MENTAL HEALTH AND SUBSTANCE ABUSE PROBLEMS AMONG JUVENILE OFFENDERS AT GETATHURU CHILDREN RECEPTION CENTRE & REHABILITATION SCHOOL NAIROBI; KENYA

A dissertation submitted in part fulfillment for the award of the degree, Master of Science in Clinical psychology of the University of Nairobi. *

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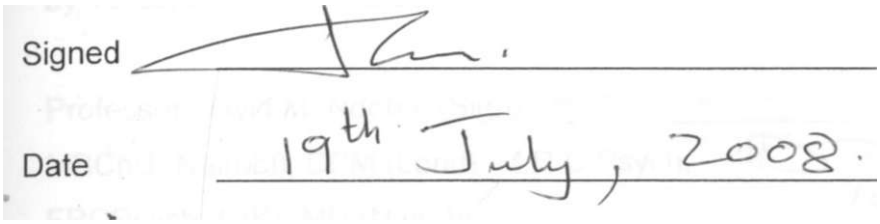
DECLARATION

I, Teresia N. M Okumu, do hereby declare that this is my original work and that is has not been presented for award of any degree or to any other university



CERTIFICATE

This is to certify that this dissertation is research work carried out independently by Teresia N.M. Okumu under our guidance and supervision:

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DEDICATION

This work has been dedicated to the Youths admitted at Getathuru Children Reception Centre & Rehabilitation School Nairobi; Kenya.

ACKNOWLEDGEMENT

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ABSTRACT

Background: Researchers, clinicians, and juvenile justice program administrators have known of the link between drug use (alcohol use), mental health problems and juvenile crime. In many communities, the majorities of juveniles currently entering the justice system are drug users or have mental health problems

Objective: This study provides an overview of the prevalence, diagnosis of mental disorders among juvenile offenders at Getathuru children reception centre & rehabilitation school Nairobi; Kenya.

METHODS: This study was a descriptive cross-sectional survey of all sentenced adolescents ages 13-18 years incarcerated at Getathuru children reception centre & rehabilitation school. The selected sample constituted adolescents who answered questions objectively without help of their guardian by filling out Socio-demographic, reason who admission at the centre and MINI KID questionnaires

RESULTS: Most (54.6%) of the youth were admitted at the centre for care and protection. The prevalence of mental disorders among these juvenile offenders varied significantly in the rates of prevalence found, with results showing that this population had high rates of mental disorders; 41.2% had major depressive disorder current episode, 22.7% had high suicide risk behaviour, 81.4% had Post Traumatic stress disorder current 27.8% had alcohol dependence and 41.2% drug dependence. The identification of mood disorders is critical because these disorders are a leading cause of suicide among adolescents and because mood disorders may contribute to or exacerbate delinquent and disruptive behaviors.

CONCLUSIONS: Juvenile detainees have a constitutional right to needed mental health treatment. More comprehensive mental health services are required to ensure that juvenile offenders with mental illness are identified and cared for appropriately. Doing so, may not only will alleviate painful symptoms but may also contribute significantly to improvements in psychosocial functioning, interpersonal relations, and school performance and to decreases in delinquent, disruptive, and suicidal behaviors.

CHAPTER 1

1.0 INTRODUCTION

Researchers, clinicians, and juvenile justice program administrators have known of the link between drug use (alcohol use), mental health problems and juvenile crime. In many communities, the majorities of juveniles currently entering the justice system are drug users or have mental health problems. Juvenile drug use is related to recurring, chronic, and violent delinquency that continues well into adulthood. Juvenile drug use is also strongly related to poor health, deteriorating family relationships, worsening school performance, and other social and psychological problems. The drug-crime link or mental health problem-crime link does not mean that drug use or mental health problem necessarily leads to criminal activity (or vice versa). However, research indicates that there is association between a group of violent juvenile offenders who; commit serious crimes, are serious drug users, and are delinquents or offenders with serious mental health problems[1]. FBI information in 2000[2] revealed that teenagers aged 13 to 19 accounted for 10 percent of the population arrested, 23.8 percent of these arrests were for violent crime, and 40 percent of arrests for property crime. The determinants of juvenile crime such as gender, education, socio-economic status, and family environment are all strong correlates of criminal behavior.

The prevalence and persistence of adolescent substance abuse is a national health issue in Kenya, and substance use among adolescents is frequently co-morbid with other psychiatric disorders. Most studies in this area in Kenya however, have utilized samples of middle or high school students or from inpatient settings[3"26]. Less is known about substance use and psychiatric co-morbidity among delinquent adolescents who are/have involved in criminal activity. There is a growing national concern regarding the problems of alcohol abuse, drug abuse, the adequacy and quality of the national addiction treatment system, particularly for adolescents. To manage these mental health and substance abuse problems among children and adolescents, the country has to formulate programmes that can be implemented in paroling these vulnerable age Groups who are involved in criminal activity. This study examines whether mental

health and substance abuse problems have any association with crimes committed by juveniles in Kenya

1.1 Background:

Hyperactive/ADHD children are believed to be a greater risk for adolescent and young adult antisocial activity and drug use/abuse, particularly that subset having co-morbid conduct problems/disorder. Thus, the co-occurrence of mental disorders among adolescents who present for substance abuse treatment is a common phenomenon. The twelve-month prevalence[27] of mental disorders among prisoners has been shown to be higher than in the corresponding general population (74% versus 22%). A review of 62 surveys has shown that even on completing the jail terms, there is a tendency for them to repeat the crimes[28]. However, this has been under-explored in developing economies, due to unavailability of data, both for offender populations [29 30] and for non-offender populations[31"33], highlighting a need for "greater research in forensic psychiatry in these countries"[28].

1.2 Statement of the problem:

There is an undeniable link between substance abuse and delinquency. Arrest, adjudication, and intervention by the juvenile justice system are eventual consequences for many youth engaged in substance use and have also mental health problems. It cannot be claimed that substance abuse or mental health problems cause delinquent behavior or delinquency causes substance use or mental health. However, the two behaviors are strongly correlated and often bring about school and family problems, involvement with negative peer groups, a lack of neighborhood social controls, and physical or sexual abuse. Possession and use of alcohol and other drugs are illegal for all youth. Substance abuse is associated with both violent and income-generating crimes by youth. This increases fear among community residents and the demand for juvenile and criminal justice services, thus increasing the burden on these resources. Gangs, [dr]ug trafficking, prostitution, and growing numbers of youth homicides are among

the social and criminal justice problems often linked to adolescent substance abuse and mental health problems. Research studies from developed countries have shown high co-existence of mental health problems among adolescent persons with substance abuse, conduct disorder, oppositional defiant disorder, and attention deficit-hyperactivity disorders. These studies have also investigated the relationships between these disorders and conflict with the law; and have established a high prevalence rate of these disorders among juvenile offenders. In Kenya, attempts have been made to break the juvenile crime Cycle by incarcerating the offenders. Few (if any) intervention programmes are available to parole these offenders back into their communities. The young people who persistently abuse-substances or have mental health problems often experience an array of problems, including academic difficulties, health-related problems (including mental health), poor peer relationships, and involvement in crime activities. Additionally, there are consequences for family members, the community, and the entire society. This circle must be broken in any country, a process to reduce suffering of the juveniles with mental health and substance abuse problems, at same time assist the juvenile justice systems to make placement of the children/adolescents found to have these health related problems.

1.3 Purpose of the study:

This study was designed to determine types of mental health and substance abuse problems among the juvenile offenders. The determined information was used in turn to propose interventions and programmatic changes that would most likely be successful in addressing the juvenile crime cycle.

1.4 Rationale of the study:

Adolescents with mental health problems more often than not easily get involved in criminal activities and abuse substance. These inappropriate maladjusted abnormal behaviours live on like a scar that inhibits health attitudes towards societal norms and affect interpersonal relationships. These psychosocial

inappropriate experiences of a person in his or her early life in the society remains the origin of his/her learned behaviour, motives, desires and perceptions, which affect the person's psycho dynamics, cognitive development and behaviour throughout life. With increasing rates of juvenile offenders, youth abusing substances, HIV infection, abortion and high prevalence of mental disorders among the youths in Kenya, the study was designed to determine types of mental health problems among juvenile offenders and how these criminal activities are associated with mental health problems

CHAPTER 2:

2.0 LITERATURE REVIEW

Research in criminology has established strong correlates between age, gender, education, socio-economic status, mental health/substance abuse health problems and family environment to criminal behaviours.

2.1 Age

Offending in general is strongly associated with age[34]. Offending peaks in the United States between 15 and 24 and rapidly declines with age[35]. While more sophisticated and professionally skilled offenders, such as forgers and embezzlers, tend to be older, approximately two thirds of robberies, burglaries, arson and vehicle thefts, and about half of all violent crimes, are committed by people under 25[36]. In Queensland, South Australia and Victoria[37] the 2001-2002 alleged offender rates per 100,000 was roughly four times higher for 15-19 year olds (6421) than for the total offender rate (1544). In Queensland the peak ages for juvenile male (42%) and female (35%) offenders, respectively, were 16 and 15[38]. Although reductions in offending occurred among the 10-14 (-26%) and 15-19 (-22%) year olds between 1995-92 and 2001-02, chronic offending did not decline. Some combination of motivations to offend and an absence of constraints predispose individual offenders[36]. Young people who offend are especially likely to be in the company of other young offenders who are acting beyond conventional control mechanisms. The consistent relationship found between age (and gender) and crime increases the validity of biological explanations and weakens general social theories[39]. Age also is linked to having accidents, pregnancies, mental illness and school problems, all of which may lead youth to draw upon social services, medical services and justice system services.

2.2 Gender

Males are much more likely to commit crimes; they commit more serious crimes and do so more frequently than women[40]. The male/female ratio for violent crime (5.7) and total crime (3.1) exemplify this difference[41]. In Queensland, South Australia and Victoria[37] the alleged offender rate per 100,000 was roughly four times higher for males (3033) than for females (753). Lynch, Buckman and Krenske[38] found that female young offenders who entered the Queensland justice system in 1994 (22%) were less than half as likely to be imprisoned in adulthood as males (54%). In Australia declines have occurred among younger offenders of both genders. Men, especially young men, are particularly at higher risk of accidents and problems with school than are women.

2.3 Mental illness, substance abuse, personality and temperament

A connection between mental illness and crime, especially violence, has been investigated for decades[42]. Mental illness implies difficulty in conforming, though only minorities of mentally ill people commit crimes. Impulsivity[43] and psychopathy[44] are associated with criminal behaviour. Research indicates that some criminal behaviour, such as drug use, sexual abuse and violence, alleviate anxiety induced by the illness[45]. Participation in these activities also increases interaction with antisocial peers who impulsively use more drugs, experiment more with sex and perform more poorly in school than other juveniles[46].

A number of studies in the US[47"48] conducted by Bureau of Justice Statistics have shown that youth with substance abuse or mental health problems consistently have higher offending rates than those without mental health problems. For example, Van et al[49] showed that youth enrolled in a public mental health system had three times as many police referrals to the juvenile justice system as those in the general child population. In Mississippi[50], a study among 482 incarcerated juveniles, 71-85% of them made at least on criteria of mental disorder using the DSM-IV[51] a third had co-occurring mental health and substance abuse disorders. Others have shown higher rates of violence and Agression among youth with mental health problems[52]. Similarly, a number of

studies have shown that children in the juvenile justice system have a high prevalence of mental health disorders[53,54]. Some evidence suggests that mental illness may have contributed in part to youths' illegal behavior[48].

The overrepresentation of mental disorders among youth in the legal system may reflect a greater risk of criminal behavior. This has been shown by existing research results of a strong positive relationship between substance use and violent crime[52,55]. The Bureau of Justice Statistics[56] in US reported that 41% of violent male inmates in local jails reported drinking at the time of the offense compared to 35 percent of property crime inmates. Other studies comparing violent and non-violent criminals also found higher rates of alcohol use among violent offenders[57, 53,54]. When illegal drugs are considered, Chaiken and Chaiken[58] showed that 83 percent of violent inmates used drugs during the same period as the crime, although they found no association between juvenile crime and juvenile use of marijuana or experimentation with hard drugs.

In follow up studies among children with ADHD and control groups, looking at their involvement in antisocial activity and substance use, results have shown that more of the ADHD group commit a variety of antisocial acts and get arrested for doing so (corroborated through official arrest records) than does the control (community) group. The children with ADHD also committed a higher frequency of property theft, disorderly conduct, assault with fists, carrying a concealed weapon, and illegal drug possession, as well as more arrests. These activities reduced to two dimensions corresponding to predatory-overt and drug-related antisocial conduct[59]. In a study by Copur, Turkcan, and Erdogmus among juvenile detainees[60], 34.8% were found to have substance abuse excluding nicotine and alcohol. The substances abused in preferential order were cannabis (72.5%), volatile substances (21.3% bally and 3.7% thinner; 25%) and sedative hypnotic drugs and biperidents (2.5%). The rate of conduct disorder was 46.3% m substance abusers and 25.3% in the others. The rate of substance abuse was 48.5% in the juveniles who had committed multiple crimes and 14.1% in the

others. The study showed that conduct disorder was very high in juvenile detainees. Conduct disorder was higher in substance-abusing than in non-abusing juvenile detainees. Substance-abusing juvenile detainees were found to have a higher detention rate than non-abusing juvenile detainees. There was a close relation between conduct disorder and substance abuse and multiple crimes.

2.4 Substance abuse

Although experimentation with drugs is common among youth, heavy and persistent use typifies criminal offenders. The Drug Use Careers of Offenders (DUCO) study, in Australia found that most male offenders were multiple offenders who had used drugs (62%) during the six months before being apprehended[61]. As found in prior studies, the most chronic offenders in the DUCO study began using drugs and offending at earlier ages than other offenders[cT].

A study done by National Institute of Justice in US[63] found the highest association between positive drug tests of male juvenile arrestees and their commission of drug-related crimes (e.g., sales, possession). However, a substantial rate of drug use also was found among youth who committed violent, property, and other crimes. Other data support the concern for drug-involved youth in the juvenile justice system. The Survey of Youth in Custody, 1979 [64] found that more than 39 percent of youth under age 18 were under the influence of drugs at the time of their current offense. More than 57 percent reported using a drug in the previous month. In another study of 113 delinquent youth in a State detention facility, 82 percent reported being heavy (daily) users of alcohol and other drugs just prior to admission to the facility, 14 percent were regular users (more than two times weekly), and 4 percent reported occasional use (DeFrancesco, 1996[65]).

A study conducted in 1988 in Washington, D.C., found youth who sold and used drugs were more likely to commit crimes than those who only sold drugs or only

used drugs. Heavy drug users were more likely to commit property crimes than nonusers, and youth who trafficked in drugs reported higher rates of crimes against persons. Youth in this sample were most likely to commit burglary or sell drugs while using or seeking to obtain drugs. About one-fourth of the youth also reported attacking another youth to obtain drugs. However, among the youth in this sample, the majority who committed crimes did not do so in connection with drugs (Altschuler and Brounstein, 1991[66]). A breakdown of crimes that youth have committed to obtain drugs follows:

- Drug selling: 36 percent.
- Serious assault: 24 percent.
- Burglary: 24 percent.
- Robbery: 19 percent.

The 1996-97 National Parents' Resource Institute for Drug Education (PRIDE) study (1997[67]) found a significant association between crimes committed by adolescents and their use of alcohol and other drugs.

2.5 Family and community dysfunction

Gluecks and Gluecks[42] noted negative effects of dysfunctional families on re-offending, though disagreement about what constitutes functional persists. Children in single-parent households are ten to fifteen percent more likely to be delinquents than children from intact families, though children of divorced parents are less likely to be delinquent than those from unhappily intact families[68]. Broken homes are less likely to provide adequate supervision and effective socialization than intact homes[69]. Poor families have more frequently been disrupted by divorce and loss of family members and health problems[70]. Single mothers and their families are more likely to experience social and psychological disruption from unemployment, as well as unsettling changes in residence, employment and household composition[71]. Dysfunctional may also imply parents who are socially and emotionally neglectful and parents who use drugs[72]. Chronic

offenders are significantly more likely to come from deviant and multiple problem families[73].

In Kenya and the large Africa, there has been limited research, if any on the need for different treatment modalities and placement of adolescents suffering from mental health problems and at same time they have a conflict with the law and/or are in incarceration. Different groups interviewed by the media, the church, politicians, parent associations and school authorities gave many reasons for the behaviour described above. These reasons included use of drugs by the young people, parental failure to instruct children on how to behave, youth rebellion, inadequate school disciplinary measures, and copying bad examples from leaders. Ndetei states that at Kyanguli School, drugs did not play a significant role, however, some community members speculated that "the fire was the work of unhappy spirits taking revenge on the community for unspecified sins" partly because the fire raged on despite a heavy down pour of rain[74]. Within any community there are those who will think this way and desire to respond to situations from this perspective and cannot be ignored. However, harmony has to be maintained within homes as members of a family interact with each other in such a way of maintaining positive and healthy attitudes. This research aimed at determining the types of mental health problems among adolescents in a Kenyan Juvenile incarceration home and how these mental health problems were associated with criminal activity among these juvenile offenders.

CHAPTER 3:

3.0 METHODOLOGY

3.1 Broad Objective

To profile mental health problems and personality traits among adolescents incarcerated at Getathuru children reception centre & rehabilitation school

3.2 Specific Objectives

1. To determine the social demographic characteristics of juvenile (adolescent) offenders incarcerated at Getathuru children reception centre & rehabilitation school
2. To determine the family structures of juvenile (adolescent) offenders incarcerated at Getathuru children reception centre & rehabilitation school
3. To determine the prevalence of mental health problems among at Getathuru children reception centre & rehabilitation school
4. To determine the personality traits among at Getathuru children reception centre & rehabilitation school
5. To determine the prevalence of substances abuse among at Getathuru children reception centre & rehabilitation school
6. To determine types of offense committed by adolescents at Getathuru children reception centre & rehabilitation school
7. To determine the linkages between mental health problems, substance abuse and type(s) of offense among at Getathuru children reception centre & rehabilitation school

3.3 Null Hypothesis:

Mental Health problems are not significantly high in adolescents with criminal and anti-social records

3.4 Alternative Hypothesis:

Mental Health problems are significantly high in adolescents with criminal and anti-social records

3.5 Study site and Target Population

Getathuru Rehabilitation School and Reception Centre was started in 1959 by the colonial administration as a reception and discharge institution for children who were going through Rehabilitation process. Thus Getathuru has been playing the role of a National Children reception centre where it takes in children from the field (after committals by the various courts of law), identify needs of each particular child, •prioritize those needs and then come up with the best intervention methods for each case. Each child's needs are then marched with the particular Rehabilitation school. The boys are then transferred to the various Rehabilitation Schools where they would go through the process of rehabilitation for the specified period of time. After completion of the committal period as shown in the committal warrant, each boy is then released back to his community.

The Institution serves children who have been committed to the Rehabilitation School by the law courts as a result of either being into conflict with law or being in need of special protection and care (CNSP). The nature of criminal cases range from murder, defilement, rape, stealing, robbery with violence, simple robbery, handling stolen property, drug trafficking, drug abuse, refusing to go to school. Children are either referred to the centre by the children officers or probation officers. However since probation officers are found in all the districts and some divisions within the country while district children officers are found only in some districts, probation officers have more potential for sending more children to the centre. Besides, if the centre was to stick to its role of dealing with law offenders, probation officers would still have more chances of interacting with the centre as probation is more inclined to crime than children department. At

the centre, 82% of the children pass through police cells as there are only 11 children remand homes in the country.

During the child's stay at the institution, they are classified as either high or low risk. Boys who have committed crime but fall under ages 14 to 18 are viewed as very high risk and they sleep in Kiambu dormitory. Boys who have committed crime but are 10 to 13 years old are viewed as high risk are accommodated at Mombasa dormitory. While boys who are arrested in the process of committing or are about to commit crime but are still under Probation & Crime investigation unit of ages 14 to 18 are viewed as medium risk and are accommodated at Nakuru dormitory-. Those who are 10 to 13 but are seen to be vulnerable of committing crime and are under Probation & Crime unit are accommodated at Kisumu dormitory.

The centre is involved in the following activities

a) Normal learning (Classroom)
b) Playing games
c) Farming lessons
d) Cleanliness - the compound, clothes, bathing
e) Counseling
f) Pastoral
g) Vocational

h) Environmental management (Afforestation)

3.6 Method: Study design, Setting and sampling

This study was a descriptive cross-sectional survey of all sentenced adolescents of ages 13-18 years incarcerated at Getathuru children reception centre & rehabilitation school. The selected sample constituted adolescents who could answer questions objectively without help of the guardian in filling out the questionnaires that were used in the study.

3.7 Selection criteria

1. Sentenced adolescents at the centre to whom consent was given and gave assent.
2. Adolescents of ages 13-18 years at the centre.

3.8 Exclusion

Adolescents that were not consented for, not given assent and/or were younger than 13 years or older than 18 years incarcerated at Getathuru children reception centre & rehabilitation school.

3.9 Instruments

3.9.1 Social-Demographic characteristic questionnaire:

This included; history of mental illness, history of substance abuse, and criminology data such as the current charge, duration imprisonment period from the adolescents records at Getathuru children reception centre & rehabilitation school. Also included were structures of the family: adolescents parents; their marital status, whether they had criminology data (previous or current, duration of imprisonment, type of charge), divorced or separated, health status, diseased, residence (rural/urban), educational level, history of substance abuse, history of mental illness, and religion; and adolescents siblings data (similar to the parents).

3.9.2 MINI KID questionnaire:

The interview questions were designed to elicit specific diagnostic criteria for DSM **IV** diagnosis. The questions were read in verbatim. If the adolescent did not understand a particular word or concept, it had to be explained what that meant or examples that captured its essence given. If the adolescent was unsure if he had a particular symptom, he had to be asked to provide an explanation or example to determine if it matched the criterion that was being investigated. If an interview item had more than 1 question, the interviewer had to pause between questions to allow the adolescent time to respond.

Questions about the duration of symptoms were included for diagnoses when the time frame of symptoms was a critical element. Because some adolescents had difficulty estimating time, they had to be assisted by helping them connect times to significant events in their lives. All questions were rated. The rating was done at the right of each question by circling either 'Yes' or 'No'. Clinical judgment by the rater was used in coding the responses. The rater asked for examples when necessary, to ensure accurate coding. The adolescent was encouraged to ask for clarification on any question that was not absolutely clear. The clinician took each dimension of the question into account (for example, time frame, frequency, severity, and/or alternatives). Symptoms better accounted for by an organic cause or by the use of alcohol or drugs were not coded positive in the MINI KID[75]

3.10 ETHICAL CONSIDERATIONS

Ethical and Research Clearance was sought from Kenyatta National Hospital ethical Committee after clearance from the department of Psychiatry, College of Health Sciences, University of Nairobi. Ethical considerations, informed consent and consent explanation and confidentiality were addressed in details. The prison populations are a vulnerable group and therefore every effort was put into place to ensure that the adolescents participated voluntarily.

1. The style of collecting the data was on the principles of informed consent, assent and voluntary participation which were observed. The pre-selection of the adolescents for the interview from a centralized registrar which uses only numbers ensured that the clients name did not feature anywhere. Before the completed forms were forwarded to the researcher the clients' prison number was replaced by a serial number, and the code kept by the officer-in-charge at Getathuru children reception centre & rehabilitation school. Thus privacy and confidentiality was maintained all through.

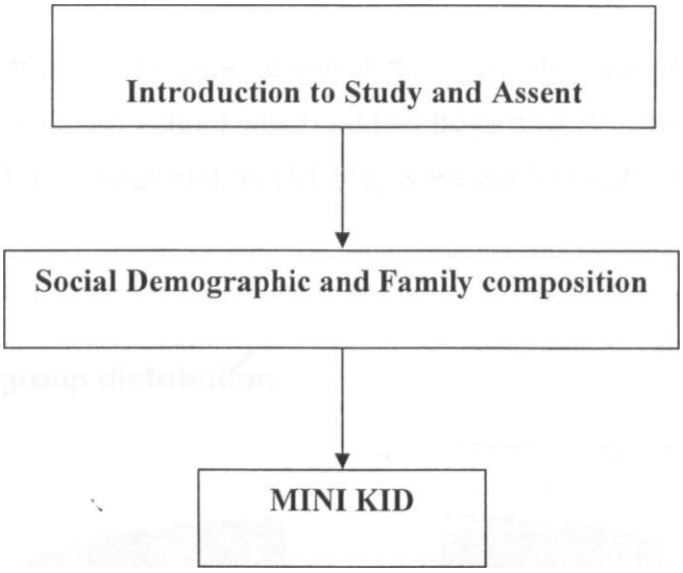
Official secrets were ensured and only at Getathuru Children Reception Centre & Rehabilitation School's staff remained privy to those secrets.

2. The risks involved were explained in the consent explanation, namely invasion of personal life on questions related to mental disorders, substance use, family structure (criminal records, marital status, mental health problems, other medical problems, residence).
3. The benefits to the clients were explained as referral within the Getathuru children reception centre & rehabilitation school system in case they have mental health problems or drug abuse problems that needed attention. Also explained were the benefits for all incarcerated persons at Getathuru children reception centre & rehabilitation school systems in putting into place appropriate policies based on the findings.

3.11 Data Collection

The adolescents were introduced to the researcher and the study as a group by the head of the institution. The Researcher explained the purpose of the study and answered any questions from the participants. The investigator then read the assent out to the adolescents at that time of enrollment/introduction, and divided them into ten groups- fixing dates of interview for each group. The socio-demographic and family composition questionnaire was first filled out, followed by the MINI KID Screen questionnaire by the investigator. Last the investigator administered the MINI KID questionnaire and stored the collected data safely for transportation and data entry.

3.12 FLOWCHART



The who process took a period of two weeks (July-August)

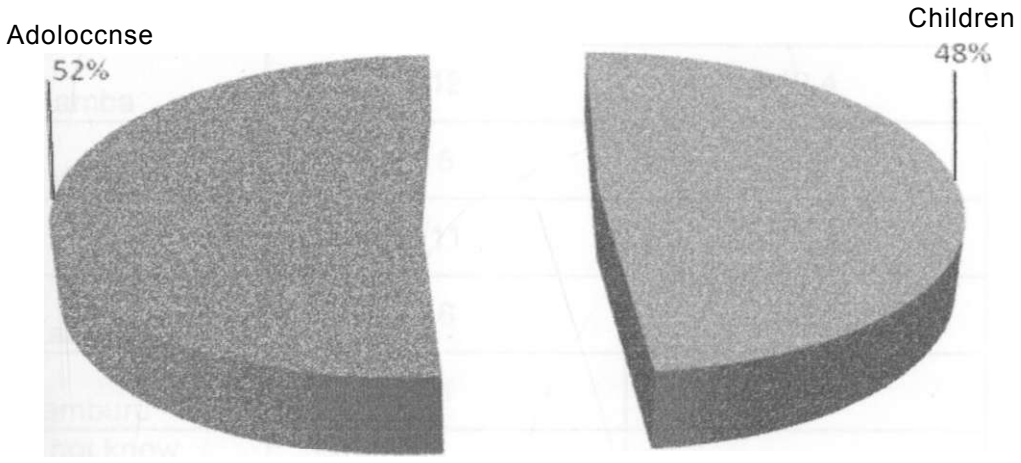
3.13 **Data Management**

Before entering into the computer, the raw data was looked at, and it was tried to select any offenders with serious mental and drug abuse problems for intervention if need be and/or inform the institution. After this the file numbers were deleted and the data entered in the computer. The analysis was done using SPSS version 11.5 by applying descriptive and inferential statistics. The reports were presented in narratives, tables, bar charts, graphs and pie-charts formats.

CHAPTER 4:

4.0 STUDY FINDINGS.

A total number of 97 youth were admitted at the Getathuru juvenile reception centre and rehabilitation school which admits boys only. 47 (48.5%) were children (age 10-12 years) and 50 (51.5%) were adolescents, as shown in figure 1.



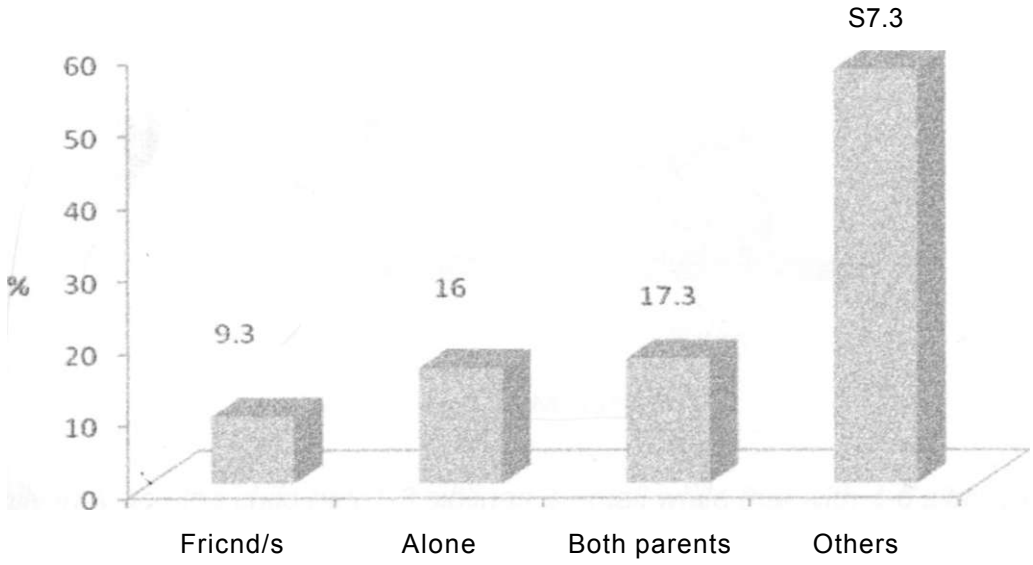
The centre admits children from all over the country as shown in table 1 below. The majority are from the kikuyu tribe (21) followed by the Luo tribe (17).

Tablel: Ethnicity of the children and adolescents.

Ethnicity	Frequency	Percent
Luhya	14	14.4
Luo	17	17.5
Kikuyu	21	21.6
Kamba	12	12.4
Meru	5	5.2
Kisii	11	11.3
Kalenjin	6	6.2
Samburu	1	1.0
Did not know	7	10.3
Total	97	100.0

As the shown in figure 2, the majority of the children were living with other relatives before coming to the reception center.

Figure 2: The living arrangement before coming to the juvenile centre



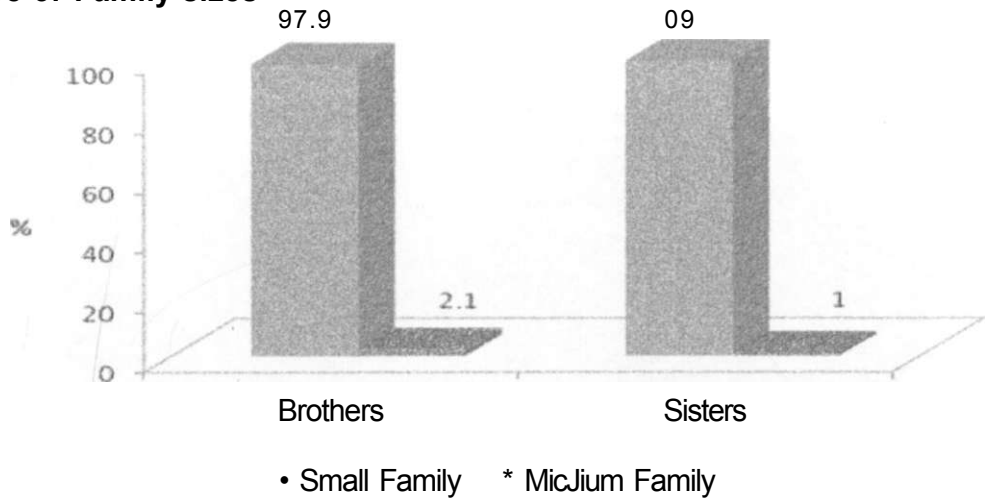
Majority of the children were from parents who were married (32%) followed by other family settings(28.9%), divorced/separated (17.5%), orphaned children (12.4%), then single parents (9.3%) as shown in table 2 below.

Table 2: Parent's marital status

Parent's marital status	Frequency	Percent
Married	31	32.0
Single	9	9.3
Divorced / separated	17	17.5
Other	28	28.9
Orphaned	12	12.4
Total	97	100.0

Figure 3 depicts family sizes; most children come from small family sizes where there 1-3 other siblings; One child didn't know if he had any sibling.

Figure 3: Family sizes

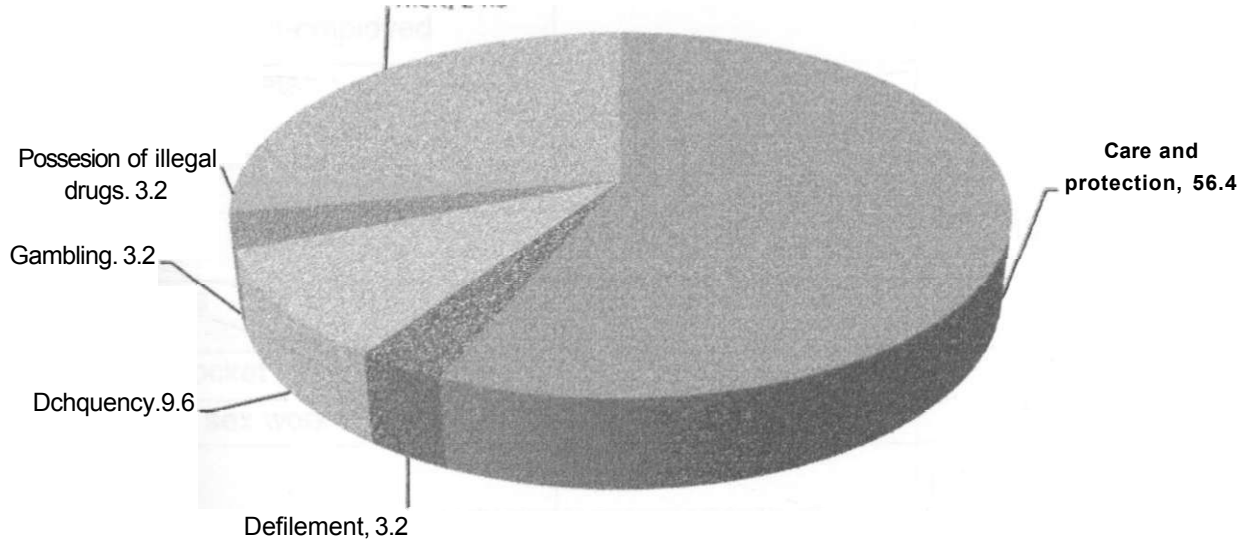


A family in which the child has 1-3 siblings is small while that with 4-6 siblings is medium.

Reasons for coming to the juvenile reception centre

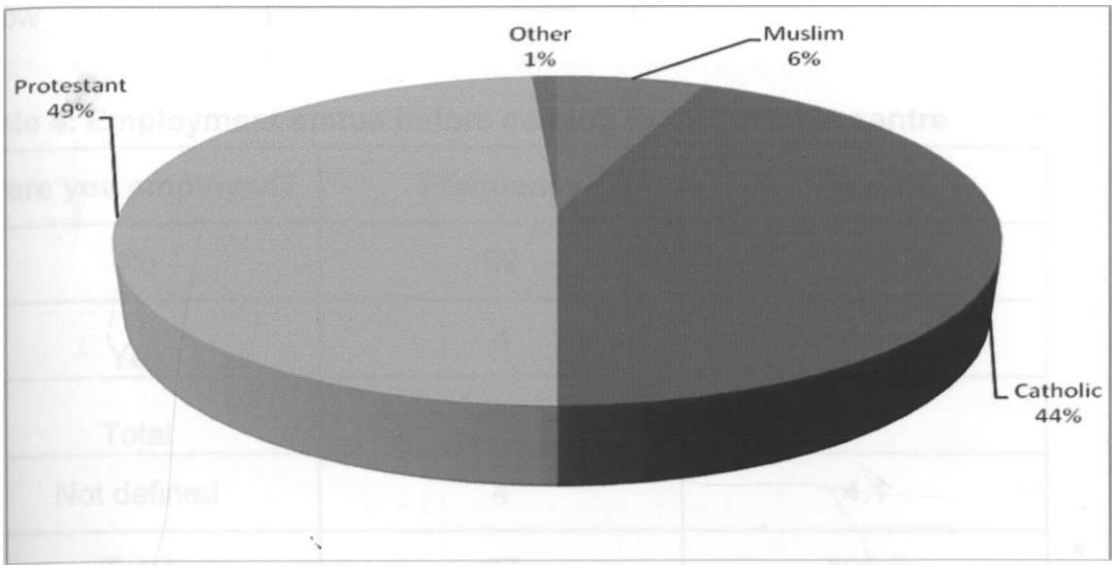
Majority of the children were admitted for care and protection in the home (56.4%); 24.5% were in the home for theft crime, 9.6% for delinquency, 3.2% for defilement; other 3 children (3.2%) because gambling and another 3 because of possessing illegal drugs as shown in figure 4 below.

Figure 4: reason for admission at the reception and rehabilitation school



Majority were Protestants (49%) and Catholics (44%) as shown in figure 5

Figure 5: Religious affiliation of the children at the school



Majority of the children (37) did odd jobs on streets as shown in the table 2

Table 3: Ways in which they got some money before comim3 to the centre

Ways of getting money	Frequency	Percent
Not earning any money	21	21.6
Steady wage/income from legal job	4	4.1
Own business/self-employed	6	6.2
Odd jobs on streets	37	38.1
Money from family/partner	9	9.3
Begging	10	10.3
Selling drugs	2	2.1
Theft/pick pocket	4	4.1
Commercial sex work	1	1.0
Not defined	3	3.1
Total	97	100.0

Only 4 juveniles were employed and one was married as shown in table 3 and 4 below

Table 4: Employment status before coming to the juvenile centre

Were you employed?	Frequency	Percent
No	89	91.8
Yes	4	4.1
Total	93	95.9
Not defined	4	4.1
Total	97	100.0

Table 5: Marital status

Marital Status	Frequency	Percent
Unmarried	96	99.0
Married	1	1.0
Total	97	100.0

Recidivism

About a third of children (30) had other arrests before the current admission to the center as shown in table 5; nineteen did not indicate whether they had had previous arrests.

Table 6: Re-offending status

Had you ever been arrested?	Frequency	Percent
No	48	49.5
yes	30	30.9
Not defined	19	19.6
Total	97	100.0

DSM IV Diagnoses

About half of the responds (41.2 percent) and a third (28.9 %) had Major Depressive Episode and dysthymia as shown in the table 6 and 7 below.

Table 7: Major Depressive Episode - Current

Disorder DSM IV	Frequency	Percent
Major Depressive Episode	40	41.2
No Depressive Episode	57	58.8
Total	97	100.0

Table 8: Dysthymia

Disorder DSM IV	Frequency	Percent
Dysthymia	28	28.9
No Dysthymia	69	71.1
Total	97	100.0

When assessed for their mood disorder; all the respondents had had a mood episode for more than one year; 16 had major depressive disorder while 81 had dysthymia as shown in table 8 below

Table 9: Unipolar disorder more than 1 year

Disorder DSM IV	Frequency	Percent
Depressed > 1 year	16	16.5
-_____Dysthymia	81	83.5
Total	97	100.0

Suicide behaviour

A third (31) of the respondents had some suicide risk behaviour; 7.2 % had low, 2.1% moderate, and 22.7% high as shown in table 9.

Table 10: Suicidality.

Suicide risk according to Disorder DSM IV	Frequency	Percent
Low	7	7.2
Moderate	2	2.1
High	22	22.7
No suicide risk	66	68.0
Total	97	100.0

Exposure to traumatic event

Most of the respondents had experienced traumatic events with 79 (81.4%) having PTSD as shown in table 10 below

Table 11: PTSD

Disorder DSM IV	Frequency	Percent
Current PTSD	79	81.4
No Current PTSD	18	18.6
Total	97	100.0

Substance dependence

About a half of the children were using drugs; 27 being dependent on alcohol and 40 on other drugs as shown in table 11 and 12 below.

Table 12: Alcohol Dependence Current

Disorder DSM IV	Frequency	Percent
Alcohol Dependence Current	27	27.8
None Alcohol Dependence Current	70	72.2
Total	97	100.0

Table 13: Drug Dependence

Disorder DSM IV	Frequency	Percent
Drug Dependence	40	41.2
None Drug Dependence	57	58.8
Total	97	100.0

Association between mental disorders

There was association between mental disorder(s) and being admitted for care and protection (p=0.008) as shown in table 13. Also there was association between conduct disorder and admission in the home as shown in table 14.

Table 14: Comparing Reason For Being In The Juvenile Center With Mental Disorder Prevalences

Reasons for being at the centre	Any mental disorder		Total	Fisher extract
	Yes	No		
	15		24	
^Iggj^and^protection	48		53	0.008
	14	63	63	

Table 15: Compare Stealing vs. Needing Protection and Conduct Disorder Current

Reasons for being at the centre	Conduct disorder		Total	Fisher extract
	Yes	No		0.078
J5tealincj_	9	14	23	1 sided fisher's extract= 0.051
Child care and protection	32	19	51	
total	41	33	74	

CHAPTER 5:

5.0 DISCUSSION

There are a number of important findings from this study, as it was depicted by significant relationship between mental disorders and need for protection (p=0.008). The study showed many problem areas that have needs which were unmet among the participants; these included:

1. Mental health areas where the findings are higher than in other studies that have highlighted the psychosocial adversity within this group. Kroll *et al*[77], in 2002 found 31% of the young offenders to have mental health needs (compared to 100% with unipolar disorder over one year and 81.4% with PTSD, 32% with suicide risk, 27.8% with alcohol dependence and 41.2% with drug dependence in the study). The prevalence of mental illness and substance abuse disorders among incarcerated juvenile offenders in Mississippi[50] are slightly lower when compared to this study; where in Mississippi, 71-85% of offenders made at least one criteria of mental disorder using the DSM-IV. Thus, the findings demonstrate that delinquent children and youths have underlying psychiatric disorders irrespective of age. There is need therefore for psychiatric interventions for these populations; the most frequent disorders being depression, post traumatic stress disorder and substance related disorders.
2. Educational needs; all participants were not in school compared to Kroll[76] in 2002 where only 36% needed education/work; although in the study included up to age 24 years; and
3. Social needs, most participants were from dysfunctional family settings with more than a half requiring care and protection (table 2 & figure 5) unlike in the study by Kroll[77] where only 48% needed some social relationships assistance, but not care and protection.

One can postulate therefore that delinquent behaviour is a symptom of underlying unmet needs; of which the affected child or youth in our setting is seeking attention by involving themselves in conduct behavioural problems.

Putting this group in secure accommodation may meet some of the needs. The secure homes provide statutory education, particularly for that in need for protection, and also the secure environment can reduce access to alcohol and drugs, although these may depend on intense supervision in these secure environments and after discharge back to the communities where they come from. Putting these groups in secure environment can also reduce opportunities for peer relationship difficulties. However, after completion of the committal period as shown in the committal warrant, each boy is then released back to his community where they face same problems and cannot meet their needs; explaining the high rate of recidivism (30 of the respondents). These needs are social stressors which impair decision-making ability, lower inhibitions, increases impulsivity, and reduce perceptions of personal risk, exposing the youth and children into re-offending.

5.1 Mood Disorders

Most of the respondents had unipolar disorders; 16.5% with major depressive episode for over a year and 83.5% with dysthymia and 22.7% high risk behaviour, meaning therefore that these disorders co-exist with conduct disorder. Wasserman and colleagues[78] used the Voice Diagnostic Interview Schedule for Children-IV (DISC-IV)—a computerized diagnostic instrument that presents questions to youths with use of headphones—with 292 recently incarcerated males. They found that more than 3 percent reported a suicide attempt in the Past month, and 11.7 percent met criteria for a mood disorder within the past month. An earlier version of the DISC was used to assess 118 substance abusing juvenile offenders (80 percent male) on probation and found that 9 percent met criteria for major depression, 3 percent for dysthymia, and 4 percent for mania[79].

From the study, it shows that mood disorders are relatively common among juvenile offenders and if untreated, mood disorders carry the risk of significant morbidity and even mortality (high risk behaviour). One can postulate therefore that mood disorders contribute to or exacerbate delinquent and disruptive behaviors in a variety of ways. One of the ways the juvenile offenders with mood disorders are abused or neglected in juvenile justice settings is that mood disorder symptoms such as irritability, hostility, and aggression are easily mistaken for delinquent or defiant behavior. Staff may respond to these behaviours by restraining or isolating these youths, rather than by ensuring that they receive mental health treatment. From these results, it can also be postulated that symptoms of conduct disorder emerge at an earlier age among boys who are depressed; these has been shown by Riggs et al[80]. Thus depression frequently co-occurs with conduct disorder and many aggressive youths have depressive symptoms. This was also shown by Moeller in 2001[81].

The results showed high levels of major depressive disorder, current episode (41.2%) which are much high than what has been found in other studies; Kadzin[82] found rates between 17 and 78 percent, while Kashani and colleagues[83] who studied 100 adolescents and found the prevalence of major depressive disorder to be 18 percent among incarcerated adolescents. This high prevalence can be attributed to the fact that the participants were under confinement and detention which has been shown to trigger symptoms of depression in other studies, although symptoms always predate the arrest as described by Riggs in 1995[79]. Incarceration has been shown to precipitate major depression among vulnerable individuals as described by Eileen and her colleagues[79]. Given that there is frequent co-occurrence of depression with substance use disorder; conduct disorder, which has attendance for impulsivity and low frustration tolerance, adolescents who become depressed or their depression will intensify when they are placed in correctional settings, 'ncarcerating this group can be used to explain why they may be more prone to 'mPUlsive suicide attempts than depressed adolescents in community settings,

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thus making the identification and treatment of mood disorders in the incarcerated juvenile population more critical (the results had high levels of suicidal behavioural risk). Depression is the single most common mental disorder associated with suicide among adolescents, and the co-occurrence of depression with other disorders increases the risk. Adolescents with disruptive behavior disorders are at greater risk of suicide when substance abuse and a history of previous suicide attempts are present as revealed in the results of this study.

Adolescents are at greater risk of developing mood disorders if they come from dysfunctional families; in the study many of the youths come from dysfunctional families, this explains therefore the higher need of care and protection (54.6%) among them. Since no parental care is available they use drugs, or are drug peddlers, all these increase the risk of contact with the juvenile justice system as it shown by Hyman in 2000[84]. Depression can also impair social functioning and peer relations. Thus depression distorts information processing in ways that can make a juvenile more vulnerable to engaging in delinquent behavior, thus become more susceptible to peer pressure and more likely to make hostile attributions in social situations, to which they may respond aggressively; this increases their suicidal tendencies (32% of the respondents had some suicidal behaviour).

5.2 Post Traumatic Stress Disorder:

Majority (81.4%) of the participants had post traumatic stress disorder; this can be postulated that delinquent behaviour exposes the youth to traumatic events. Exposure to trauma is a fact of life for delinquent behaviour. The prevalence of PTSD in study (81.4%) is much higher than reported in other studies; Garland et al[184] reported 3.1%, past year, Wasserman et al[78] reported 4.8% in past month, and Duclos et al[85] found 1.3% in the past year. In these studies, the researchers used DISC and a modified version of the Composite International Diagnostic Interview (CIDI); the CIDI is similar in structure to the DISC. Perhaps this can be because the instrument and methods used were different; the MINI KID interview

used in this study assesses symptoms of PTSD independent of a particular trauma or perhaps the traumatic experiences by the participants precipitated other conditions besides PTSD. In contrast to other studies where assessment of PTSD is based on the participant's perceived worst trauma; the prevalence of PTSD varies depending on the type of sample, the measure used, and the time frame assessed (within the past year, within the past month, or at the time of the interview). Alternatively, the findings of this study are consistent with research linking traumatic victimization in childhood and subsequent psychosocial problems, such as delinquency, perpetration of violence, and drug use done by Abram et al[86] where most of the participants (92.5%) had experienced 1 or more traumas. Exposure to trauma is a serious public health problem among vulnerable groups, yet the youth when being escorted to these correctional schools/homes, they are re-traumatized (are under handcuffs and treated like capital offenders). In correctional schools, the services are insufficient. Timely interventions may avert subsequent and often chronic social problems common among traumatized youth. Posttraumatic stress disorder is frequently overlooked even in the best psychiatric settings. Because PTSD frequently co-occurs with other psychiatric disorders, it can be difficult to detect without systematic screening.

One can postulate therefore that the youth are re-traumatized because the conditions of confinement often exacerbate symptoms of mental disorder, including PTSD. Juvenile justice providers also increase the likelihood that youth will be re-traumatized during routine processing. Symptoms of PTSD are exacerbated by such common practices as handcuffs and searches. In detention centers, psychiatric crises are often handled by isolating and restraining symptomatic detainees. These practices can trigger or escalate symptoms of PTSD (e.g., severe anxiety, aggression, and numbing of emotions).

5.3 Drug use:

At same time in their life, the delinquent youth and children are likely to start using drugs (27.8% had alcohol dependence while 41.2% drug dependence). These findings demonstrate that prevention is of drug use is key in managing this group of children. Although heroin use is just beginning in Kenya, many of the most serious risk behavior is injection drugs of dependence and sharing needles; this has been found to be uncommon but may develop among youths as they age as shown by Taylor and Bennett in 1999[87]. As it was indicated by Mullen et al in 2002[88], early interventions can reduce the likelihood that other risk behaviors of injecting drugs of dependence will be initiated. In Kenya, most schools now provide primary education on drug prevention; many youths involved in the juvenile justice system do not attend school regularly, hence miss out on primary prevention strategies.

In the study, most of the respondents had other living arrangements; a few were ling with parents (17%). This can be postulated to mean that most of the youth with delinquency behaviour lack parental care, causing the youth to get involved in criminal activities. From previous studies done by Zhang, Wieczorek & Welte[62] and National Institute of Justice[63]; examining co-morbid substance use disorders is critical because they are so prevalent in populations that are at risk of getting involved in criminal activities, such as youths in mental health treatment, homeless youths, and adult jail detainees. Slightly more than a half of the children and the youth had been taken to the home (54.6%) for care and protection. Secure accommodation may meet some of the needs of children and young people by providing statutory education, particularly for those under 16 years of age, and reducing access to alcohol and drugs. The intense supervision provided may also reduce opportunities for peer relationship difficulties and involvement in criminal activities. However, more studies need to been done on how much of this reduction in needs is sustained once young people leave secure accommodation.

5.4 CONCLUSION

The results of this study support the alternative hypotheses that Mental Health problems are significantly high in adolescents with criminal and anti-social records. Screening instruments for psychiatric symptoms should therefore be administered as part of the initial evaluation process and then periodically thereafter, especially when juveniles make a transition from one correctional facility to another (at the reception school; these youth stay for three months than are placed into other correctional centres across the country). When screening instruments indicate the possible presence of a mood disturbance, a more thorough clinical assessment is warranted to determine the need for treatment, follow-up, and risk assessment. More comprehensive mental health services, including access to psychiatric assessment and treatment, are required to ensure that juvenile offenders with mental illness are identified and cared for appropriately. Doing so will not only alleviate painful symptoms but may also contribute significantly to improvements in psychosocial functioning, interpersonal relations, and school performance and to decreases in delinquent, disruptive, and suicidal behaviors.

These children and youths should therefore be linked to community-based mental health services. It is clear that a sufficient number of youths with these conditions could be identified at the Rehabilitation School and Reception Centre. Furthermore, it appears that these youths and children can successfully be linked to mental health and other services in their community (majority who needed care and protection). The assessment of mental health and the promotion of mental well-being of young people within juvenile justice system are integral to the delivery of effective youth justice services. In practice the mental health screening Programme must therefore be launched within the youth correctional services where mental health workers form integral part of the team. However, including the mental health providers in the team may not meet the high levels of unmet ^ds. Other unmet needs must be identified by interviewing carers, to document

poor access to services and the difficulties of engaging young people in treatment programmes.

In terms of education, although there appeared to be good provision of educational services for young offenders in custody (at the centre, the juvenile are only kept for 3 months and thereafter placed in rehabilitation schools countrywide), services were less comprehensive for those placed in the community, especially for those under 16 years old for whom non-mainstream alternatives were limited. It is important to address these issues of service provision for young offenders with unmet needs, as they may be a particularly vulnerable group.

5.5 Recommendations (clinical implications)

1. Incorporate mental health assessment in the evaluation of children and adolescents with criminal and anti-social behaviour. Needs of young offenders are high but often unmet; a structured assessment programme across custody and community sites is recommended, mental health workers should form part of the team that assesses and cares for youth in the juvenile justice system.
2. A care programme approach where it is run by mental health workers is recommended to improve continuity of care for these children and young offenders with unmet needs.
3 Review of the educational provision for children and young offenders is required, as a significant number of them have unmet needs.
4 The characteristics of youths who are rearrested suggest opportunities for service development for these re-offenders, which should involve mental health workers and social workers.
5 Juvenile justice providers must also reduce the likelihood that youth will be re-traumatized during routine processing in the correctional schools/centres

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5 Juvenile justice providers must also reduce the likelihood that youth will be re-traumatized during routine processing in the correctional schools/centres

6. Develop mental Health Policy for children and adolescents with criminal and anti-social behaviour.
7. Mental health providers should help to develop strategies to manage emergencies more humanely and, ultimately, more cost-effectively

BUDGET

PROPOSAL PREPARATION

1. Proposal typing and printing	Kshs. 1, 000.00
2. Photocopies	Kshs.3,000.00
3. KNH Ethical Committee fees	Kshs. 500.00
4. 512MB Flash disk	Kshs.3,000.00
TOTAL	**Kshs.7,500.00**

B. MATERIALS AND EQUIPMENT

1. 10 pens	Kshs. 100.00
2. 10 folders	Kshs.300.00
3. Staples (2 packets)	Kshs.400.00
4. 1 stapler	Kshs.500.00
TOTAL	Kshs.l,300.00

C. QUESTIONNAIRES

1. Typing and printing	Kshs.80.00
2. Photocopying 150 subjects x Kshs.2.00 Per page x 20 pages	Kshs.6,000.00
TOTAL	Kshs.6080.00

D. SUPPORT STAFF

1. Researcher (30 days x Kshs.2,000/day)	Kshs.60,000.00
2. Biostatistician	Kshs. 50,000.00
TOTAL	**Kshs.110,000.00**

E. COMMUNICATION

1. Proposal preparation	Kshs.3,000.00
2. Telephone/email	Kshs.3,000.00
TOTAL	**Kshs6000.00**

F. DATA PROCESSING AND BOOK BINDING

1. Typing preliminary results	Kshs.3,000.00
2. Photocopies to supervisors	Kshs.5,000.00
3. Final draft (Typing)	Kshs.3,000.00
4. 5 Printing and binding final report	Kshs.5,000.00
6. Binding of 10 books	Kshs.5,000.00
TOTAL	**Kshs.21,00.00**

1. Proposal preparation	Kshs. 7,500.00
2. Materials and equipment	Kshs. 1,300.00
3. Questionnaire	Kshs. 10,000.00
4. Researcher + Biostatistician	Kshs. 110,000.00
5. Transport + Communication	Kshs. 6,080.00
6. Data processing and book binding	Kshs. 21,000.00
7. Contingency 10%	Kshs. 13,088.00
TOTAL	**kshs.143,176.00**

RESEARCH STUDY TIME SCHEDULE

No.	Activity	Period
1.	Presentation of the research topic	February - 2007
2.	Preparation of research concept	March - 2007
3.	Writing of Research Proposal	March - July 007
4.	Presentation of proposal to ethical committee	August 2007
5.	Collection of data	November - December 2008
6.	Data analysis	February - April - 2008
7.	Writing the report	May - June
8.	Presentation	June - July 2008

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APPENDICES

Consent Forms For Participants in a Study Of Mental Health Problems and Substance Abuse Among Juvenile Offenders at Gatathuru Children Reception Centre & Rehabilitation School in Kenya

Appendix A1: CONSENT EXPLANATION FOR THE INSTITUTION

Consent Form: Consent for Institutional Head of adolescents at Gatathuru children reception centre & rehabilitation school homes in Kenya participating in the study:

I Teresia Nasenya Okumu, am a master's student in Clinical Psychology at the University of Nairobi. I am collecting data on the prevalence of mental health problems, substance abuse and their relationship with offenses among the adolescents at Gatathuru children reception centre & rehabilitation school in Kenya. I am trying to find out how big a problem it is, and how to treat it. We will ask you if would like the adolescents (13-18years of age) at the centre to be a part of this research study. If you agree, we would like to ask the adolescents some questions about these problems. The questions will be about your adolescent's mental illness, substance use and how they have managed or have treated the problem(s).

Risk/Discomfort: this involves invasion of personal life on questions related to mental disorders, substance use, family structure (criminal records, marital status, mental health problems, other medical problems, residence) , but only I and the research assistant asking you the questions will know the answers as an individual.

Benefits: The adolescents will be referred within the system at Gatathuru children reception centre & rehabilitation school in case they have mental health problems or drug abuse problems and they need attention. Also to be explained are the benefits to the whole systems at Gatathuru children reception centre & rehabilitation school in putting into place appropriate policies based on the findings. The study will also help us to learn how to better treat mental health problems and substance abuse among juvenile offenders in Kenya

Confidentiality: What we talk about will be kept private to the extent allowed by law. To protect the adolescents' privacy, we will keep the records under a code number and not the name. We will keep the records in a safe place and only the researcher and the supervisors will be allowed to look at them. The adolescents' name or other facts that might point to them will not appear when we present this study or publish the results.

Participation in this study is by choice by you and the adolescents. If any of them do not join the study, they will still get the best possible medical care here at the clinics in the prison health services or hospitals. The adolescents can withdraw

from the study at any time without any loss of benefits or any victimization whatsoever. **If you have any questions about your rights as a subject, you can get in touch with the Officer in charge of that particular institution.**

Appendix A2: CONSENT FORM

Name of Institutional head:
Today's date _/__/

Institutional head statement:
The above study has been explained to me and I agree to allow adolescents to take part. If I change my mind and decide to withdraw the permission at any time, I understand that I and my youth will continue to receive medical care.

Institutional head's signature*:
(Or mark of consent)

Witness Name and signature*:

Investigator Name and signature:

Appendix A3: ASSENT EXPLANATION

Assent for adolescent and children at Gatathuru children reception centre & rehabilitation school Kenya participating in the study.

The investigator will read this consent to the adolescents at the time of enrollment.

Introduction
Although we got the permission of your Institutional head to talk to you, I want to explain to you what we want so that you can decide yourself whether you want to participate.

We want you to join a research study about mental health problems and substance abuse among in Kenya. We want to find out how big a problem it is and how to treat it.

If you want to join the study you will be asked to do something. We will ask you some questions about yourself, your family, mental illness and substance use. This will take about 45 minutes.

Discomfort: Invasion of personal life on questions related to mental disorders, substance use, family structure (criminal records, marital status, mental health problems, other medical problems, residence).

Benefits: The results of mental illness and substance abuse will be ready within two months. The results can help you get the treatment for mental illness, and substance abuse. The study will also help us to learn how to better treat mental illness and substance abuse among juvenile offender populations of Kenya

Confidentiality: What we talk about and the test results will be kept private to the extent allowed by law. To protect your privacy, we will keep the records under a code number rather than their name. We will keep the records in a safe place and only study staff will be allowed to look at them. The name or other facts that roight point to you will not appear when we present this study or publish the results.

be in this study it is their choice. If they choose not to join the study, you will get the best possible medical care here at the clinic at Gatathuru children reception centre & rehabilitation school health services or government hospitals. | you join the study, but then have questions or decide you don't want to go on in • you can leave it. If you decide that you do not want to go on in the study, you get the best possible medical care at the clinics or hospitals.

If you have any further questions about this research study, please ask your guardians/parents.

Will you be a part of our study (CIRCLE, ONE) YES/ NO

CONSENT

Name of child (Print Date

Name of child (Signature or mark of consent)

To be signed by witness:

The above statement has been read to the child and the child agrees to participate in the research project.

Witness Signature: Date
Name of witness (Print)

Name of witness (Signature or mark of consent)
Investigator Name and signature:

***APPENDIX B1: SOCIAL* DEMOGRAPHIC QUESTIONNAIRE**

***Specify whether* consent and/or assesnt is signed and on record: Yes No If No do not continue with *the* interview. *If yes* specify consent/assent reference number**

PARTICIPANT ID: |__|__|__|__|__|__|. DORMITORY INCARCERATED IN: DATE OF INTERVIEW: / /

CURRENT CHARGE: INTERVIEW START TIME: .(24-hr) DURATION OF INCARCERATION (YEARS) _/_

FAMILY SOCIAL DEMOGRAPHIC CHARACTERSISTICS AND COMPOSITION (1)

LINE NO.	Family members (line them in birth order)	RELATIONSHIP TO the father	RELATIONSHIP TO the mother	SEX	AGE	RESIDENCE		MARITAL STATUS	History of mental illness/substance use		
	1 =father 2=mother	What is the relationship of {—} to the head of the father	What is the relationship of {—} to the head of the mother?	Is male or female? 1 = Male 2=Female	Which year and month was {._..} born? Mo n m | | | | | Year	In which District was {—} born?	Where has {—} lived most of his/her life?	What is {—}' s marital status?	Has the member been treated for mental illness/admitted with history pf abnormal behaviour	Does the member drink alcohol until he/she is drunk	Has the member ever/is using hard drugs (can have >1 choice) Yes—~ No If yes, 1=heroin 2=cocaine 3=khat 4 Bhang 5 smokes 6 others
1	2	3	3	4	5	6	7	8	9	10	11
2											

FAMILY SOCIAL DEMOGRAPHIC CHARACTERSISTICS AND COMPOSITION (2)

Health status of the parents		SCHOOL AGE	SCHOOL ATTENDANCE	REASONS FOR LEAVING/DROPPING OUT OF SCHOOL OR COLLEGE (those aged 5 yrs & above)	HIGHEST GRADE	Criminal activity/types of offense committed, if incarcerated, duration of incarceration				
Is s natural mother alive?	Is natural father alive? Yes=1 No=2	Is (NAME) 5 years or older? **If YES, GO**	Is — currently in school /college? **If**	Why did leave school?	What is the highest level (NAME) has attended?	Has been incarcerated before	What type of offense did—	If been in jail before, how many times has	If incarcerated previously,	If is currently incarceration, duration of incarceration in

—)			[aoiuMmj		highest grade **(NAME)** completed at that level?	Incarcerat\ ion? Yes=1 No=2	^	incarcerated ?	\ \\ncarcerat'v \ **on in years**	
12	13	14	15	16	17	18	19	20	21	22

APPENDIX B2: MINI KID SCREEN

patient Name :_____ Date of Birth:

oATE OF INTERVIEW:

jf YESf go t0 the ***corresponding M.I.N.I. Kid module***

QUESTIONNAIRE COMPLETED

BY;

V Have you felt sad or depressed, down or empty, or grouchy or annoyed, most of the day, nearly every day for the past two weeks? IF YES TO ANY, CODE YES	NO YES
> in the past two weeks, have you been bored a lot or much less interested in things (like playing your favorite games) for most of the day, nearly every day? Have felt that you couldn't enjoy things? IF YES TO ANY, CODE YES	NO YES
/ Have you ever felt so bad that you wished you were dead, tried to hurt yourself, or tried to kill yourself? IF YES TO ANY, CODE YES	NO YES
IF YOU SAID YES TO THE FIRST QUESTION, SKIP THIS QUESTION.	NO YES
' In the past year have you felt sad or depressed, down or empty, or grouchy or annoyed, most of the time? IF YES TO ANY, CODE YES	
' Has there ever been a time when you were so happy that you felt really 'up' or 'high' or 'hyper'? By 'up' or 'high' I mean feeling really 9ood; full of energy; needing less sleep; having racing thoughts or bemg full of ideas.	^ ^^
NOT CONSIDER TIMES WHEN YOU WERE INTOXICATED ON	N0 YES
dUGS OR ALCOHOL OR DURING SITUATIONS THAT	
n0RMALLY OVERSTIMULATE AND MAKE CHILDREN VERY	
EXCITEd. LIKE CHRISTMAS, BIRTHDAYS, ETC.	
V0U currently feeling 'up' or 'high' or full of energy?	
* hgc: 6re ever been a time when you were so grouchy or annoyed,	^ ^^

that you yelled or started fights; or yelled at people not counting your family? Have you or others noticed that you have been more grouchy than other kids, even when you thought you were right to act this way? IF YES TO ANY, CODE YES

DO NOT CONSIDER TIMES WHEN YOU WERE INTOXICATED ON DRUGS OR ALCOHOL OR DURING SITUATIONS THAT NORMALLY OVERSTIMULATE AND MAKE CHILDREN VERY GROUCHY OR ANNOYED.

NO YES

D

, Are you currently feeling grouchy or annoyed?

, Have you ever been really frightened or nervous for no reason; or have you ever been really frightened or nervous in a situation where most kids would not feel that way? IF YES TO EITHER, CODE YES

NO YES

> Do you feel anxious, scared or uneasy in places or situations where you might become really frightened: like being in a crowd, standing in a line (queue), when you are all alone, or when crossing a bridge, traveling in a bus, train or car? IF YES TO ANY, CODE YES

NO YES

iPTurn Page

IF YES, GO TO THE CORRESPONDING M.I.N.I. MODULE

1

' In the past month, have you been really afraid about being away from someone close to you ; or have you been really afraid that you would lose somebody you are close to? (Like getting lost from your parents or having something bad happen to them.) IF YES TO EITHER, CODE YES

NO YES

G

' In the past month, were you afraid or embarrassed when others were watching you? Were you afraid of being teased? Like talking in front of the class? Or eating or writing in front of others? IF YES TO ANY, CODE

NO YES

H

' In the past month, have you been really afraid of something like : snakes or bugs? Dogs or other animals? High places? Storms? The dark? Or being blood or needles?

L'stthe specific phobia ;

NO YES

In the past month, have you been bothered by bad things that come into your mind that you couldn't get rid of? Like bad thoughts or urges? Or nasty pictures? For example, did you think about hurting somebody even though you knew you didn't want to? Were you afraid you or someone would get hurt because of some little thing you did or didn't do? Did you worry a lot about having dirt or germs on you? Did you worry a lot that you would give someone else germs or make them sick somehow? Or were you afraid that you would do something really shocking? IF YES TO ANY, CODE YES

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PRORI **fms nn** MOT IMP.I I **inF nRSFSftinNS** RIRFP.TI Y RFI ATFD

^ S

In the past month, did you do something over and over without being able to stop doing it, like washing over and over? Straightening things up over and over? Counting something or checking on something over and over? Saying or doing something over and over? IF YES TO ANY, CODE YES

NO YE -» J

Has anything really awful happened to you? Like being in a flood, tornado or earthquake? Like being in a fire or a really bad accident? Like seeing someone get killed or hurt really bad? Like being attacked by someone?

NO S

Did you respond with intense fear, feel helpless or horrified or did you feel agitated or fall apart ?

NO YE S

' In the past month, has this awful thing come back to you in some way? Like dreaming about it or having a stonq memorv of it? IF YES TO ANY,

NO -» K

In the past year, have you had 3 or more drinks of alcohol in a day? At those times, did you have 3 or more drinks in 3 hours? Did you do this 3 or more times in the past year? IF YES TO ANY, CODE YES

NO YE ^ L

i£Turn Page

— ^ IF YES, GO TO THE <£SgPgNDING M.I.N.I. MODULE

1

READ THE LIST BELOW of street drugs or medicines.

high? PaSt year, have you taken any of them more than one time to 9et N0 YE M

- To feel better or to change your mood? S

-7Iphetamine	Speed	crystal meth	Dexedrin	Ritalin, diet pills
^ine	n ,			
	^rack	freebase	speedball	
	morphine, methadone	opium	Demerol	codeine, Percodan, OxyContin

LSD	Mescaline	PCP, angel dust	MDA.MD MA	ecstasy, ketamine
inhalants	Glue	ether	GHB	steroids
THC, marijuana	cannabis, hashish	grass	weed, reefer	barbiturates, Valium, Xanax, Ativan

In the past month, did you have movements of your body called 'tics'? Tics are quick movements of some part of your body that are hard to control. A tic might be blinking your eyes over and over, twitches of your face, jerking your head, making a movement with your hand over and over, or squatting, or shrugging your shoulders over and over.

NO YES -> N

Have you ever had a tic that made you say something or make a sound over and over and it was hard to stop it? Like coughing or sniffing or clearing your throat over and over when you did not have a cold; or grunting or snorting or barking; having to say certain words over and over, having to say bad words, or having to repeat sounds you hear or words that other people say? IF YES TO ANY, CODE YES

NO YES -> N

nthe past 6 months:

> Have you often not paid enough attention to details? Made careless mistakes in school?

NO YES -> 0

Have you often had trouble keeping your attention focused when playing or doing homework?

NO YES -> 0

Have you often been told that you do not listen when others talk directly to you?

NO YES -> 0

Have you often tried to avoid things that make you concentrate or think hard (likeschoolwork)? Do you hate or dislike things that make you concentrate or think hard?

•F YES TO EITHER, CODE YES

NO YES H > 0

Have you often lost or forgotten things you needed? Like homework assignments, pencils or toys?

Do you often get distracted easily by little things (like sounds or things outside the room)?

NO YES - > 0

NO YES -> 0

x^Turn Page

IF YES, GO TO THE ENDING M.I.N, MODULE

" N

the past year:

Have you been in trouble repeatedly?	NO	YES	
Have you bullied or threatened other people?	NO	YES	
Have you hurt or threatened someone (physically) on purpose?	NO	YES	-> P
Have you hurt animals on purpose?	NO	YES	-> P
Have you stolen things?	NO	YES	
Have you Started fires on purpose?	NO	YES	->P
Have you lied many times in order to get things from people?	NO	YES	-» P
Have you skipped school often?			

the past 6 months:

- Have you often argued with adults and refused to do what they asked you to do?	NO	YES	-» Q
, Have you often annoyed people on purpose?	NO	YES	-»Q
|> Have you ever heard things other people couldn't hear, such as voices?	NO	YES	-> R
Have your friends or family ever thought any of your beliefs were strange	NO	YES	-> R

How tall are you ? |__|__|__| inches

> What was your lowest weight in the past 3 months ? |__|__|__| lbs

IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? SEE TABLE BELOW — NO YES

HEIGHT_	4'6	4 7	4'8	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4
Weight (lbs)	72	75	78	81	84	87	89	92	94	97	99
Height	5'5	5'6	57	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3
Weight .Jte]	102	104	107	110	108	110	111	113	115	115	118

Have you lost 5 lbs. or more in the last 3 months?	NO	YES	-+S
' If ^onth[31]? 'eSS thaP haVe ^ailec‹to 9ain any we'9ht in the last 3	NO	YES	
' Has anyone thought that you lost too much weight in the last 3 months?	NO	YES	-> S
'•nth a ve ^ast ^ree months, did you have eating binges or times when you ate ^ ar9e amount of food within a 2-hour period?	NO	YES	T
' 'n the last 3 months, did you have eating binges as often as twice a week?	NO	YES	

| y Have you worried excessively or been anxious about several things over the past 6 months? N0 Y E S u

y Are you stressed out about something? Is this making you upset or making your behavior worse? N0 v

M.I.N.I. KID: MINI INTERNATIONAL NEUROPSYCHIATRY INTERVIEW
For Children and Adolescents

Patient Name: *Patient Number:*
Date of Birth: *Time Interview Began:*
Interviewer's Name: *Time Interview Ended:*
Date of Interview: *Total Time:*

MODULES CRITERIA	TIME FRAME	MEETS DSM-IV	MEETS ICD-10
A MAJOR DEPRESSIVE EPISODE	Current (Past 2 weeks)	• 296.20-	
B SUICIDALLY '	Lifetime • N/A	N/A	
	Current (Past Month) •		
	Risk: • Low • Medium • High	N/A r	
C DYSTHYMIA	Current (Past 1 year) •		
D (HYPO)MANIC EPISODE 296.06	Current • 296.00- F30.**X**-F31.9		300.4
	Past •		
E PANIC DISORDER	Current (Past Month) •		300.01/300.
	Lifetime •		
F AGORAPHOBIA	Current • 300.22		F40.00
G SEPARATION ANXIETY DISORDER Month)	Current (Past • 309.21	F93.0	
H SOCIAL PHOBIA (Social Anxiety Disorder) Month)	Current (Past • 300.23	F40.1	
SPECIFIC PHOBIA	Current (Past Month) •		300.29
J OBSESSIVE COMPULSIVE DISORDER Month)	Current (Past • 300.3	F42.8	
* POST TRAUMATIC STRESS DISORDER Month)	Current (Past • 309.81	F43.1	

	ALCOHOL DEPENDENCE	Past 12 Months	•	303.9	F10.2x
	ALCOHOL ABUSE	Past 12 Months	•	305.00	F10.1
M	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	•	304.00	
M	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	•	304.00	
N	TOURETTE'S DISORDER	Current	•	307.23	F95.2
	MOTOR TIC DISORDER	Current	•	307.22	F95.1
	VOCAL TIC DISORDER	Current	•	307.22	F95.1
	TRANSIENT TIC DISORDER	Current	•	307.21	F95.0
0	ADHD COMBINED	Past 6 Months	•	314.01	F90.0
	ADHD INATTENTIVE	Past 6 Months	•	314.00	F98.8
	ADHD HYPERACTIVE/IMPULSIVE	Past 6 Months	•	314.01	
P	CONDUCT DISORDER	Past 12 Months	•	312.8	F91.x
Q	OPPOSITIONAL DEFIANT)ER	Past 6 Months	•	313.81	
R	PSYCHOTIC DISORDERS	Lifetime	•	295.10-	
295.90/297.1/		F20.**XX**-F29			
		Current	•		
	297.3/293.81/293.82/				
	293.89/298.8/298.9				
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime	•	296.24	
S	ANOREXIA NERVOSA	Current (Past 3 Months)	•	307.1	F50.0
T	BULIMIA NERVOSA	Current (Past 3 Months)	•	307.51	F50.2
U	GENERALIZED ANXIETY DISORDER	Current (Pasit 6			
Months)		•	300.02	F41.1	
v	ADJUSTMENT DISORDERS	Current	•		
	309.24/309.28	F43.**XX**			
	309.3/309.4				

W PERVASIVE DEVELOPMENTAL DISORDER Current • 299.00/299.

A. MAJOR DEPRESSIVE EPISODE

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

In the past two weeks:

A1 Have you felt sad or depressed? Felt down or empty? Felt grouchy or annoyed?

IF YES TO ANY, CONTINUE. IF NO TO ALL CODE NO.

Have you felt this way, most of the day, nearly every day ? NO YES

A2 Have you been bored a lot or much less interested in things (Like playing your favorite games)?
Have you felt that you couldn't enjoy things?

IF YES TO ANY CONTINUE. IF NO TO ALL CODE NO.

Have you felt this way, most of the day, nearly every day ? NO YES

•

IS A1 OR A2 CODED YES? NO YES

A3 In the past two weeks, when you felt depressed / grouchy / uninterested:

a Were you less hungry or more hungry most days? Did you lose or gain weight without trying? [i.e., by ±5% of body weight or ±8 lbs. in the past month]? NO YES

IF YES TO EITHER, CODE YES

b Did you have trouble sleeping almost every night ("trouble sleeping" means NO YES
trouble falling asleep, waking up in the middle of the night, waking up too early or sleeping too much)?

c Did you talk or move slower than usual? Were you fidgety, restless or couldn't sit still? NO YES

IF YES TO EITHER, CODE YES

d Did you feel tired most of the time? NO YES

e D'd you feel bad about yourself most of the time? Did you feel guilty NO YES

most of the time?

IF YES TO EITHER, CODE YES

f Did you have trouble paying attention? Did you have trouble making up your mind? NO YES

IF YES TO EITHER, CODE YES

g Did you feel so bad that you wished that you were dead? Did you think about hurting yourself? Did you have thoughts of death? Did you think about killing yourself? NO YES

IF YES TO ANY, CODE YES

ARE 5 OR MORE ANSWERS (A1, A2 AND A3a-g) CODED YES] NO YES

MAJOR DEPRESSIVE
cnirr\nn nt innc^MT

B. SUICIDALITY

(•MEANS ! GO TO THE SUICIDE RISK CURRENT BOX, CIRCLE NO IN THAT BOX, AND MOVE TO THE NEXT MODULE)

Poil

B1 a Have you ever felt so bad that you wished you were dead? NO YES

b Have you ever tried to hurt yourself? NO YES

c Have you ever tried to kill yourself? NO YES

IF YES TO ANY, CODE YES

•
NO YES

SUICIDE RISK
LIFETIME

•n the past month did you:

Wish you were dead? NO YES

Want to hurt yourself? NO YES

Think about killing yourself? NO YES

B5	Think of a way to kill yourself?	NO	YES
B6	Try to kill yourself?	NO	YES

IS AT LEAST 1 OF THE ABOVE (B1-B6) CODED YES?

NO ***YES***

IF YES ADD THE TOTAL NUMBER OF POINTS FOR THE jjSWERS (B1-B6)

CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE BSK

AS FOLLOWS:

SUICIDE RISK CURRENT

1-8 points Low

9-12 points Moderate

C. DYSTHYMIA

(PMEANS ! 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.

C1 Have you felt sad or depressed, or felt down or empty, or felt grouchy or annoyed, most of the time, for the last two years,? • NO YES

C2 In the past two years, have you felt OK for two months or more in a row? • NO YES

C3 During the past two years, most of the time:

a Were you less hungry than you used to be? Were you more hungry than you used to be? NO YES

IF YES TO EITHER, CODE YES

b Did you have trouble sleeping ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, waking up too early or sleeping too much)? NO YES

c Did you feel more tired than you used to? NO YES

d Did you feel less confident of yourself? Did you feel bad about yourself? NO YES

IF YES TO EITHER, CODE YES

e Did you have trouble paying attention? Did you have trouble making up your mind? NO YES

IF YES TO EITHER, CODE YES

f Did you feel that things would never get better? NO YES

ARE 2 OR MORE C3 ITEMS CODED YES? • NO YES

q4 Did these feelings of being depressed / grouchy / uninterested NO
jpset you a lot? YES

Did they cause you problems at home? At school? With friends?

DYSTHYMIA

IF YES TO ANY, CODE YES CURRENT

D. (HYPO) MANIC EPISODE

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

D1 a Has there ever been a time when you were so happy that you felt'up'or 'high' or'hyper'? NO
By 'up[1] or 'high' or 'hyper' I mean feeling really good; full of energy; needing less sleep;
having racing thoughts or being full of ideas.

DO NOT CONSIDER TIMES WHEN THE PATIENT WAS INTOXICATED ON DRUGS OR ALCOHOL
OR DURING SITUATIONS THAT NORMALLY OVER STIMULATE AND MAKE CHILDREN VERY
EXCITED LIKE CHRISTMAS, BIRTHDAYS, ETC.

IF NO TO ALL, CODE NO TO D1b: IF YES TO ANY, ASK:

b Are you currently feeling 'up' or 'high' or 'hyper' or full of energy? NO

D2 a Has there ever been a time when you were so grouchy or annoyed, that you yelled or NO
started fights; with people outside your family? Have you or others noticed
that you have been more grouchy than other kids, even when you thought you were
right to act this way?

DO NOT CONSIDER TIMES WHEN THE PATIENT WAS INTOXICATED ON DRUGS OR ALCOHOL.

IF NO TO ALL, CODE NO TO D2b: IF YES TO ANY, ASK:

b Are you currently feeling grouchy or annoyed? NO

•

IS D1a or D2a CODED YES? NO

IF D1 b OR D2b = YES: EXPLORE ONLY CURRENT EPISODE, OTHERWISE
IF D1 b AND D2b = NO: EXPLORE THE MOST SYMPTOMATIC PAST EPISODE

During the time(s) when you felt up, high, full of energy or irritable did you:

a Feel that you could do things others couldn't do? Feel that you are a very important person? NO YES

IF YES TO EITHER, CODE YES

b Need less sleep (Did you feel rested after only a few hours of sleep)? NO YES

c Talk too much without stopping? Talk so fast that people couldn't understand you? NO YES

IF YES TO EITHER, CODE YES

d Have racing thoughts? NO YES

e Get distracted very easily by little things? NO YES

f Get so active or fidgety that people worry about you? NO YES

g Want to do fun things even if you could get hurt doing them? Want to do things even NO YES
though it could get you into trouble? (Like staying out late, skipping school, driving dangerously or spending too much money)?

IF YES TO ANY, CODE YES

• •

ARE 3 OR MORE D3 ANSWERS CODED YES (OR 4 OR MORE IF D1 a IS NO [IN RATING PAST EPISODE] OR D1b IS NO [IN RATING CURRENT EPISODE])? NO YES

For at least one week or more:

Did they cause problems at home? At school? With friends? With other people? NO YES
Were you put into the hospital for these problems?

IF YES TO ANY, CODE YES

• •

	THE EPISODE EXPLORED	
WAS A:	•	•
	HYPOMANIC	
	MANIC	
	EPISODE	
	EPISODE	

IS D4 CODED NO? NO YES

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

HYPOMANIC EPISODE

CURRENT •
PAST •

IS D4 CODED YES? NO YES

SPECIFY IF THE EPISODE IS CURRENT OR PAST.

MANIC EPISODE

CURRENT •
PAST

E. PANIC DISORDER

(•MEANS : CIRCLE NO IN E5, E6 AND E7 AND SKIP TO F1)

E1 a Have you ever been really frightened or nervous for no reason; or have you ever been really frightened or nervous in a situation where most kids would not feel that way? • NO *YEi*

IF YES TO EITHER, CODE YES. IF NO TO ALL CODE NO. •

b Did this happen more than one time? NO *YEi*

c Did this nervous feeling increase quickly over the first few minutes? NO YEJ

E2 Has this ever happened when you didn't expect it? • NO *YEi*

E3 After this happened, were you afraid it would happen again or that something bad would happen as a result of these attacks? NO *YEi*
Did you have these worries for a month or more?
IF YES TO BOTH QUESTIONS, CODE YES

E4 Think about the time you were the most frightened or nervous for no good reason:

a Did your heart beat fast or loud? NO YE£

b Did you sweat? Did your hands sweat a lot? NO YES

IF YES TO EITHER, CODE YES

c Did your hands or body shake? NO YES

d Did you have trouble breathing? NO YES

e Did you feel like you were choking? Did you feel you couldn't swallow? NO YES

IF YES TO EITHER, CODE YES

f Did you have pain or pressure in your chest? NO YES

g Did you feel like throwing up? Did you have an upset stomach? Did you have diarrhea? NO YES

IF YES TO ANY, CODE YES

h Did you feel dizzy or faint? NO YES

i Did things around you feel strange or like they weren't real? Did you feel or see things as if they were far away? Did you feel outside of or cut off from your body? NO YES

IF YES TO ANY, CODE YES

j Were you afraid that you were losing control of yourself? Were you afraid that you were going crazy? NO YES

IF YES TO EITHER, CODE YES

k Were you afraid that you were dying? NO YES

l Did parts of your body tingle or go numb? NO YES

m Did you feel hot or cold? NO YES

E5 ARE BOTH E3, AND 4 OR MORE E4 ANSWERS, CODED YES? NO YES
PANIC DIZ LIFETIME

IF YES TO E5, SKIP TO E7

E6 IF E5=NO, ARE ANY E4 QUESTIONS CODED YES? NO YES
LIMITED S ATTACKS

THEN SKIP TO F1.

E7 In the past month, did you have these problems more than one time? If this happened, did you worry for a month or more that it would happen again? NO YE£ *PANIC Dlt*

IF YES TO EITHER, CODE YES *CURREN1*

F. AGORAPHOBIA

F1 Do you feel anxious, scared, or uneasy in places or situations where you might become really frightened; like being in a crowd, standing in a line (queue), when you are all alone, NO YES

or when crossing a bridge, traveling in a bus, train or car?

IF YES TO ANY, CODE YES

IF F1 = NO, CIRCLE NO IN F2.

Are you so afraid of these things that you try to stay away from them? NO YES
Or you can only do them if someone is with you? Or you do them, but *AGORAPHOBIA*

IS F2 (CURRENT AGORAPHOBIA) CODED NO NO YES

AND

IS E7 (CURRENT PANIC DISORDER) CODED YES? *PANIC DISORDER without Agoraphobia CURRENT*

IS F2 (CURRENT AGORAPHOBIA) CODED YES NO YES

AND

IS E7 (CURRENT PANIC DISORDER) CODED YES? *PANIC DISORDER with Agoraphobia CURRENT*

k i .

IS F2 (CURRENT AGORAPHOBIA) CODED YES NO YES

AND *AGORAPHOBIA, CURRENT*

is E5 (PANIC DISORDER LIFETIME) CODED NO? *without history of*

G. SEPARATION ANXIETY DISORDER

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

•

G1 a In the past month, have you been really afraid about being away from someone close to you; or have you been really afraid that you would lose somebody you are close to ? (Like getting lost from your parents or having something bad happen to them) NO YES

IF YES TO EITHER, CODE YES

b Who are you afraid of losing or being away from_____?

G2 a Did you get upset a lot when you were away from_____? NO
Did you get upset a lot when you thought you would be away from ?

IF YES TO EITHER, CODE YES

b Did you get really worried that you would lose_____? NO YES
Did you get really worried that something bad would happen to_____? (like having a car accident or dying).

IF YES TO EITHER, CODE YES

c Did you get really worried that you would be separated from_____? NO YES
(Like getting lost or being kidnapped?)

d Did you refuse to go to school or other places because you were afraid to be away from_____? NO YES

e Did you get really afraid being at home if_____wasn't there? NO YES

f Did you not want to go to sleep unless_____was there? NO YES

g Did you have nightmares about being away from_____? NO YEJ
Did this happen more than once?

IF NO TO EITHER, CODE NO

h Did you feel sick a lot (like headaches, stomach aches, nausea or vomiting, NO YEJ
heart beating fast or feeling dizzy) when you were away from_____?
Did you feel sick a lot when you thought you were going to be away from ?

IF YES TO EITHER, CODE YES

G2 SUMMARY: ARE AT LEAST 3 OF G2a-h CODED YES? • NO YES

G3 Has this persisted for at least 4 weeks? • NO YES

G4 Did your fears of being away from_____really bother you a lot? •
Cause you a lot of problems at home? At school? With friends? NO YES
In any other way?

IF YES TO EITHER, CODE YES

ARE G1, G2 SUMMARY, G3 AND G4 CODED YES? NO
YES
SEPARATION ANXIETY DISORDER

H. SOCIAL PHOBIA (Social Anxiety Disorder)

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

H1 In the past month, were you afraid or embarrassed when others were watching you? • NO YES
Were you afraid of being teased? Like talking in front of the class?
Or eating or writing in front of others?

IF YES TO ANY, CODE YES

m Are you more afraid of these things than other kids your age? • NO YES

H3 Are you so afraid of these things that you try to stay away from them? Or you can only do them if someone is with you? Or you do them but it's really hard for you? • NO YEJ

H4 Does this fear really bother you a lot? Does it cause you problems at home or at school? Does this make you afraid to go to school? Does this make you want to be alone? NO YES

SOCIAL PHOBIA (Social Anxiety Disorde CURRENT

I. SPECIFIC PHOBIA

(•MEANS ! GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

11 In the past month, have you been really afraid of something like: snakes or bugs? Dogs or other animals? High places? Storms? The dark? Or seeing blood or needles? • NO YE!

12 List any specific phobia(s):

13 Are you more afraid of than other kids your age are? • NO YEJ

14 Are you so afraid of that you try to stay away from it / them? Or you can only be around it / them if someone is with you? Or can you be around it / them but it's really hard for you? • NO YEJ

IF YES TO ANY, CODE YES

15 Does this fear really bother you a lot? Does it cause you problems at home NO YES

or at school? Does it keep you from doing things you want to do?

IF YES TO ANY, CODE YES

IS 15 CODED YES? NO YES

SPECIFIC PHOBIA CURRENT

J. OBSESSIVE COMPULSIVE DISORDER

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

J1 In the past month, have you been bothered by bad things that come into your mind that you couldn't get rid of? Like bad thoughts or urges? Or nasty pictures? For example, did you think about hurting somebody even though you knew you didn't want to? Were you afraid you or someone would get hurt because of some little thing you did or didn't do? Did you worry a lot about having dirt or germs on you? Did you worry a lot that you would give someone else germs or make them sick somehow? Or were you afraid that you would do something really shocking?

NO YEJ •

SKIP TO J

IF YES TO ANY, CODE YES

DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS.
DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL BEHAVIOR, 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

J2 Did they keep coming back into your mind even when you tried to ignore or NO YES

get rid of them?

•
SKIP TO.

J3 Do you think that these things come from your own mind and not from outside of your head? NO *YEi* fob:

J4 In the past month, did you do something over and over without being able to stop doing it, like washing over and over? Straightening things up over and over? Counting something or checking on something over and over? Saying or doing something over and over? NO *YEi* [co

IF YES TO ANY, CODE YES

•
IS J3 OR J4 CODED YES? NO YES

•
J5 Did you have these thoughts or rituals we just spoke about, more than other kids your age? NO YES

Did these thoughts or actions cause you to miss out on things at home?
At school? With friends? Did they cause you problems with other people?
Did thfisfi thinas take* more than one hour a dav altoafither?

NO YES

O.C.D. CURRENT

K. POSTTRAUMATIC STRESS DISORDER (optional)

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

•
K1 Has anything really awful happened to you? Like being in a flood, tornado or earthquake? Like being in a fire or a really bad accident? Like seeing someone get killed or hurt really bad. Like being attacked by someone? NO YES

•
K2 Did you respond with intense fear, feel helpless or horrified? NO YES

K3	In the past month, has this awful thing come back to you in some way? Like dreaming about it or having a strong memory of it or feeling it in your body ?	• NO	
K4	In the past month:		
a	Have you tried not to think about this awful thing?	NO	*YEI*
b	Have you tried to stay away from things that might remind you of it?	NO	YE!
c	Have you had trouble remembering some important part of what happened?	NO	*YEI*
d	Have you been much less interested in your hobbies or your friends?	NO	*YEI*
e	Have you felt cut off from other people?	NO	*YEI*
f	Have you noticed that you don't have strong feelings about things?	NO	YES
g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
	SUMMARY OF K4: ARE 3 OR MORE K4 ANSWERS CODED YES?	• NO	YES
K5	In the past month:		
a	Have you had trouble sleeping?	NO	YES
b	Have you been moody or angry for no reason?	NO	YES
c	Have you had trouble paying attention?	NO	YES
d	Were you nervous or "jumpy"?	NO	YES
e	Would you jump when you heard noises? Or when you saw something out of the corner of your eye? IF YES TO EITHER, CODE YES	NO	YES
	SUMMARY OF K5: ARE 2 OR MORE K5 ANSWERS CODED YES?	• NO	YES:

5 In the past month, have these problems upset you a lot? NO YES
ve they caused
you to have problems at school? At home? With your friends? *PTSD* CURRENT

L. ALCOHOL ABUSE AND DEPENDENCE

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

L1 In the past year, have you had 3 or more drinks of alcohol in a day? NO *YEi*
At those times, did you have 3 or more drinks in 3 hours? Did you do this 3 or more times in the past year?

IF NO TO ANY, CODE NO

L2 In the past year:

a Did you need to drink more alcohol to get the same feeling you got when you first started drinking? NO YES

b Whenever you cut down on drinking or stopped drinking, did your hands shake? Did you sweat? Did you feel nervous or like you couldn't sit still? Did you ever drink to keep from getting those problems? Did you drink again to keep from getting a hangover? NO YES

IF YES TO ANY, CODE YES

c When you drank alcohol, did you end up drinking more than you had planned to? NO YES

d Have you tried to cut down or stop drinking alcohol but were not able to? NO YES

e On days when you drank, did you spend more than three hours doing it? Count the time it took you to get the alcohol, drink it, and get over it. NO YES

f Did you spend less time on other things because of your drinking (Like school, hobbies, or being with friends)? NO YES

g Did you keep on drinking even though you knew that it caused problems (Like with your health or with your mind)? NO YES

ARE 3 OR MORE L2 ANSWERS CODED YES? **NO**
YES[y]

- YES, SKIP L3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX
ID MOVE TO THE NEXT DISORDER. *ALCOHOL DEPENDENCE*
;PENDENCE PREEMPTS ABUSE. CURRENT

In the past year:

L3 a Have you been drunk or hung-over more than once when you had something important NO VE:
to do, like schoolwork or responsibilities at home? Did this cause any problems?
CODE YES ONLY IF THIS CAUSED PROBLEMS

b Were you drunk more than once while doing something risky (Like riding a bike, NO YE:
driving a car or boat, or using machines)?

c Have you had legal problems more than once because of your drinking NO YE:
(Like getting arrested or stopped by the police)?

d Have you kept drinking even though your drinking caused NO Y ^
problems with your family? With other people?
IF YES TO EITHER, CODE YES

ARE 1 OR MORE OF L3 ANSWERS CODED YES? NO N/A
YES

~~*Al r^uni ARIISF*~~

M. NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS

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

•
M1 a Now I am going to read you a list of street drugs or medicines. NO
Stop me if, in the past year, you have taken any of them more than one time to get high? To feel better or to change your mood?

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", "rush", Dexadrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("angel dust", "peace pill"), psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA or ketamine, ("special K").

Inhalants: "glue", ethyl chloride, "rush", 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, GHB, Roofinol, "Roofies".

Miscellaneous: Steroids, non prescription sleep or diet pills. Any others?

Specify MOST USED Drug(s):

CHECKC

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. •

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY M2 AND ~ M3 AS NEEDED)

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE:

Think about your use of (NAME THE DRUG/DRUG CLASS SELECTED) over the last year:

a Did you need to take more of the drug to get the same feeling you got when you first started taking it? NO YE

b Whenever you cut down or stopped using the drug(s), did your body feel bad NO YE;
or did you go into withdrawal? ("Withdrawal" might mean feeling sick, achy,

shaking, running a temperature, feeling weak, having an upset stomach or diarrhea,
sweating, feeling your heart pounding, trouble sleeping, feeling nervous, moody
or like you can't sit still.) Did you use the drug(s) again to keep from getting sick
or to feel better?

IF YES TO EITHER, CODE YES

c When you used (NAME THE DRUG/DRUG CLASS SELECTED), did you end
up taking more than you had planned to? NO YE:

d Have you tried to cut down or stop taking (NAME THE DRUG/DRUG CLASS
SELECTED)? Did you find out that you couldn't do it? NO YE:

IF NO TO EITHER, CODE NO

e On days when you took (NAME THE DRUG/DRUG CLASS SELECTED), did
you spend more than three hours doing it? Count the time it took you to get (NAME
THE DRUG/DRUG CLASS SELECTED), use it and get over it. NO YE:

f Did you spend less time on other things because of your use of (NAME THE
DRUG/DRUG CLASS SELECTED)? Like school, hobbies or being with friends? NO YE!

g Did you keep on using (NAME THE DRUG/DRUG CLASS SELECTED) even
though you knew it caused problems? Like with your health or with your mind? NO YEJ

ARE 3 OR MORE M2 ANSWERS CODED YES? NO YES'

SPECIFY DRUG(S):

SUBSTANCE

F VES, SKIP M3 QUESTIONS, CIRCLE N/A IN ABUSE BOX DEPENDENCE
MD MOVE TO THE NEXT DISORDER. DEPENDENCE CURRENT
TEMPTS ABUSE.

Think about your use of (NAME THE DRUG/DRUG CLASS SELECTED) over the last year:

In the past year:

M3 a Have you been high or hungover from the drug(s) more than once, when you had something important to do? Like schoolwork or responsibilities at home? Did this happen more than one time? Did this cause any problems? CODE YES ONLY IF THIS CAUSED PROBLEMS — NO YE:

b Have you been high from the drug(s) more than once while doing something risky (Like riding a bike, driving a car or boat, or using machines)? — NO YE:

c Have you had legal problems because of your use of the (NAME THE DRUG/DRUG CLASS SELECTED) more than once? (Like getting arrested or stopped by the police)? — NO YE:

d Have you kept using the (NAME THE DRUG/DRUG CLASS SELECTED) even though it caused problems with your family? With other people? IF YES TO EITHER, CODE YES — NO YE:

ARE 1 OR MORE M3 ANSWERS CODED YES? NO N/A YES

SPECIFY DRUG(S): *SUBSTANCE ABUSE* CURRENT

N. TIC DISORDERS

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

N1 a In the past month did you have movements of your body called "Tics"? "Tics" are quick movements of some part of your body that are hard to control. A tic might be blinking your eyes over and over, twitches of your face, jerking your head, making a movement with your hand over and over, or squatting, or shrugging your shoulders over and over. — NO YES

b Have you ever had a tic that made you say something or make a sound over and NO YES
over and it was hard to stop it? Like coughing or sniffling or clearing your throat
over and over when you did not have a cold; or grunting or snorting or barking;
having to say certain words over and over, having to say bad words, or having to repeat sounds you hear or words that other people say?

IF BOTH N1A AND N1B ARE CODED NO,
CIRCLE NO IN ALL DIAGNOSTIC BOXES AND SKIP TO 01

N2 a Did these "tics" happen many times a day? NO YE:

b Did they happen nearly every day for at least 4 weeks? NO YE:

c Did they happen for a year or more? NO YE:

d Did they ever go away completely for 3 months in a row during this time? NO YE:

N3 Did these "tics" upset you a lot? Did they get in the way of school? Did they cause you problems at home? Did they cause you problems with friends? Did other kids pick on you because of your tics?
IF YES TO ANY, CODE YES NO YE:

N4 Did the tics only occur when you are taking Ritalin, Adderal, Cylert, Dexedrine,
Provigil, Concerta or other medications for ADHD ? NO YE:

ARE N1a+ N1b + N2a + N2c AND N3 CODED YES? NO YES
TOURETTE'S DISORDER, CURRENT

ARE N1a + N2a + N2c + N3 CODED YES AND IS N1b CODED NO YES
MOTOR TIC DISORDER, CURRENT

N5c ARE N1b + N2a + N2c + N3 CODED YES AND IS N1 a CODED NO? • NO YES

VOCAL TIC DISORDER, CURRENT

N5 d ARE N1 (a or b) AND N2a AND N2b AND N3 CODED YES, AND N2c CODED NO.? NO YES

TRANSIENT TIC DISORDER, CURRENT

O. ATTENTION DEFICIT/HYPERACTIVITY DISORDER

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

SCREENING QUESTION FOR 3 DISORDERS (ADHD, CD, ODD)

01 Has anyone (teacher, baby sitter, friend or parent) ever complained about your behavior? • NO YE:

IF NO TO THIS QUESTION, ALSO CODE NO TO CONDUCT DISORDER AND OPPOSITIONAL DEFIANT DISORDER?

In the past six months:

02 a Have you often not paid enough attention to details? Made careless mistakes in school? NO YEv

b Have you often had trouble keeping your attention focused when playing or doing schoolwork? NO YEi

c Have you often been told that you do not listen when others talk directly to you? NO *YEi*

d	Have you often had trouble following through with what you were told to do (Like not following through on schoolwork or chores)? Did this happen even though you understood what you were supposed to do? Did this happen even though you weren't trying to be difficult? IF NO TO ANY, CODE NO	NO	YE!
e	Have you often had a hard time getting organized?	NO	YE!
f	Have you often tried to avoid things that make you concentrate or think hard (like schoolwork)? Do you hate or dislike things that make you concentrate or think hard? IF YES TO EITHER, CODE YES	NO	YE!
g	Have you often lost or forgotten things you needed? Like homework assignments, pencils, or toys?	NO	YE!
h	Do you often get distracted easily by little things (Like sounds or things outside the room)?	NO	YE!
i	Do you often forget to do things you need to do every day (Like forget to comb your hair or brush your teeth)?	NO	YE!
	02 SUMMARY: ARE 6 OR MORE 02 ANSWERS CODED YES?	NO	YE!
	In the past six months:		
03 a	Have you often fidgeted with your hands or feet? Squirmed in your seat? IF YES TO EITHER, CODE YES	NO	YEJ
b	Did you often get out of your seat in class when you were not supposed to?	NO	YEJ
c	Have you often run around or climbed on things when you weren't supposed to? Did you want to run around or climb on things even though you didn't? IF YES TO EITHER, CODE YES	NO	*YEi*
d	Have you often had a hard time playing quietly?	NO	YE£
e	Were you always "on the go"?	NO	YES
f	Have you often talked too much?	NO	YES
g	Have you often blurted out answers before the person or teacher has	NO	YES

finished the question?

h Have you often had trouble waiting your turn? NO YE

i Have you often interrupted other people? Like butting in when other people are talking or busy or when they are on the phone? NO YE.

03 SUMMARY: ARE 6 OR MORE 03 ANSWERS CODED YES? NO YE:

•

04 Did you have problems paying attention, being hyper, or impulsive before you were 7 years old? NO YE:

•

05 Did these things cause you problems at school? At home? With your family? With your friends? NO YE:

CODE YES IF TWO OR MORE ARE ENDORSED YES.

IS 02 SUMMARY & 03 SUMMARY CODED YES? NO YE:
Attention Deficit/ Hyperactivity Disorde
COMBINED

IS 02 SUMMARY CODED YES AND 03 SUMMARY CODED NO? NO YE:
Attention Deficit/ Hyperactivity Disorde
INATTENTIVE

IS 02 SUMMARY CODED NO AND 03 SUMMARY CODED YES? NO YE!
Attention Deficit/ Hyperactivity Disorde
HYPER/IMPULSIVE

P. CONDUCT DISORDER

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

SCREENING QUESTION

P1 IF QUESTION 01 IN ADHD IS ANSWERED NO, CODE NO TO CONDUCT DISORDER

IF 01 WAS NOT ASKED ALREADY, ASK THE QUESTION BELOW

•

(Has anyone (teacher, baby sitter, friend, parent) ever complained about your behavior?) NO YES

P2 In the past year:

a Have you bullied or threatened other people? NO YES

b Have you started fights? NO YES

c Have you used a weapon to hurt someone? Like a knife, gun, bat, or other object? NO YES

d Have you hurt someone (physically) on purpose? NO YES

e Have you hurt animals on purpose? NO YES

f Have you stolen things using force? Like robbing someone using a weapon or grabbing something from someone like purse snatching? NO YES

g Have you forced anyone to have sex with you? NO YES

h Have you started fires on purpose in order to cause damage? NO YES

i Have you destroyed things that belonged to other people on purpose? NO YES

j Have you broken into someone's house or car? NO YES

k Have you lied many times in order to get things from people or to get out of things? Tricked other people into doing what you wanted? NO YES

IF YES TO EITHER, CODE YES

l Have you stolen things that were worth money (Like shoplifting or forging a check)? NO YES

m Have you often stayed out a lot later than your parents let you? Did this start before you were 13 years old? NO YES

IF NO TO EITHER, CODE NO

n Have you run away from home two times or more? NO YE!

o Have you skipped school often? Did this start before you were 13 years old? NO YE!

IF NO TO EITHER, CODE NO

•

P2 SUMMARY: ARE 3 OR MORE P2 ANSWERS CODED YES WITH AT LEAST ONE PRESENT IN THE PAST 6 MONTHS? NO YE!

P3 Did these behaviors cause big problems at school? At home? With your family? Or with your friends? NO YES

IF YES TO ANY, CODE YES

CONDUCT DISORDE. CURRENT

Q. OPPOSITIONAL DEFIANT DISORDER

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

IF CODED POSITIVE FOR CONDUCT DISORDER, CIRCLE NO IN DIAGNOSTIC BOX AND MOVE TO THE NEXT MODULE.

SCREENING QUESTION

Q1 IF QUESTION 01 IN ADHD IS ANSWERED NO, CODE NO TO OPPOSITIONAL DEFIANT DISORDER

IF 01 WAS NOT ASKED ALREADY, ASK THE QUESTION BELOW

•

(Has anyone (teacher, baby sitter, friend, parent) ever complained about your behaviour?) NO YES

Q2 In the past six months:

a	Have you often lost your temper?	NO	YE:
b	Have you often argued with adults?	NO	YE:
c	Have you often refused to do what adults tell you to do? Refused to follow rules?	NO	YEJ
	IF YES TO EITHER, CODE YES		
d	Have you often annoyed people on purpose?	NO	YE:
e	Have you often blamed other people for your mistakes or for your bad behavior?	NO	YE:
f	Have you often been "touchy" or easily annoyed by other people?	NO	YE:
g	Have you often been angry and resentful toward others?	NO	YE:
h	Have you often been "spiteful" or quick to "pay back" somebody who treats you wrong?	NO	YEJ

Q2 SUMMARY: ARE 4 OR MORE OF Q2 ANSWERS CODED YES? • NO *YE** •

Q3 Did these behaviors cause problems at school? At home? With your family? Or with your friends? NO YE!

IF YES TO ANY, CODE YES

ARE Q2 SUMMARY & Q3 CODED YES? NO YES

OPPOSITIONAL DEFIANT DISORDER CURRENT

R. PSYCHOTIC DISORDERS AND MOOD DISORDERS WITH PSYCHOTIC FEATURES

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

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT 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 LIFE EXPERIENCE.

HALLUCINATIONS ARE SCORED "BIZARRE" IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

Now I am going to ask you about unusual experiences that some people have. BIZ

R1 a Have you ever believed that people were secretly watching you? NO YES
Have you believed that someone was trying to get you, or hurt you? YES

IF YES TO ANY, CODE YES

NOTE: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING YES

R2 a Have you ever believed that someone was reading your mind? Or that someone could hear your thoughts? Or that you could actually read someone else's mind? Or hear what they were thinking? NO YES YES

IF YES TO ANY, CODE YES YES

R3 a Have you ever believed that someone or something put thoughts in your mind that were not your own? Have you believed that someone or something made you act in a way that was not your usual self? NO YES YES

IF YES TO ANY, CODE YES YES

p a Have you ever believed that you were being sent special messages through the TV or radio? Through your toys? NO YES YES

IF YES TO ANY, CODE YES YES

R5 a Have your family or friends ever thought that any of your beliefs were strange or weird? Please give me an example. NO YES YES

INTERVIEWER:, ONLY CODE YES IF THE EXAMPLES ARE CLEARLY DELUSIONAL AND ARE m/^t cvni nncn hi r\i icotiaho D A -rr\ DA rnn rvfiuni c OnMATIP VCC

R6 a Have you ever heard things other people couldn't hear, such as voices? NO YES

[HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS YES TO THE FOLLOWING]: YES NO

IF YES: Did you hear a voice talking about you? Did you hear YES

R7 a Have you ever had visions or have you ever seen things other people couldn't see? NO YES

NOTE:CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

b IF YES: Have you seen these things in the past month? NO YES

CLINICIAN'S JUDGMENT

R8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

R9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

R10 b

E 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? AR NO

R11

AR

E 1 OR MORE « a » QUESTIONS FROM R1a TO R7a 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
YES

• R

13

IF NO TO R11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO R13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

NO YES

Did you have the beliefs and experiences you just described [GIVE EXAMPLES TO PATIENT FROM SYMPTOMS CODED YES FROM R1A TO R7A] only when you were feeling depressed? high? very moody? very irritable?

MOOD DISORDER WITH PSYCHOTIC FEATURES

LIFETIME

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY

NO YES

MAJOR DEPRESSIVE EPISODE, (CURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT) CODED YES?

MOOD DISORDER WITH PSYCHOTIC FEATURES

IF THE ANSWER IS YES TO THIS DISORDER, CIRCLE NO TO R13 AND R14 AND MOVE TO THE NEXT MODULE

CURRENT

R13 ARE 1 OR MORE « b » QUESTIONS CODED YES BIZARRE? MO YES

OR

ARE 2 OR MORE « b » QUESTIONS CODED YES (RATHER THAN YES BIZARRE)? *PSYCHOTIC DISORDER* CURRENT

R14 IS R13 CODED YES OR NO YES
ARE 1 OR MORE « a » QUESTIONS FROM R1a TO R7a, CODED YES BIZARRE?

OR

ARE 2 OR MORE « a » QUESTIONS FROM R1 a TO R7a, CODED YES (RATHER THAN YES BIZARRE) *PSYCHOTIC DISORDER* LIFETIME

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME TIME PERIOD?

S. ANOREXIA NERVOSA

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

a How tall are you? oft ooin.

b. What was your lowest weight in the past 3 months? o o c
o o 0
o o 0

c IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW) (THIS IS = A BMI OF < 17.5 KG/M^2) NO *YEI*

d Have you lost 5 lbs. or more (2.3 kgs. or more) in the last 3 months?
NO YES

e If you are less than age 14, have you failed to gain any weight in the last 3 months?
NO YES
If over 14, code NO.

f Has anyone thought that you lost too much weight in the last 3 m onths?
NO YES

•

c IF YES TO S1c OR d OR e OR f, CODE YES, OTHERWISE CODE NO.

In the past 3 months:

52	Have you been trying to keep yourself from gaining any weight?	P NO	YE:
53	Have you been very afraid of gaining weight? Have you been very afraid of getting fat? IF YES TO EITHER, CODE YES	• NO	YE:
54 a	Have you seen yourself as being too big / fat or that part of your body was too big / fat? IF YES TO EITHER, CODE YES	NO	YE!
b	Has your weight strongly affected how you feel about yourself? Has your body shape strongly affected how you feel about yourself? IF YES TO EITHER, CODE YES	NO	YE:
c	Did you think that your low weight was normal or overweight ?	NO	YE:
55	ARE 1 OR MORE S4 ANSWERS CODED YES?	P NO	YE!
56	FOR POST PUBERTAL FEMALES ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)?	• NO	YE!

NO YES

FOR GIRLS: ARE S5 AND S6 CODED YES?

ANOREXIA NERVOSA

FOR BOYS : IS S5 CODED YES? CURRENT

TABLE HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.5 KG/M^2

Height/Weight

ft/in	3'0	3'1	3'2	3'3	3'4	3*5	3'6	37	3'8	3'9	3'10
	3'11	4'0	4'1								
lbs.	32	34	36	38	40	42	44	46	48	50	53
	55	57	60								
cm	91	94	97	99	102	104	107	109	112	114	117
	119	122	125								
kgs	15	15	16	17	18	19	20	21	22	23	24
	25	26	27								

ft/in	4'2	4'3	4'4	4'5	4'6	47	4'8	4'9	4'10	4*11	5'0
	5'1	5'2	5'3								
libs.	62	65	67	70	72	75	78	81	84	87	89
	92	96	99								
cm	127	130	132	135	137	140	142	145	147	150	152
	155	158	160								
kgs	28	29	31	32	33	34	35	37	38	39	41
	42	43	45								

ft/in	5'4	5'5	5'6	57	5'8	5'9	5'10	5'11	6'0	6'1	6'2
	6'3										
lbs.	102	105	108	112	115	118	122	125	129	132	136
	140										
cm	163	165	168	170	173	175	178	180	183	185	188
	191										
kgs	46	48	49	51	52	54	55	57		59	60
	62	64									

fhe height thresholds above are calculated using a body mass index (BMI) equal to or below 17.5 kg/m^2 for the patient's height. This is the threshold guideline below which a person is deemed underweight by the DSM-IV and the ICD-10 Diagnostic Criteria for Research for Anorexia Nervosa.

T. BULIMIA NERVOSA

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

In the past 3 months:

T1	Did you have eating binges? An "eating binge" is when you eat a very large amount of food within two hours.	NO	YE:
T2	Did you have eating binges two times a week or more?	NO	YE!
T3	During an eating binge, did you feel that you couldn't control yourself?	NO	YE:
T4	Did you do anything to keep from gaining weight? Like making yourself throw up or exercising very hard? Trying not to eat for the next day or more? Taking pills to make you have to go to the bathroom more? Or taking any other kinds of pills to try to keep from gaining weight? IF YES TO ANY, CODE YES	NO	YEJ
T5	Does your weight strongly affect how you feel about yourself? Does your body shape strongly affect how you feel about yourself? IF YES TO EITHER, CODE YES	NO	YEJ
T6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO	YE!
			SKIP to Ti
T7	Do these binges occur only when you are under (_____lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE (), THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT/WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE		

	NO	YES
IS T5 CODED YES AND IS EITHER T6 OR T7 CODED NO?		

BULIMIA NERVOSA
CURRENT

IS T7 CODED YES? NO YES

ANOREXIA NERVOSA
Binge Eating Type
CURRENT

U. GENERALIZED ANXIETY DISORDER

.(• MEANS : GO TO END OF DISORDER, CIRCLE NO AND MOVE TO NEXT DISORDER)

SKIP THIS DISORDER IF THE PATIENT'S ANXIETY IS RESTRICTED TO OR BETTER EXPLANINED BY ANY DISORDER PRIOR TO THIS POINT.

U1 a For the past six months, have you worried a lot or been nervous? Have you been worried or nervous about several things, (like school, your health, or something bad happening)? Have you been more worried than other kids your age? IF YES TO ANY, CODE YES • NO YE

b Do you worry most days? NO YE

IS THE PATIENTS ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT? • NO YE

U2 Do you find it hard to stop worrying? Do the worries make it hard for you to pay attention to what you are doing? IF YES TO EITHER, CODE YES NO YE

U3 FOR THE FOLLOWING, CODE NO IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT

When you are worried, do you, most of the time:

a Feel like you can't sit still? NO YE

b Feel tense? NO YE

c Feel tired, weak or exhausted easily? NO YE

d Have a hard time paying attention to what you are doing? Does your mind go blank? NO YE

e Feel grouchy or annoyed? NO YE

f Have trouble sleeping almost every night ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, wakening up too early or sleeping too much)? NO YE

ARE 3 OR MORE U3 ANSWERS CODED YES? NO YES

GENERALIZED ANXIETY DISORDER CURRENT

V. ADJUSTMENT DISORDERS

(•MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, 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 MODULE IF THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOTHER SPECIFIC AXIS I DISORDER OR ARE MERELY AN EXACERBATION OF A PREEXISTING AXIS I OR II DISORDER.

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

•

V1 Are you stressed out about something? Is this making you upset or making your behavior worse? NO YE

IF NO TO EITHER, CODE NO

[Examples include anxiety/depression/physical complaints; misbehavior such as
fighting, driving recklessly, skipping school, vandalism, violating the rights of others,
or illegal activity].

IDENTIFIED STRESSOR:

DATE OF ONSET OF STRESSOR:

V2 Did your upset/behavior problems start soon after the stress began? [Within 3 months of the onset of the stressor] NO • YE

V3 a Are you more upset by this stress than other kids your age would be? NO • YE

b Are these problems causing you to have trouble in school? Trouble at home? Trouble with your family or with your friends? IF YES TO ANY, CODE YES NO • YE:

V4 BEREAVEMENT IS PRESENT IF THESE EMOTIONAL/BEHAVIORAL SYMPTOMS ARE DUE ENTIRELY TO THE LOSS OF A LOVED ONE AND ARE SIMILAR IN SEVERITY, LEVEL OF IMPAIRMENT AND DURATION TO WHAT MOST OTHERS WOULD SUFFER UNDER SIMILAR CIRCUMSTANCES

HAS BEREAVEMENT BEEN RULED OUT? NO • YE:

V5 Have these problems gone on for 6 months or more after the stress stopped? NO • YE:

WHICH OF THESE EMOTIONAL / BEHAVIORAL SUBTYPES ARE PRESENT? Mark all th

A Depression, tearfulness or hopelessness. •

B Anxiety, nervousness, jitteriness, worry. •

C Misbehavior (Like fighting, driving recklessly, skipping school, vandalism, violating other's rights, doing illegal things). •

D School problems, physical complaints or social withdrawal. IF MARKED: •

» A only, then code as Adjustment disorder with depressed mood. 309.0
• B only, then code as Adjustment disorder with anxious mood. 309.24

- C only, then code as Adjustment disorder of conduct. 309.3
- A and B only, then code as Adjustment disorder with mixed anxiety and depressed mood. 309.28
- C and (A or B), then code as Adjustment disorder of emotions and of conduct. 309.4
- D only, then code as Adjustment Disorder unspecified. 309.9
- C and D, then code as Adjustment disorder of conduct. 309.3
- B and D, then code as Adjustment disorder with anxious mood. 309.24
- B, C and D, then code as Adjustment disorder with anxious mood and of conduct. 309.24/309.3
- A and D, then code as Adjustment disorder with depressed mood. 309.0
- A, C and D, then code as Adjustment disorder with depressed mood and of conduct. 309.0/309.3
- A, B and D, then code as Adjustment disorder with mixed anxiety and depressed mood. 309.28
- A, B and C, then code as Adjustment disorder with mixed anxiety and depressed mood, and of conduct. 309.28 / 309.3
- A, B, C and D, then code as Adjustment disorder with mixed anxiety and depressed mood, and of conduct. 309.28 / 309.3

IF V1 AND V2 AND (V3a or V3b) ARE CODED YES, AND V5 IS CODED NO, THEN CODE DISORDER YES WITH SUBTYPES.	NO *Adjustment with*	YES *Disorder*

W. PERVASIVE DEVELOPMENT DISORDER

W1	Since the age of 4, have you had difficulty making friends? Do you have problems because you keep to yourself? Is it because you are shy or because you don't fit in? IF YES TO ANY, CODE YES	NO	YE
W2	Are you fixated on routines and rituals or do you have interests that are special and intrude on other activities?	NO	YE:
W3	Do other kids think you are weird or strange or awkward?	NO	YE:
W4	Do you play mostly alone, rather than with other children?	NO	YEJ

ARE ALL W ANSWERS CODED YES? IF SO, CODE YES. NO UNSURE YES *

IF ANY W ANSWERS ARE CODED UNSURE, CODE UNSURE.

OTHERWISE CODE NO.

PERVASIVE DEVELOPMENT DISORDER

P.1IRRFNT

* Pervasive Developmental Disorder is possible, but needs to be more thoroughly investigated by a board certified child psychiatrist. Based on the above responses, the diagnosis of PDD cannot be ruled out. The above screening is to rule out the diagnosis, rather than to rule it in.

Appendix B3: Personality Inventory for the Youth (PIY)

C S C 3

KENYATTA NATIONAL HOSPITAL
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P.O. Box 20723, Nairobi.
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP", Nairobi.
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Ref: KNH-ERC/01/4645

10th August 2007

Ms. Teresia M. Okumu
Dept. of Psychiatry
School of Medicine
University of Nairobi

Dear Teresia

RESEARCH PROPOSAL: "MENTAL HEALTH AND SUBSTANCE ABUSE PROBLEMS AMONG JUVENILE OFFENDERS AT GETATHURU CHILDREN RECEPTION CENTRE & REHABILITATION SCHOOL, NAIROBI, KENYA" (P182/7/2007)

This is to inform you that the Kenyatta National Hospital Ethics and Research Committee has reviewed and approved your above cited research proposal for the period 10th August 2007 - 9th August 2008.

You will be required to request for a renewal of the approval if you intend to continue with the study beyond the deadline given. Clearance for export of biological specimen must also be obtained from KNH-ERC for each batch.

On behalf of the Committee, I wish you fruitful research and look forward to receiving a summary of the research findings upon completion of the study.

This information will form part of database that will be consulted in future when processing related research study so as to minimize chances of study duplication.

Yours sincerely

PROF A N GUANTAI
SECRETARY, KNH-ERC

c.c. Prof. K.M.3hatt, Chairperson, KNH-ERC
The Deputy Director CS, KNH
The Dean, School of Medicine, UON
The Chairman, Dept. of Psychiatry, UON
Supervisors: Prof. David M. Ndetei, Dept. of Psychiatry, UON
Dr. L. I. Khasakhala, Dept. of Psychiatry, UON