects, or thinking about it? Katika siku ambazo ulitumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA)Je, ulipoteza muda mwingi (> masaa 2) kupata, kutumia au kupata nafuu kutoka katika madawa au kufikiria juu ya madawa?	NO HAPANA	YES 5 NDIYO 5

f. Did you spend less time working, enjoying hobbies, or being with family or friends, because of your drug use? g. Je, ulitumia muda mchache kufanya kazi, kufurahia uvipendavyo, au kuwana familia yako au marafiki kwa sababu ya kutumia kwako madawa?	NO HAPANA	YES 6 NDIYO 6
h. Have you continued to use [NAME OF SELECTED DRUG / DRUG CLASS] even though it caused you health or mental problems? Je, uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), matatizo ya kiafya nakiakili?	NO HAPANA	YES 7 NDIYO 7

ARE 3 OR MORE K2 ANSWERS CODED YES?

SPECIFY DRUG(S) : _____

JE VIPENGELE 3 AU ZAIDI VYA K2 VIMEJIBIWA NDIYO?

TAJA DAWA / MADAWA:

NO	YES
DRUG DEPENDENCE CURRENT	

DOES PATIENT CODES POSITIVE FOR DRUG DEPENDENCE?	NO	YES

K3 In the past 12 months:

Fikiria matumizi yako ya madawa (Jina la kundi la dawa lililochaguliwa)

Katika kipindi cha miezi 12 iliyopita:

a. Have you been intoxicated, high, or hangover from [NAME OF SELECTED DRUG / DRUG CLASS], more than once when you had other responsibilities at school, at work, or at home? Did this cause any problem? (CODE YES ONLY IF THIS CAUSED PROBLEMS)? Je, umewahi kurukwa akili, kuwa na hali ya juu, au kuwa na uchovu wa dawa (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), zaidi ya mara moja, wakati ambapo ulikuwa na majukumu mengine shuleni, kazini au nyumbani? Je hili lilileta matatizo yeyote? (JAZA NDIYO IKIWA TU HILI LILILETA MATATIZO)	NO HAPANA	YES 1 NDIYO 1

b. Have you been high or intoxicated from [NAME OF SELECTED DRUG / DRUG CLASS] in any situation where you were physically at risk (e.g., driving a car, or a motorbike, using machinery, boating, etc.)?
Je, umewahi kujisikia na hali ya juu au kurukwa akili kutokana na (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA) katika mazingira yeyote ambapo ulikuwa hatarini (mfano, kuendesha gari, kuendesha pikipiki, kutumia machine, kusafiri kwa mashua, nk)..?

NO HAPANA — YES 2 NDIYO 2

c. Did you have any legal problems because of your [NAME OF SELECTED DRUG/ DRUG CLASS] use, e.g., an arrest or disorderly conduct?
Je, ulipata matatizo yeyote ya kisheria kwa sababu ya matumizi ya madawa mf. Kutiwa mbaroni au kufanya vurugu?

NO HAPANA — YES 3 NDIYO 3

d. Did you continue to use [NAME OF SELECTED DRUG / DRUG CLASS] evend though it caused problems with your family or other people?
Je uliendelea kutumia (JINA LA DAWA/ KUNDI LA DAWA LILILOCHAGULIWA), japokuwa ilisababisha matatizo kwa familia yakoau watu wengine?

NO HAPANA — YES 4 NDIYO 4

ARE 1 OR MORE K3 ANSWERS CODED YES?

SPECIFY DRUG(S) : _____

JE, KIPENGELE KIMOJA AU ZAIDI CHA K3 KIMEJIBIWA NDIYO?

TAJA DAWA / MADAWA:

NO	YES
DRUG ABUSE CURRENT	
HAPANA NDIYO	
MATUMIZI YA MADAWA KWA SASA	

L. PSYCHOTIC DISORDERS
MAGONJWA YA SAIKOSIS

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OFTHOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE.

BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS « BIZARRE ».

DELUSIONS ARE BIZARRE IF : CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFEEXPERIENCE.

HALLUCINATIONS ARE RATED BIZARRE IF : A VOICE COMMENTS ON THE PERSON‘S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MOREVOICES ARE CONVERSING WITH EACH OTHER.

OMBA MFANO KWA KILA SWALI LINAJIBIWA NDIYO. JAZA NDIO IWAPO TU MIFANO INAONYESHA WAZI MABADILIKO YAMAWAZO AU UTAMBUZI AU KAMA HAIHUSIANI NA MILA NA DESTURI KABLA YA KUJAZA CHUNGUZA IWAPO IMANI ZA UWONGO ZINA SIFA ZA KUWA SI ZA KAWAIDA.

IMANI POTOFU AMBAZO ―SI ZA KAWAIDA‖ KAMA: ISIYOWEZEKANA KUWA KWELI, UPUUZI, ISIYOELEWEKA, NAISIYOTOKANA NA MAISHA YA KAWAIDA.

HISIA POTOFU AMBAZO ―SI ZA KAWAIDA‖ NI KAMA: SAUTI KUELEZEA JUU YA MAWAZO YA MTU AU TABIA, AU WAKATISAUTI 2 AU ZAIDI ZINAZUNGUMZA

ZENYEWE.

Now I‘m going to ask you about unusual experiences that some individualsmay experience.

Sasa ninakuuliza kuhusu matukio yasiyo ya kawaida ambayo watu wanaweza pitia

L1		NO	YES 1
a.	Have you ever believed that people were spying on you, or that someone wasplotting against you, or trying to hurt you? Je, umewahi kuamini kwamba watu wanakupeleleza, au kwamba mtuanapanga njama juu yako, au kujaribu kukudhuru? KUMBUKA: Ulizia mifano ili kupata uhalisia.	HAPANA	NDIYO 1
b.	IF YES: Do you currently believe these things? KAMA NDIYO: Je kwa sasa unaamini mambo haya?	NO HAPANA	YES 2 NDIYO 2 ➡ L6a

L2

a. Have you ever believed that someone was reading your mind or could hearyour thoughts or that you could actually read or hear what another person was thinking?
Je, umewahi kuamini kwamba mtu alikuwa anasoma mawazo yako au kuweza kusikia mawazo yako, au kwamba wewe kuweza kusoma mawazoya mtumwingine au kusikia kile anachowaza mtu mwingine?

NO HAPANA — YES 3 NDIYO 3

b. IF YES: Do you currently believe these things?
KAMA NDIYO: Je kwa sasa unaamini mambo haya?

NO HAPANA — YES 4 NDIYO 4 → L6a

L3

a. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way thatwas not your usual self ? Have you ever felt that you were possessed?
Je, umewahi kuamini kwamba mtu au nguvu Fulani kutoka nje zimeweka mawazo ndani yako na kwamba umekuwa siyo wewe mwenyewe, au imekufanya utende matendo ambapo haikuwa kawaida yako?
TABIBU: ULIZIA MIFANO NA UONDOE YEYOTE ISIYOHUSIANA NA KURUKWA AKILI

NO HAPANA — YES 5 NDIYO 5

b. IF YES: Do you currently believe these things?
KAMA NDIYO: Je, kwa sasa unaamini mambo haya?

NO HAPANA — YES 6 NDIYO 6 → L6a

L4

a. Have you ever believed that you were being sent special messages through the TV,radio or newspaper or that a pwrson you did not personally know was particularly interested in you?
Je, umewahi kuamini kwamba umekuwa ukipokea ujumbe maalum kupitia TV, radio, magazeti?

NO HAPANA — YES 7 NDIYO 7

b. IF YES: Do you currently believe these things?
KAMA NDIYO: Je kwa sasa unaamini mambo haya?

NO HAPANA — YES 8 NDIYO 8 → L6a

L5

a. Have your relatives or friends ever considered your beliefs strange or out of reality?
Je, ndugu zako au marafiki walishawahi kuona kwamba unavyohisia au amini ni za ajabu au si za kawaida? Tafadhali, naomba mifano. MSAILI: Jaza ndiyo ikiwa tu mifano inaonyesha wazi kuwa ni imani za uwongo ambazo hazikuelezwa katika

NO HAPANA — YES 9 NDIYO 9

	maswali L1 mpaka L4, mfano, za kujifaharisha, za unyong‘onyevu, za maangamizi, kuwa na hatia, n.k.?		
b.	IF YES: Do they currently consider your beliefs strange? KAMA NDIYO: Je, kwa sasa wanaona nikama unayodhania au kuamini ni za ajabu?	NO HAPANA	YES 10 NDIYO 10 ➡ L6a
	L6	NO	YES 11
a.	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE CODED « BIZARRE » ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING: Did you hear a voice commenting on your thoughts or behavior, or did youhear two or more voices talking to each other? Je umewahi kusikia mambo ambayo wengine hawasikii, kama vile sauti? HISIA POTOFU ZINAKUWA —SI ZA KAWAIDA Je ulisikia sauti ikielezea mawazo yako au tabia au kusikia sauti mbili auzaidi zikizungumza zenyewe?	HAPANA	NDIYO 11
b.	IF YES: Have you heard these things in the past month? KAMA NDIYO: Je, umesikia vitu hivi ndani ya mwezi 1 uliopita?	NO HAPANA	YES 12 NDIYO 12 ➡ L8b
	L7	NO	YES 13
a.	Have you ever had visions when you were awake or have you ever seenthings other people couldn't see? CODE YES ONLY IF THE VISIONS ARE CULTURALLY INAPPROPRIATE. Je, umewahi ona vitu mchana au ukiwa umeamka ilihali watu wenginehawavioni? TABIBU: chunguza ili kujua kama havihusiani na mambo ya kimila nadesturi?	HAPANA	NDIYO 13
b.	IF YES: have you ever seen these things in the past month? INTERVIEWER’S JUDGMENT KAMA NDIYO: Je, umeviona vitu hivyo kwa mwezi mmoja uliopita? UAMUZI WA TABIBU	NO HAPANA	YES 14 NDIYO 14
	L8 b. IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZEDSPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? JE, KWA SASA MGONJWA ANAONYESHA DALILI ZA KUTOONGEA VIZUEI?	NO HAPANA	YES 3 NDIYO 3
	L9 b. IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR?	NO HAPANA	YES 5 NDIYO 5

JE, KWA SASA MGONJWA ANAONYESHA DALILI ZA KUTOWAJIBIKA?

L10 b. ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW?

NO HAPANA — YES 7 NDIYO 7

JE, NI DALILI GANI ZA SIZIFRANIA, KAMA VILE KUTOKUWA NA HISIA AUKUSHINDWA KUONGEA VIZURIi?

L11 a. ARE 1 OR MORE « a » QUESTIONS FROM L1a TO L7a CODED YES OR YES BIZARRE AND IS EITHER:
MAJOR DEPRESSIVE EPISODE, (CURRENT OR RECURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED YES?

NO HAPANA → L13 — YES 8 NDIYO 8

NO	YES
PSYCHOTIC SYNDROME CURRENT	

IF NO TO L11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO L13.

FROM L1 TO L10 :

ARE 1 OR MORE « b » QUESTIONS CODED YES BIZARRE ?

OR

ARE 2 OR MORE « b » QUESTIONS CODED YES (RATHER THANYES BIZARRE) ?

L12 FROM L1 TO L7 :

ARE 1 OR MORE « a » QUESTIONS CODED YES BIZARRE ?

OR

ARE 2 OR MORE « a » QUESTIONS CODED YES (RATHER THANY

(CHECK THAT THE 2 SYMPTOMS OCCURRED DURING T PERIOD)OR

IS L11 CODED YES ?

NO	YES
PSYCHOTIC SYNDROME LIFETIME	

L12

JE, KIPENGELE 1 AU ZAIDI YA MASWALI (a) VIMEPITIWA NDIYO SI YA KAWAIDA?

AU

JE, VIPENGELE 2 AU ZAIDI VYA MASWALI (a) VIMEJIBIWA NDIYO

(BADALA YA NDIYO SI YA KAWAIDA)

UAMUZI WA TABIBU

CHUNGUZA KAMA DALILI 2 ZILITOKEA WA KATI MMOJA

AU

JE, KIPENGELE L11 KIMEJIBIWA NDIYO?

L13a IF L12 IS CODED YES OR AT LEAST ONE YES FROM L1 TO L7 : DOES THE PATIENT CODE POSITIVE FOR EITHER MAJOR DEPRESSIVE EPISODE (CURRENT OR PAST) OR MANIC EPISODE (CURRENT OR PAST)? L13a KAMA L12 IMEJIBIWA NDIYO NA ANGALAU NDIYO MOJA KUTOKA L1 MPAKA L7: JE DALILI HIZO ZIMEJIBIWA NDIYO KWA AIDHA TUKIO LA SONONA, (KWA SASA) AU TUKIO LA MANIA, (KWA SASA AU MUDA ULIOPITA)?	NO HAPANA	YES NDIYO
L13b. Uliniambia mwanzoni kwamba kulikuwa na vipindi ambavyo ulijisikia(huzuni/hali ya juu/mwepesi wa kuudhika mara zote). Je, kuamini kwako na matukio uliyoyaeleza hivi punde (dalili zimejibiwa ndiyo kutoka L1 mpaka L7).vimekuwepo pale tu ulipojisikia huzuni/hali yajuu/mwenyekuudhika?	NO HAPANA	YES NDIYO

NO	YES
MOOD DISORDER WITH PSYCHOTIC FEATURES CURRENT	

IS L13b CODED YES ?
JE, L13b IMEJIBIWA NDIYO?

M. ANOREXIA NERVOSA

M. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KUTOKULA

M1

a. How tall are you? ☐☐☐ Ft / Ins / Cm
Una urefu kiasi gani?

b. What was your lowest weight in the past 3 months? ☐☐☐ Lbs / kg
Ni uzito upi mdogo kuliko wote katika miezi mitatu iliyopita

c. IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDINGTO HIS / HER HEIGHT ? SEE TABLE BELOW → NO / YES 1
JE, UZITO WA MGONJWA NI MDOGO KULIKO KIWANGO KINACHOLINGANA NA UREFU WAKE? (ANGALIA JEDWALI CHINI) HAPANA / NDIYO 1

In the past 3 months:

Katika miezi 3 iliyopita

M2

In spite of this low weight, have you tried not to gain weight? → NO / YES 2
Pamoja na uzito huu mdogo, je ulijaribu kutoongeza uzito? HAPANA / NDIYO 2

M3

Have you feared gaining weight or becoming fat, even though you were underweight? → NO / YES 3
Je, ulihofia kuongezeka uzito au kuwa mnene hata kama ulikuwa na uzito mdogo? HAPANA / NDIYO 3

M4

a. Have you considered yourself fat or that part of your body was too fat? NO / YES 4
Je ulijiona wewe mwenyewe mnene, au sehemu ya mwili wako nene sana? HAPANA / NDIYO 4

b. Has your body weight or shape greatly influenced how you felt about yourself? NO / YES 5
Je, uzito wa mwili wako au umbile umeathiri kwa kiasi kikubwa jinsi unavyojiona?? HAPANA / NDIYO 5

c. Have you thought that your current low body weight was normal or excessive?
Je, ulifikiria kwamba uzito wako mdogo wa sasa ni kawaida au umezidi?

NO / HAPANA — YES 6 / NDIYO 6

M5

ARE 1 OR MORE M4 ANSWERS CODED YES?
JE, KIPENGELE KIMOJA AU ZAIDI VYA M4 VIMEJIBIWA NDIYO?

NO / HAPANA — YES / NDIYO

M6

FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)?
Kwa wanawake tu: Katika miezi mitatu iliyopita, Je ulikosa siku zako zote za hedhi pale ambapo ulizitarajia kutokea (wakati hukuwa mjamzito)?

NO / HAPANA — YES 7 / NDIYO 7

NO	YES
ANEROXIA NERVOSA	
CURRENT	

FOR WOMEN: ARE M5 AND M6 CODED YES?

FOR MEN: IS M5 CODED YES?

KWA WANAWAKE: JE, M5 NA M6 VIMEJIBIWA NDIYO?

KWA WANAUME: JE, M5 IMEJIBIWA NDIYO?

TABLE HEIGHT / WEIGHT THRESHOLD (HEIGHT-WITHOUT SHOES; WEIGHT-WITHOUT CLOTHING)

HEIGHT(cm) UREFU (sm)	140	145	150	155	160	165	170	175	180	185	190
Females	37	38	39	41	43	45	47	50	52	54	57

Wanawake WEIGHT (kg) UZITO (kilo) Males Wanaume	41	43	45	47	49	51	52	54	56	58	61

THE WEIGHT THRESHOLDS ABOVE ARE CALCULATED AS A 15% REDUCTION BELOW THE NORMAL RANGE FOR THE PATIENT'S HEIGHT AND GENDER AS REQUIRED BY DSM-IV.

N. BULIMIA NERVOSA

N. UGONJWA WA TAFSIRI YA MAUMBILE BINAFSI UNAOHUSIANA NA KULA MNO

N1 In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	NO →	YES 8
Katika miezi mitatu iliyopita, je uliwahi kula kupita kiasi au wakati ambapo umekula chakula kingi sana ndani ya masaa mawili?	HAPANA	NDIYO 8
N2 In the last three months, did you have eating binges as often as twice a week?	NO →	YES 9
Katika miezi 3 iliyopita, je umewahi kula kupita kiasi kila mara, ara 2 kwa wiki?	HAPANA	NDIYO 9
N3 During these binges, did you feel that your eating was out of control?	NO →	YES 10
Katika milo hii, ulijisikia kwamba kula kwako ni kwa kushindwa kujitawala?	HAPANA	NDIYO 10
N4 Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications?	NO →	YES 11

	HAPANA	NDIYO 11
Je ulifanya kitu chochote kufidia, au kuzuia kuongezeka uzito kutokana na milo hii, kama vile kutapika, kushinda na njaa, kufanya mazoezi, kumeza dawa za kuharisha, enema, kuongeza mkojo au dawa nyinginezo?		
N5 Does your body weight or shape greatly influence how you feel aboutyourself?	NO	YES 12
Je uzito wako au umbile lako linaathiri kwa kiasi kikubwa jinsi unavyojiona?	HAPANA	NDIYO 12
N6 N6 DOES THE PATIENT'S SYMPTOMS MEET CRITERIA FORANOREXIA NERVOSA? IF N6 = NO, SKIP TO N8	NO	YES 13
N7 Do these binges occur only when you are under _____kg/lbs.*? TAKE THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THEHEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA	NO	YES 14
Je, milo hii ya kupita kiasi hutokea pale tu una uzito chini ya kilo_____?ANDIKA KIWANGO CHA UZITO KUTOKULA	HAPANA	NDIYO 14

N8

IS N5 CODED YES AND N7 CODED NO (OR SKIPPED)?

JE, N5 IMEJIBIWA NDIYO N7 IMEJIBIWA HAPANA (AU IMERUKWA KWA SABABU DALILI ZA MGONJWA HAZIFIKII VIGEZO VYA UGONJWA WA KUTOKULA)?

IS N7 CODED YES? JE, N7 IMEJIBIWA NDIYO?	NO YES *BULIMIA NERVOSA* NO YES *ANOREXIA NERVOSA* *Binge-Eating/Purging Type*

O. GENERALIZED ANXIETY DISORDER
UGONJWA WA WASIWASI MKUBWA

O1 a. Have you worried excessively or been anxious about several things of day to day life, at work, at home, in your close circle over the past 6 months?Je, umewahi kuwa na mawazo sana kuhusiana na maswala mengi kwa miezi 6 iliyopita?	NO HAPANA	YES NDIYO
DO NOT CODE YES IF THE FOCUS OF THE ANXIETY IS CONFINED TO ANOTHER DISORDER EXPLORED PRIOR TO THIS POINT SUCH AS HAVING A PANIC ATTACK (PANIC (OCD), GAINING WEIGHT (ANOREXIA NERVOSA)...	NO	YES
Je, ulikuwa na woga sana au kupata wasiwasi juu ya mambo mawili au zaidi(mf. Pesa, afya ya watoto, msiba) kwa kipindi cha miezi 6 iliyopita?Zaidi ya watu wengi webgine wanavyokuwa?	HAPANA	NDIYO

O2 Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing?	NO	YES
Je, huwa unapata ugumu wowote kuthibiti hali yako ya wasiwasi au huwa unapata shida ya kufanya kazi zako za kawaida?	HAPANA	NDIYO

FROM O3a TO O3f, CODE NO THE SYMPTOMS CONFINED TO FEATURES OF ANYDISORDER EXPLORED PRIOR TO THIS POINT

When you were anxious over the past 6 months, did you, most of the time:
Je, wakati ulikuwa na shauku katika miezi 6 iliyopita, uliwahi, kwa mara nying:

a.	Feel restless, keyed up or on edge? Ulijisikia kutotulia, kuamshwa, au mwenye kiherehere?	NO HAPANA	YES NDIYO
b.	Feel tense? Ulijisikia kukakamaa?	NO HAPANA	YES NDIYO
c.	Feel tired, weak or exhausted easily? Ulijisikia kuchoka, mdhaifu, au kuchoka mapema?	NO HAPANA	YES NDIYO
d.	Have difficulty concentrating or find your mind going blank? Ulipata tabu ya kuwa makini, au kuona unapoteza kumbukumbui?	NO HAPANA	YES NDIYO
e.	Feel irritable? Ulijisikia mwenye kuudhika upesi?	NO HAPANA	YES NDIYO

f. Have difficulty sleeping (difficulty falling asleep, waking up in middle of the night, early morning wakening or sleep excessively)?
Kuwa na ugumu wa kulala au kupata uzingizi, kuamka katikat usiku (usiju wa manane), au kuamka asubuhi na mapema au ku sana visivyo kawaida.

NO	YES
HAPANA	NDIYO

GENERALIZED ANXIETY DISORDER CURRENT

ARE 3 OR MORE O3 ANSWERS CODED YES?

Kuna majibu 3 au zaidi ya 3 na majibu ya NDIYO?

P. ANTISOCIAL PERSONALITY DISORDER (optional)

UGONJWA WA MAKUZI YA HULKA NA TABIA ZINAZOPINGANA NA JAMII (hiari)

P1 Before you were 15 years old, did you:

Kabla hujawa na umri wa miaka 15, je:

a.	Repeatedly skip school or run away from home overnight? Ulikuwa ukitoroka shule mara kwa mara au kuondoka nyumbani usiku?	NO HAPANA	YES 1 NDIYO1
b.	Repeatedly lie, cheat, « con » others, or steal? Ulikuwa ukidanganya mara kwa mara, ukilaghai, kutapeli wengine, au kuiba?	NO HAPANA	YES 2 NDIYO2
c.	Start fights or bully, threaten, or intimidate others? Ulianzisha ugomvi au kudhulumu, kutishia au kutisha wengine?	NO HAPANA	YES 3 NDIYO3
d.	Deliberately destroy things or start fires? Kwa makusudi uliharibu vitu au kuwasha moto?	NO HAPANA	YES 4 NDIYO4
e.	Deliberately hurt animals or people? Kwa makusudi kuwadhuru wanyama au watu?	NO HAPANA	YES 4 NDIYO4
f.	Force someone to have sex with you? Kumlazimisha mtu kufanya mapenzi na wewe?	NO HAPANA	YES 4 NDIYO4

ARE 2 OR MORE P1 ANSWERS CODED YES? JE, VIPENGELE 2 AU ZAIDI VYA P1 VIMEJIBIWA NDIYO?	NO HAPANA	YES NDIYO

P2

DO NOT CODE YES THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED

USIJIBU NDIYO KWA TABIA ZILIZO HAPA CHINI IKIWA ZIMESABABISHWA NA MAMBO YA KISIASA AU KIDINI

Since you were 15 years old, have you:

Tangu umri wa miaka 15, je:

a.	Repeatedly skip school or run away from home overnight? Mara kwa mara ulikuwa na tabia ambayo watu wengine wangeona kama ni kutowajibika, kama vile kushindwa kulipa madeni, kwa makusudi kuwa jazba au kwa makusudi kutofanya kazi ili kujitegemea?	NO HAPANA	YES 7 NDIYO 7
b.	Done things that are illegal even if you didn‘t get caught (i.e., destroying property, shoplifting, stealing, selling drugs, or committing a felony? Hufanya mambo kinyume cha sheria hata kama hukutiwa mbaroni (kama vile, kuharibu mali, kuiba vitu dukani, wizi, kuuza madawa ya kulevya, aukufanya kosa la jinai?	NO HAPANA	YES 8 NDIYO 8
c.	Been in physical fights repeatedly (including physical fights with yourc spouse or children)? Ulikuwa ukipigana mara kwa mara (ikiwemo kupigana na mke / mume wakoau watoto)?	NO HAPANA	YES 9 NDIYO 9
d.	Often lied or « conned » other people to get money or pleasure, or lied justfor fun? Mara kwa mara kudanganya au ―kutapeli‖ watu wengine ili kupata pesa austarehe, au kudanganya kwa kuchekesha watu tu?	NO HAPANA	YES 10 NDIYO 10
e.	Exposed others to danger without caring? Kuwaweka wengine katika hatari bila ya kujali?	NO HAPANA	YES 11 NDIYO 11
f.	Felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property?	NO HAPANA	YES 12 NDIYO 12

Kujiona huna hatia baada ya kuleta madhara, kufanya maovu, kudanganya,au kuwaibia watu, au baada ya kuharibu mali?

ARE 2 OR MORE P1 ANSWERS CODED YES?
JE, VIPENGELE 2 AU ZAIDI VYA P1 VIMEJIBIWA NDIYO?

NO	YES
HAPANA	NDIYO

ANTISOCIAL PERSONALITY DISORDER

R. SOMATIZATION DISORDER (optional)

MATATIZO/MALALAMIKO YA KIMWILI BILASABABU BAYANA

➡ MEANS: (GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

R1

a. Have you had many physical complaints not clearly related to a specific disease beginning before age 30?
Je umekuwa ukijisikia kuwa na matatizo mengi ya kimwili ambayo hazihusuani na ugonjwa wowote unaojulikana kabla ya umri wa miaka 30?

NO HAPANA | YES NDIYO

b. Did these physical complaints occur over several years?
Je shida hizi za kimwili zilitokea kwa miaka mingi?

NO HAPANA | YES NDIYO

c. Did these complaints lead you to seek treatment?
Je shida hizi zilikufanya utafute matibabu?

NO HAPANA | YES NDIYO

d. Did these complaints cause significant problems at school, at work, socially, or in other important areas?
Je shida hizi zilikuwa kubwa kiasi cha kuathiri shughuli zako za kikazi, kishule, kijamii aukatika nyanja nyingine muhimu?

NO HAPANA | YES NDIYO

R2 Did you have pain in your:
Je ulikuwa na maumivu katika sehemu zifuatazo:

a. Head
Kichwa

NO HAPANA | YES NDIYO

b.	Abdomen Tumbo	NO HAPANA	YES NDIYO
c.	Back Mgongo	NO HAPANA	YES NDIYO
d.	joints, extremities, chest, rectum Viungo, miguuni, kifua, sehemu ya haja kubwa	NO HAPANA	YES NDIYO
e.	during menstruation Wakati wa hedhi	NO HAPANA	YES NDIYO
f.	sexual intercourse Wakati wa kujamiana	NO HAPANA	YES NDIYO
g.	urination Wakati wa kukojoa	NO HAPANA	YES NDIYO
	ARE 2 OR MORE R2 ANSWERS CODED YES? JE VIPENGELE VIWILI AU ZAIDI VYA R2 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO

R3 Did you have any of the following abdominal symptoms:
Je ulikuwa na dalili zozote za tumbo kama zifuatazo?

a.	Nausea Kichefuchefu	NO HAPANA	YES NDIYO
b.	Bloating Kuvimbiwa	NO HAPANA	YES NDIYO
c.	Vomiting Kutapika	NO HAPANA	YES NDIYO
d.	Diarrhea Kuharisha	NO HAPANA	YES NDIYO
e.	intolerance of several different foods Kusumbuliwa na vyakula mbalimbali baada ya kuvila	NO HAPANA	YES NDIYO
	ARE 2 OR MORE R3 ANSWERS CODED YES? JE VIPENGELE VIWILI AU ZAIDI VYA R5 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO

R4 Did you have any of the following sexual symptoms:
Je ulikuwa na shida zozote zifuatazo?

a.	loss of sexual interest Kukosa hamu ya mapenzi	NO HAPANA	YES NDIYO
b.	erection or ejaculation problems Kushinwa kusimamisha uume au utoaji manii wakatiwa kujamiiana	NO HAPANA	YES NDIYO
c.	irregular menstrual periods Hedhi inayobadilikabadilika	NO HAPANA	YES NDIYO
d.	excessive menstrual bleeding Kutokwa na damu nyingi wakati wa hedhi	NO HAPANA	YES NDIYO
e.	vomiting throughout pregnancy Kutapika kipindi chote cha ujauzito	NO HAPANA	YES NDIYO
	ARE 2 OR MORE R4 ANSWERS CODED YES? JE VIPENGELE VIWILI AU ZAIDI VYA R4 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO

R5 Did you have any of the following symptoms:
Je uliwahi kuwa na dalili zozote kama zifuatazo?

a.	paralysis or weakness in parts of your bodyKukosa Kuparalais au kukosa nguvu/ udhaifu katika sehemu za mwili	NO HAPANA	YES NDIYO
b.	impaired coordination or imbalance Kukosa balansi/kuyumbayumba	NO HAPANA	YES NDIYO
c.	difficulty swallowing or lump in throat kushindwa kumeza au kuhisi donge kwenye koo	NO HAPANA	YES NDIYO
d.	difficulty speaking Kushindwa kuongea	NO HAPANA	YES NDIYO
e.	difficulty emptying your bladder Kushindwa kukojoa	NO HAPANA	YES NDIYO
f.	loss of touch or pain sensation Kupoteza uwezo wa kuhisi maumivu na kugusa	NO HAPANA	YES NDIYO
g.	double vision or blindness Kuona vitu viwiliviwili au upofu	NO HAPANA	YES NDIYO

h.	deafness, seizures, loss of consciousness Kushindwa kusikia, kifafa, kupoteza fahamu	NO HAPANA	YES NDIYO
i.	significant episodes of forgetfulness Kusahausahau sana kwa vipindi	NO HAPANA	YES NDIYO
j.	unexplained sensations in your body Kuhisi vitu visivyoeleweka kwenye mwili	NO HAPANA	YES NDIYO

(CLINICIAN: PLEASE EVALUATE IF THESE ARE SOMATIC)

HALLUCINATIONS) ARE 2 OR MORE R5 ANSWERS CODED YES? JE VIPENGELE VIWILI AU ZAIDI VYA R5 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO
R6 .Were the symptoms investigated by your physician? Je hizi dalili zilifanyiwa uchunguzi na daktari?	NO HAPANA	YES NDIYO
R7.Was any medical illness found, or were you using any drug or medication could explain these symptoms? Je kuna ugonjwa wowote wa kimwili uliopatikana au kuna dawa zozote ulizokuwa unatumia ambazo zilihusishwa kusababisha hizo dalili?	NO HAPANA	YES NDIYO
R6 AND R7 (SUMMARY): CLINICIAN: HAS AN ORGANIC CAUSE BEEN RULED OUT?	NO	YES
R8. Were the complaints or disability out of proportion to the patient's physical illness? Je malalamiko au kutokujiweza huku hakulingani matatizo ya mgonjwa?	NO HAPANA	YES NDIYO
IS R7 (SUMMARY) OR R8 CODED YES? JE VIPENGELE R7 (UFUPISHO) AU R8 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO
R9. Were the symptoms a pretense or intentionally produced (as in factitious disorder)? Je dalili hizi zilitokana na kujifanyisha au kwa makusudi? (Kama ugonjwa wa kujiifanyisha?	NO HAPANA	YES NDIYO

NO	YES
HAPANA	NDIYO
SOMATIZATION DISORDER LIFETIME LLLLIFET	

IS R9 CODED NO?

JE KIPENGELE R9 KIMEJIBIWA NO?

R10 Are you currently suffering from these symptoms?

Je kwa sasa unasumbuliwa na hizi dalili?

NO	YES
HAPANA	NDIYO
SOMATIZATION DISORDER CURRENT SOMATIZATION DISORDER	

S. HYPOCHONDRIASIS

S .WASIWASI WA KUWA NA UGONJWA HATARI WA KIMWILI

➡MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE

S1. In the past six months, have you worried a lot about having a serious physical illness? DO NOT CODE YES IF ANY PHYSICAL DISORDER CAN ACCOUNT FOR THE PHYSICAL SENSATIONSOR SIGNS THE PATIENT DESCRIBES Je katika kipindi cha miezi sita iliyopita umekuwa na wasiwai mwingi kuwa huenda ukawa na ugonjwa hatari katika mwili wako? USIREKODI NDIYO ENDAPO UGOJWA ANAOELEZEA MGONJWA UNAWEZA KUWA UMETOKANA NA UGONJWA WA KIMWILI	NO HAPANA	YES NDIYO
S2. Have you had this worry for 6 months or more? Umekuwa na wasiwasi huu kwa kipindi cha miezi sita au zaidi?	NO HAPANA	YES NDIYO
S3. Have you ever been examined by a doctor for these symptoms? Umewahi kupimwa na daktari kwa ajili ya hizi dalili?	NO HAPANA	YES NDIYO
S4. Have your illness fears persisted in spite of the doctor's reassurance? Je uoga wa ugonjwa wako bado upo licha ya kuhakikishiwa na daktari kuwa hakuna tatizo?	NO HAPANA	YES NDIYO

S5. Does this worry cause you significant distress, or does it interfere with your ability to function at work, socially, or in other important ways?
Je wasiwasi huu unakupa shida kubwa au kuathiri shughuli zako za kikazi, kijamii au katikanyanja nyingine muhimu?

NO HAPANA YES NDIYO

NO HAPANA YES NDIYO

HYPOCHONDRIASIS CURRENT

S6. IS S5 CODED YES?
JE KIPENGELE S5 KIMEJIBIWA NDIO?

T. BODY DYSMORPHIC DISORDER

KUHISI TOFAUTI YA KIMAUMBILE KATIKA SEHEMU YA MWILI

➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE

T1. Are you preoccupied with a defect in your appearance?
Je mara nyingi unafikiri kuwa una kasoro katika muonekano wako?
NO HAPANA YES NDIYO

S3. Have you ever been examined by a doctor for these symptoms?
Umewahi kupimwa na daktari kwa ajili ya hizi dalili?
NO HAPANA YES NDIYO

T2. Has this preoccupation persisted in spite of others (including a physician) genuinely feeling that your worry was excessive?
Je fikira hizi za mara kwa mara bado zipo licha ya kuambiwa na daktari ama watu wengine kuwa wasiwasi wako ulikuwa wa kupita kiasi?
NO HAPANA YES NDIYO

T3. Does this preoccupation cause you significant distress, or does it interfere significantly NO YESwith your ability to function at work, socially, or in some other important way?
Je fikira hizi za mara kwa mara zinakupa shida kubwa au kuathiri shughuli zako za kikazi, kijamiiau katika nyanja nyingine muhimu?
NO HAPANA YES NDIYO

NO HAPANA YES NDIYO

BODY DYSMORPHIC DISORDER CURRENT

T4. IS T3 CODED YES??
JE KIPENGELE T3 KIMEJIBIWA NDIO?

U. PAIN DISORDER

MAUMIVU YA KISAIKOLOJIA

➡ MEANS: GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

U1. Currently, is pain your main problem? Je kwa sasa shida yako kuu ni maumivu?	NO HAPANA	YES NDIYO
U2. Currently, is the pain severe enough to need medical attention? Je kwa sasa maumivu haya ni makali sana kiasi cha kuhitaji matibabu?	NO HAPANA	YES NDIYO
U3. Currently is the pain causing you significant distress, or interfering significantly with your ability to function at work, socially, or in some other important way? Je kwa sasa maumivu haya yanakupa shida kubwa au kuathiri shughuli zako za kikazi, kijamii aukatika nyanja nyingine muhimu?	NO HAPANA	YES NDIYO
U4. Did psychological factors or stress have an important role in the onset of the pain, or did NO YESthey make it worse, or keep it going? Je matatizo ya kisaikolojia au msongo wa mawazo ulihusika katika kuanzisha, kuzidisha au kufanya maumivu haya yaendelee kuwepo?	NO HAPANA	YES NDIYO
U5. Is the pain a pretense or intentionally produced or feigned (As in, fictitious disorder)? Je matatizo haya yanatokana na kujifanyisha au kwa makusudi (kama katika ugonjwa wa kujifanyisha)?	NO HAPANA	YES NDIYO
U6 Did a medical condition have an important role in the onset of the pain, or did the medical condition make it worse, or keep it going?	NO HAPANA	YES NDIYO

Je shida ya kitabibu inahusika katika kuanzisha a, kuzidisha au kufanya maumivu haya yaendelee kuwepo?

U7 Has the pain been present for more than 6 months? NO YES
U7 Je maumivu haya yamekuwepo kwa kipindi cha zaidi ya miezi sita? HAPANA NDIYO

Acure Cronic

NO YES
HAPANA NDIYO

PAIN DISORDER
Associated with psychological factors
CURRENT

U8 IS U6 CODED NO?
U8 JE KIPENGELE U6 KIMEJIBIWA HAPANA?

U9 IS U6 CODED YES?
U9 JE KIPENGELE U6 KIMEJIBIWA NDIO?

NO YES
HAPANA NDIYO

PAIN DISORDER
associated with psychological factors and heneral medical condition
CURRENT

IF U8 OR U9 ARE CODED YES
KAMA KIPENGELE U8 AU U9 KIMEJIBIWA NDIO

AND U7 = NO, ADD: ACUTE TO DIAGNOSIS TITLE

W. ATTENTION DEFICIT/HYPERACTIVITY DISORDER (Adult)

➡ (MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

W5 As a child:
Ulipokuwa motto

NO YES
HAPANA NDIYO

a. Were you active, fidgety, restless, always on the go?
Ulikuwa mchangamfu sana, mwenye kuhangaika sana?

b.	Were you inattentive and easily distractible? Hukuwa msikivu au ulikuwa mwenye kuvurugwa na kitu kidogo?	NO HAPANA	YES NDIYO
c.	Were you unable to concentrate at school or while doing your homework? Je ulishindwa kuwa makini shuleni au wakati wa kufanya kazi ya nyumbani?	NO HAPANA	YES NDIYO
d.	Did you fail to finish things, such as school work, projects, etc.? Ulikuwa huwezi kumaliza vitu kama kazi ya shule, au shughuli nyingine?	NO HAPANA	YES NDIYO
e.	Were you short tempered, irritable, or did you have a short fuse‖, or tend to explode? Ulikuwa unakasirika haraka sana, au kuwa na jazba au hamaki?	NO HAPANA	YES NDIYO
f.	Did things have to be repeated to you many times before you did them? Je mambo yalilazimika kurudiwa rudiwa kabla hujayafanya?	NO HAPANA	YES NDIYO
g.	Did you tend to be impulsive without thinking of the consequences? Ulikuwa na tabia ya kufanya mambo kwa jazba bila kufikiria matokeo yake?	NO HAPANA	YES NDIYO
h.	Did you have difficulty waiting for your turn, frequently needing to be first? Ulikuwa na shida ya kusubiria zamu yako ifike au kutaka kuwa wa kwanza mara zote?	NO HAPANA	YES NDIYO
i.	Did you get into fights and/or bother other children? Ulikuwa unapigana au kuudhi sana watoto wengine?	NO HAPANA	YES NDIYO
j.	Did your school complain about your behavior? Shule yako imewahi kulalamika juu ya hizo tabia zako?	NO HAPANA	YES NDIYO
	W5 (SUMMARY): ARE 6 OR MORE W5 ANSWERS CODED YES? W5 (UFUPISHO) VIPENGELE 6 AU ZAIDI VYA W5 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO

W6 Did you have some of these hyperactive-impulsive or inattentive symptoms before you were 7 years old?
W6 Je ulikuwa na baadhi ya hizi dalili za kuhangaika, kutenda bila kufikiria au kutokutulia kabla ya umri wa miaka?

NO HAPANA | YES NDIYO

W7 As an adult:
Kama mtu mzima:

a. Are you still distractible?
Je bado unavurugwa kwa urahisi?

NO HAPANA | YES NDIYO

b. Are you intrusive, or do you butt in, or say things that you later regret either to friends at work or home?
Je bado unaingilia au kuropoka mambo ambavyo baadae unajuta kwa marafiki, kazini au nyumbani?

NO HAPANA | YES NDIYO

c. Are you impulsive, even if you have better control than when you were a child?
Je bado unafanya mambo bila kufikiria japokuwa umejitahidi zaidi kujitawala zaidi ya ulivyokuwa mtoto?

NO HAPANA | YES NDIYO

d. Are you still fidgety, restless, always on the go, even if you have better control than when you were a child?
Je bado huwezi kutulia sehemu moja, unahangaika , kila mara unataka kwenda, japokuwa umejitahidi zaidi kujitawala zaidi ya ulivyokuwa motto?

NO HAPANA | YES NDIYO

e. Are you still irritable and get angrier than you need to?
Je bado unakuwa mkali, na kukasirika kupita kiasi?

NO HAPANA | YES NDIYO

f. Are you still impulsive? For example, do you tend to spend more money than you really should?
Bado unafanya mambo bila ya kufikiria/jazba mfano, unatumia pesa zaidi ya unavyotakiwa kutumia?

NO HAPANA | YES NDIYO

g. Do you have difficulty getting work organized?
Je unapata ugumu wa kupangilia kazi zako?

NO HAPANA | YES NDIYO

h. Do you have difficulty getting organized even outside of work?
Je unapata ugumu wa kuwa na mpangilio hata nje ya kazini?

NO HAPANA | YES NDIYO

i.	Are you under-employed or do you work below your capacity? Je una ajira iliyo chini ya kiwango chako au unafanya kazi iliyo chini ya kiwango chako?	NO HAPANA	YES NDIYO
j.	Are you not achieving according to people's expectations of your ability? Je unafikia malengo yako kulingana na matarajio ya watu juu ya uwezo wako?	NO HAPANA	YES NDIYO
k.	Have you changed jobs or have been asked to leave jobs more frequently than other people? Je umekuwa ukibadili kazi au kuambiwa uache kazi mara nyingi kuliko watu wengine?	NO HAPANA	YES NDIYO
l.	Does your spouse complain about your inattentiveness or lack of interest in him/her and/or the family? Je mwenza wako amewahi kulalamika juu ya kutokutulia kwako au kukosa mvuto kwake au kwa familia?	NO HAPANA	YES NDIYO
m.	Have you gone through two or more divorces, or changed partners more than others? Umewahi hutalakishwa mara mbili au zaidi au kubadilisha wapenzi zaidi ya wengine?	NO HAPANA	YES NDIYO
n.	Do you sometimes feel like you are in a fog, like a snowy television or out of focus?	NO	YES
	W7 (SUMMARY): ARE 9 OR MORE W7 ANSWERS CODED YES? W7 (UFUPISHO) JE VIPENGELE 9 AU ZAIDI VYA W7 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO
	W8 Have some of these symptoms caused significant problems in two or more of the following situations at school, ay work, home, or with family or friends? Je baadhi ya dalili hizi zimesababisha matatizo makubwa katika sehemu mbili au zaidi ya zifuatazo: shuleni, kazini, nyumani, marafiki au familia?	NO HAPANA	YES NDIYO

NO	YES
HAPANA	NDIYO
Attention Deficit/Hyperactivity Disorder	

IS W8 CODED YES?

JE KIPENGELE W8 KIMEJIBIWA NDIO?

X. ADJUSTMENT DISORDERS

X. MAGOJWA REKEBISHO

➡MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

EVEN IF A LIFE STRESS IS PRESENT OR A STRESS PRECIPITATED THE PATIENT'S DISORDER, DO NOT USE AN ADJUSTMENT DISORDER DIAGNOSIS IF ANY OTHER PSYCHIATRIC DISORDER IS PRESENT. SKIP THE ADJUSTMENT DISORDER SECTION IF THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOTHER SPECIFIC AXIS IDISORDER OR ARE MERELY AN EXACERBATION OF A PREEXISTING

AXIS I OR II DISORDER

HATA KAMA MSONGO WA KIMAISHA UPO AU MSONGO ULIZIDISHA UGONJWA USITUMIE ADJUSTMENT DISORDER ENDAPOKUNA UGONJWA MWINGINE WA KIAKILI

RUKA KIPENGELE CHA ADJUSTMENT DISORDER KAMA DALILI ZA MGONJWA ZINATOSHELEZA AINA FULANI YA MAGONJWA YAMUHIMILI WA KWANZA WA MAGONJWA YA AKILI AU NI MUENDELEZO WA UGONJWA ULIOKUWEPO WA MUHIMILI 1 AU II DISORDER

ONLY ASK THESE QUESTIONS IF PATIENT CODES NO TO ALL OTHER DISORDERS.

ULIZA MASWALI HAYA ENDAPO VIPENGELE VINGINE VYOTE VIMEJIBIWA NDIO

X1 Are you having emotional or behavioral symptoms as a result of a life of stress? [Examples include anxiety/depression/misbehavior/physical complaints (examples of misbehavior include fighting, driving recklessly, skipping school, vandalism, violating the rights of others,or doing illegal things)?	NO HAPANA	YES NDIYO

X1 Je una matatizo ya mhemko/kihisia au kitabia yatokanayo na msongo wa kimaisha? Mfano wasiwasi mwingi,/sonona, tabia mbaya/ shida za kimwili. Mfano wa tabia mbaya ni kama kupigana, kuendesha rafu, kukataa/kutoroka shule, na kufanya mambo kinyume cha sheria?

X2 Did these emotional/behavioral symptoms start within 3 months of the onset of the stressor? NO HAPANA YES NDIYO
Je dalili hizi za kihisia/ kimawazo zilianza ndani ya miezi matatu baada ya kuanza kwa shida/msongo?

X3

a. Are these emotional/behavioral symptoms causing marked distress beyond what would be expected?? NO HAPANA YES NDIYO
Je dalili hizi za kihisia/ kimawazo zinakusababishia matatizo zaidi ya inavyotegemewa/ kupita kiasi?

b. Are these emotional/behavioral symptoms causing significant impairment in your ability to function socially, at work, or at school? NO HAPANA YES NDIYO
Je dalili hizi za kihisia/ kimawazo/ kitabia zinakusababishia matatizo makubwa kaiasi chakuathiri uwezo wako wa kikazi, kijamii au katika nyanja nyingine muhimu?

X4 Are these emotional/behavioral symptoms due entirely to the loss of a loved one (bereavement) and are they similar in severity, level of impairment and duration to what most others would suffer under similar circumstances? (If so this is uncomplicated bereavement.)? NO HAPANA YES NDIYO
X4 Je dalili hizi za kihisia/ kimawazo/ kitabia zinatokana na kufiwa na mtu uliyempenda (maombolezo)? Na je unadhani watu wengine wangeteseka kama wangekumbana na hali kama hiyo? (kwa kiwango, kushindwa kufanya shuguli na kwa kipindi?) (Kama ndivyo itakuwa ni maombolezoya kawaida)?

HAS UNCOMPLICATED BEREAVEMENT BEEN RULED OUT? NO HAPANA YES NDIYO
YESJE MAOBOLEZO YA KAWAIDA YAMEENGULIWA?

X5 Have these emotional/behavioral symptoms continued for more than 6 months after the stress stopped? NO HAPANA YES NDIYO
X5 Je dalili hizi za kihisia/ kimawazo/ kitabia zimeendelea kwa zaidi ya miezi sita baada ya tatizo kuisha?

WHICH OF THESE EMOTIONAL / BEHAVIORAL SUBTYPES ARE PRESENT? ***MARK ALL THAT APPLY***

AINA GANI YA HISIA/TABIA ZIFUATAZO ZIPO?

A. Depression, tearfulness or hopelessness Sonono, kutaka kulia au kukosa matumaini	NO HAPANA	YES NDIYO
B. Anxiety, nervousness, jitteriness, worry Wasiwasi, kuogopa sana, kutetemeka	NO HAPANA	YES NDIYO

C. Misbehavior (for example, fighting, driving recklessly, skipping school, vandalism, violating other's rights, doing illegal things).
Tabia mbaya kama kupigana, kuendesha vibaya, kukataa/ kutoroka shule, kuonea wengine, kufanya mambo kinyume cha sharia.

D. Work problems, school problems, physical complaints or social withdrawal
Shida za kikazi, kishule, kimwili, au kushindwa kujihusisha kijamii

IF MARKED:

• A only, then code as Adjustment disorder with depressed mood. 309.0
Kama kimejibiwa kipengele A peke yake, recodi Adjustment disorder with depressed mood. 309.0
• B only, then code as Adjustment disorder with anxious mood. 309.24
Kama kimejibiwa kipengele B peke yake, recodi Adjustment disorder with anxious mood. 309.24
• C only, then code as Adjustment disorder of conduct. 309.3
Kama kimejibiwa kipengele C peke yake, recodi Adjustment disorder of conduct 309.3
• A and B only, then code as Adjustment disorder with mixed anxiety and depressed mood.
309.28
Kama kimejibiwa kipengele A na B peke yake, recodi Adjustment disorder with mixed anxiety and depressed mood. 309.28
• C and (A or B), then code as Adjustment disorder of emotions and conduct. 309.4
Kama kimejibiwa kipengele C na (A au B), recodi Adjustment disorder with Emotionl and conduct. 309.4
• D only, then code as Adjustment Disorder unspecified. 309.9
Kama kimejibiwa kipengele D peke yake, recodi Adjustment disorder unspecified 309.9

NO	*YES*
HAPANA	*NDIYO*

Adjustment Disorder with subtype___see above with _____(see above for subtypes)

IF X5 IS CODED NO, THEN CODE DISORDER YES WITH SUBTYPE.

KAMA X5 KIMEJIBIWA NDIO REKODI DISORDER NDIO NA AINA YAKE

Y. PREMENSTRUAL DYSPHORIC DISORDER

Y. HALI YA KUJISIKIA HASIRA KALI/KUUDHIKAKABLA YA SIKU ZA HEDHI

➡MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

Y1 During the past year, were most of your menstrual periods preceded by a period lasting about one week when your mood changed significantly? Y1 Katika kipindi cha mwaka mmoja uliopita, je siku zako za hedhi zilitanguliwa na kipindi cha muda wa wiki moja ambapo hisia zako zilibalilika sana?	NO HAPANA	YES NDIYO
Y2 During these periods, do you have difficulty in your usual activities or relationships with others, are you less efficient at work, or do you avoid other people? Y2 Je katika kipindi hiki, una shida katika shughuli zako za kawaida au mahusiano na wengine, na je ufanisi wako katika kazi umepungua au unaepukawatu?	NO HAPANA	YES NDIYO
Y3 During these premenstrual episodes (but not at in the week after your period ends) do youhave the following problems most of the time: Y3 Je katika vipindi hivi vya kabla ya hedhi(lakini sio wiki inayofuata baada ya hedhi kuisha) unakuwa na shida zifuatazo muda mwingi?	NO HAPANA	YES NDIYO

Y3

a.	Do you feel sad, low, depressed, hopeless, or self-critical? Unakuwa na huzuni, kujihisi huna furaha, kukosa matumaini au kujikosoa kosoa?	NO HAPANA	YES NDIYO
b.	Do you feel particularly anxious, tense, keyed up or on edge? Je unajihisi uoga mwingi, kukakamaa kuamshwa, au mwenye kiherehere?	NO HAPANA	YES NDIYO

c.	Do you often feel suddenly sad or tearful, or are you particularly sensitive to others' comments? Unajisikia huzuni ghafla au kutaka kulia, au kikisemwa chochote kukuhusu kinakugusa sana?	NO HAPANA	YES NDIYO
d.	Do you feel irritable, angry or argumentative? Unaudhika haraka au kushikwa na hasira au kubishana sana?	NO HAPANA	YES NDIYO
	ARE 1 OR MORE Y3 ANSWERS CODED YES? JE KIPENGELE KIMOJA AU ZAIDI CHA Y3 KIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO
e.	Are you less interested in your usual activities, such as work, hobbies or meeting with friends? Je umepoteza hamu katika shuguli zako za kila siku kama kazini, vitu unavyovipendelea, au kukutana na marafiki	NO HAPANA	YES NDIYO
f.	Do you have difficulty concentrating? Je unapatwa na shida ya kuwa makini?	NO HAPANA	YES NDIYO
g.	Do you feel exhausted, tire easily, or lack energy? Je unajisikia kuishiwa na nguvu au kuchoka sana?	NO HAPANA	YES NDIYO
h.	Does your appetite change, or do you overeat or have specific food cravings? Je hamu yako ya kula inabadilika au kula kupita kiasi au kuna chakula ambacho unakitamani sana?	NO HAPANA	YES NDIYO
i.	Do you have difficulty sleeping or do you sleep excessively? Je una shida ya kupata usingizi au kulala sana?	NO HAPANA	YES NDIYO
j.	Do you feel you are overwhelmed or out of control? Je unajisikia kuelemewa na mambo au kushindwa kujitawala?	NO HAPANA	YES NDIYO
k.	Do you have physical symptoms such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of bloating, or weight gain? Je una dalili za kimwili kama vile matiti kuuma au kuvimba, kichwa kuuma, maumivu ya viungo, maumivu ya misuli, kuhisi kuvimbiwa aukuongezeka uzito?	NO HAPANA	YES NDIYO

NO HAPANA YES NDIYO

Premenstrual Dysphoric Disorder

Probable CURRENT

ARE 5 OR MORE Y3 ANSWERS CODED YES?

JE VIPENGELE VITANO AU ZAIDI VYA Y3 VIMEJIBIWA NDIO?

IF YES, DIAGNOSIS MUST BE CONFIRMED BY PROSPECTIVE DAILY RATINGS DURING AT LEAST 2 CONSECUTIVE CYCLES.

Z. MIXED ANXIETY-DEPRESSIVE DISORDER

Z. MCHANGAYIKO WA UGONJWA WA WASIWASI MKUBWA NA HUZUNI

DO NOT USE THIS MODULE ALONE WITHOUT FIRST COMPLETING ALL THE ANXIETY AND MOOD DISORDERS. MEANS : GO TO THE DIAGNOSTIC BOX AND CIRCLE NO.

[SKIP THIS DISORDER IF PATIENT 'S SYMPTOMS HAVE ALREADY MET CRITERIA FOR ANY OTHER DISORDER AND CODE NO IN THE DIAGNOSTIC BOX.]

Z1 Have you been depressed or down consistently for at least a month? Z1 Je umekuwa ukijihisi kukosa furaha au kuwa mnyonge muda mwingi kwa kipindi cha angalau mwezi mmoja?	NO HAPANA	YES NDIYO
Z2 When you felt depressed did you have any of the following symptoms for at least one month: Ulipojihisi kukosa furaha ulikuwa na dalili zozote zifuatazo kwa kipindi cha angalau mwezi mmoja?	NO HAPANA	YES NDIYO

Z2

a.	Did you have difficulty concentrating or find your mind going blank? Je ukushindwa kuwa makini au kuhisi akili yako inakuwa tupu?	NO HAPANA	YES NDIYO
b.	Did you have trouble sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? Je ulikuwa na shida ya usingizi(shida ya kupata usingizi, kuamka katikati ya usiku,kuamka asubuhi na mapema au kulala kupita kiasi?	NO HAPANA	YES NDIYO
c.	Did you feel tired or low in energy? Je ulijisikia kuchoka au kukosa nguvu?	NO HAPANA	YES NDIYO

d.	Did you feel irritable? Je ulijisikia kuudhika haraka?	NO HAPANA	YES NDIYO
e.	Did you worry too persistently for at least a month? Je, ulishikwa na wasiwasi muda wote kwa kipindi cha angalau mwezi mmoja?	NO HAPANA	YES NDIYO
f.	Did you cry easily? Je ulilia kwa urahisi?	NO HAPANA	YES NDIYO
g.	Were you always on the lookout for possible dangers? Je ulikuwa muda wote unaangalia kama kuna hatari ingeweza kutokea?	NO HAPANA	YES NDIYO
h.	Did you fear the worst? Je iliogopa kupita kiasi?	NO HAPANA	YES NDIYO
i.	Did you feel hopeless about the future? Je ulikosa matumaini kuhusu siku za mbeleni?	NO HAPANA	YES NDIYO
j.	Was your self-confidence low, or did you feel worthless? Je ujasiri wako ulipungua au ulijihisi kutokuwa na thamani?	NO HAPANA	YES NDIYO
	Summary of Z2: ARE 4 OR MORE OF Z2 ANSWERS CODED YES? UFUPISHO WA Z2: JE VIPENGELE VINNE AU ZAIDI VYA Z2 VIMEJIBIWA NDIO?	NO HAPANA	YES NDIYO
	Z3 Do these symptoms cause you significant distress or impair your ability to function at work, socially, or in some otherimportant way? Z3 Je dalili hizi zilikupa shida kubwa au kuathiri uwezo wako wa kikazi, kijamii aukatika nyanja nyingine muhimu?	NO HAPANA	YES NDIYO

Z4

a.	Were you taking any drugs or medicines just before these symptoms began? Je kuna dawa zozote ulikuwa unatumia kabla ya kuanza kwa hizi dalili?	NO HAPANA	YES NDIYO
b.	Did you have any medical illness just before these symptoms began? Je ulikuwa na ugonjwa wowote wa kitabibu kabla ya kuanza kwa hizi dalili?	NO HAPANA	YES NDIYO

IN THE CLINICIAN‘S JUDGMENT are either of these likely to be direct causes of thepatient's symptoms? HAS AN ORGANIC CAUSE BEEN RULED OUT? NO YES UNCERTAIN

Z5

a. The patient's symptoms meet criteria for: Major Depression LIFETIME? NO YES
Dalili za mgonjwa zimefikia kigezo vya: Tukio la sonona LIFETIME? HAPANA NDIYO

Dysthymia LIFETIME NO YES
Disthimia LIFETIME HAPANA NDIYO

Panic Disorder LIFETIME NO YES
Ugonjwa wa hofu kubwa LIFETIME HAPANA NDIYO

Generalized Anxiety Disorder LIFETIME NO YES
Tukio la sonona LIFETIME HAPANA NDIYO

b. The patient's symptoms CURRENTLY meet criteria for:
Dalili za mgonjwa kwa sasa ziefikia vigezo vya:

any other anxiety disorder NO YES
aina yoyote nyingine ya ugonjwa wa Wasiwasi mkubwa HAPANA NDIYO

any other mood disorder NO YES
aina yoyote ingine ya ya magojwa yahisia HAPANA NDIYO

c. The patient’s sym[toms are better accounted for by another psychiatric disorder NO YES
Dalili za mgonjwa zaweza kutokana zaidi na magonjwa mengine ya akili? HAPANA NDIYO

NO YES
HAPANA NDIYO

MIXED ANXIETY - DEPRESSIVE DISORDER CURRENT

Z6 IS Z5c CODED YES?

Z6 JE KIPENGELE Z5C KIMEJIBIWA NDIO?