FACTORS INFLUENCING CHOICE OF PATHWAYS TO CHILD AND ADOLESCENT MENTAL HEALTH CARE SERVICES IN KENYA

By:

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Of the University of Ibadan

DECLARATION

I hereby declare that this research project entitled "Pathways to Child and Adolescent Mental Health Services in Kenya" is the result of my own original work and has not been submitted either wholly or in part to any other institution for the award of another degree or diploma.

This research project is submitted in part fulfilment of the requirements for the award of Master of Science in Child and Adolescent Mental Health at the University of Ibadan.

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Judy W. Kamau

DEDICATION

To the caregiver of a child with mental health needs

There is light at the end of the tunnel

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CERTIFICATION BY SUPERVISORS

I certify that Judy Kamau carried out this project under my supervision

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ACRONYMS

CAMH	Child and Adolescent Mental Health
DSM	Diagnostic Statistical Manual
GP	General Practitioner
HIV	Human Immunodeficiency Virus
KNH	Kenyatta National Hospital
K-SADS-PL	Kiddie- Schedule for Affective disorders and Schizophrenia- Present and Lifetime version
SPSS	Statistical Package for Social Scientists
WHO	World Health Organisation
OR	Odds Ratio
HR	Hazards Ratio
CI	Confidence interval
IQR	Inter quartile range
UNICEF	United Nations Children's Fund
KMTC	Kenya Medical Training Centre

ABSTRACT

Background

Studies worldwide reveal that 10-20% of children and adolescents suffer from a mental illness and majority of them are unable to access care. With many of these disorders being treatable, early intervention is key for a good prognosis. In Kenya, not much is known about the determinants of mental health service use in this age group. Understanding the pathways and barriers to specialist mental health care is crucial to planning for and providing optimal child and adolescent mental health services.

In addition to outlining pathways into mental health services for children and adolescents, this study determined the socio-demographic and clinical factors associated with the pathways, the perceived challenges experienced while seeking to access the specialist services and service user's perspectives on ways to improve the services.

Methodology

This was a cross sectional descriptive study conducted at the Kenyatta National Hospital's child and adolescent mental health clinics. Data was collected over 10 weeks from 166 participants and their caregivers. Instruments used were a researcher designed socio-demographic questionnaire, a modified WHO Encounter form and the Kiddie- Schedule for Affective disorders and Schizophrenia- Present and Lifetime (K-SADS-PL 2009 Working Draft).

Quantitative data was analysed using SPSS (Statistical Package for Social Scientists). Bivariate and logistic regression was conducted to check whether the socio-demographic and clinical variables influenced choice of pathway, while cox regression analysis was used to check whether the socio-demographic and clinical variables were related to time taken to seek an intervention. Themes related to barriers to care were extracted from the qualitative data using ATLAS. ti software.

Results

There were more males (56%) than females in this study. The participants' ages ranged from 2 to 18 years, with the mean age of 13.6 years. Substance abuse disorders were the most prevalent presentation (30.1%) followed by depressive disorders (13.9%).

The medical pathway was accessed by 83% of the participants with 36% accessing the child and adolescent mental health services directly. In the non-medical pathway, 6% visited religious leaders. Care was mainly initiated by the caregiver (48.8%) while the child's teacher initiated care in 30.1% of the study participants.

The median time taken to seek any type of help after onset of symptoms was 11 months (IQR 11.5 months).

Being female was found to be predictive of the use of a medical intervention (OR 2.9, 95% CI=1.17-7.77) after adjusting for type of guardian, disruptive disorders and suicidality. Having a disruptive disorder was associated with a longer time to help seeking than not having a disruptive disorder (HR 1.77, 95%CI=1.23-2.57).

The main barriers to care themes identified by the study participants were inability to recognise the symptoms, lack of awareness of the existence of the facilities and financial problems. Lack of knowledge by the previous medical provider was the main barrier identified related to health care providers. Hospital related barrier themes derived were long waiting time, long distance of travel and inadequate facilities.

Conclusion

This study indicates a preference for the medical mediated pathway in accessing care for mental disorders in children and adolescents who presented at the Kenyatta National Hospital. It also highlights the existence of non-medical pathways and the possibility that many children with mental disorders may not be able to access comprehensive mental health care. The main barriers themes identified in this study were the inability to recognise symptoms and not knowing where to seek help. Increasing mental health literacy among health care workers and the community

through awareness campaigns and trainings would go a long way in improving access to the available child and adolescent mental health services.

Key words: pathways to care, help seeking, child and adolescent mental health, barriers to care, determinants of care

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CHAPTER ONE

INTRODUCTION

Studies worldwide reveal that between 10-20% of children and adolescents would suffer from a mental illness (Kieling *et al*. 2011). Unfortunately majority of children who have mental health problems do not have their needs met as their disorders are not detected early enough (Gore *et al*. 2011). There are also challenges to their interventions, such as shortage of mental health services with adequately trained professionals (Omigbodun 2008; Kakuma *et al*. 2011). In addition, mental disorders beginning in childhood and adolescence often persist into adulthood, and there is a mortality burden from mental disorders in the youth due to the increased suicide risk in this age group. Untreated mental disorders in the youth are therefore likely to interfere with academic accomplishments, establishment of peer relationships, and career development (Patel *et al*. 2007) It is therefore of utmost importance for measures to be put in place to appropriately cater for the mental health needs of children and adolescents.

1.1: Background

The burden of mental health problems in children and adolescents is well identified in in Sub-Saharan Africa with general psychopathology found to be at an average prevalence of 14.5% (Cortina *et al*. 2012). Africa also has the highest rate of disability adjusted life years for those aged 10-24 years (2.5 times higher than in high income countries) with neuropsychiatric disorders being the main cause of years lost due to disability in this age group, and alcohol use in the youth being a contributor to others.

Kenya, a low middle-income country in Africa with a population of 44 million, has a largely youthful population comprising of 48 % children and adolescents (WHO 2014).

The existence of psychiatric morbidity in children and adolescents living in Kenya has been documented in several prevalence studies from various settings. A pilot study by Kangethe (1988) found a psychiatric morbidity prevalence rate of 20% among children and adolescents aged 5-15 years attending a primary health care facility while Mulupi (2006) found that 41.2% of 255 adolescents had psychiatric disorders in a similar setting. A comparative study of psychiatric morbidity among rural and urban primary school pupils revealed a 26% psychiatric morbidity rate of 26% in the rural students compared to a 41.2% rate in their urban counterparts (Mwangi 1996).

Mental health care needs are also demonstrated in other cohorts of children living in Kenya. This includes children infected with HIV, at a psychiatric morbidity prevalence of 48.8%, in sexually abused children at a prevalence of 61% as well as in young criminal offenders in at a prevalence of 44.4% (Kamau *et al*. 2012; Syengo *et al*. 2008; Maru *et al*. 2003).

The Kenyan system of health care is divided into six levels that reflect the hierarchical referral system (Ministry of Medical Services 2009; Ministry of Medical Services & Ministry of Public Health & Sanitation 2009). Level one involves the community (individuals, families, households and villages); level two consists of dispensaries and clinics while level three are the health centres, maternities and nursing homes. The primary hospitals, (district and sub-district hospitals) are at level

four and level five consists of the secondary hospitals. The highest is level six where there are the tertiary hospitals, the country's national referral hospitals.

Specialist general mental health care begins at level four and is mainly provided by psychiatric nurses but there are psychiatrists in a few of the level four hospitals. Although the number of psychiatrists has increased over the years, so has the Kenyan population, giving an estimated ratio of one psychiatrist to a population of about half a million people (Jenkins *et al*. 2010; Ndetei *et al*. 2007), with most psychiatrists practicing in the capital, Nairobi.

There is also a dearth of specialist child psychiatrists to meet the needs of children and adolescents with mental health disorders, with only two-trained child psychiatrists in the country and only one of them in clinical practice. Specialist child and adolescent services are only offered in two level six centres in Kenya, the Kenyatta National Hospital and the Mathari Hospital.

1.2: Justification and relevance of the study

Prompt diagnosis and treatment can reduce mortality, lower anxiety, minimise complaints and reduce the duration of hospital stay in many diseases. Studying and understanding pathways to care is vital in the development of successful interventions to encourage early detection, presentation and diagnosis (Mills *et al*. 2013). Studies on pathways to care in mental health and their associated barriers and factors are also key during the situational analysis stage in strategic scaling up of mental health services (increasing the impact of health services so that they can benefit more people and have a lasting impact) especially in low and middle income settings (Eaton *et al*. 2011). This will facilitate the organisation of services suited to the needs of the

service users and therefore improving ownership and use of services. The foundation for any child and adolescent mental health services is the ability to engage children and caretakers into the services. Pathway to care studies that identify the limiting factors in a care pathway and improve upon them, enhance the quality of care across the continuum by improving patient outcomes, increasing patient satisfaction and optimising the use of resources in the long run (Schrijvers *et al*. 2012).

Almost 50 % of the Kenyan population encompasses children and adolescents. Fifty per cent of all mental disorders begin before the age of 14 years and with most of these disorders being chronic in nature, the earlier the intervention the better the prognosis (Kieling *et al*. 2011). It is therefore of utmost importance to provide comprehensive, integrative mental health services that are responsive to the needs of the consumer. A large population of children and adolescents who have mental health problems do not receive timely services and not much is known about the determinants of service use in this age group in Kenya.

Understanding the pathways and barriers to child and adolescent mental health care services is crucial for informing the provision of optimal CAMH services, as client satisfaction with mental health services is one of the necessary conditions of good treatment outcomes.

The findings from this study should assist to strategize and provide for timely interventions to decrease the burden of mental disorders in children and adolescents in Kenya.

1.3: Aim

This study aims to determine the various pathways to specialist child and adolescent mental health services in Kenya and their correlates.

1.4: Specific objectives

1. To outline pathways to care for children and adolescents into CAMH services
2. To determine socio-demographic and clinical factors associated with the pathways
3. To identify the perceived challenges experienced while seeking to access CAMH services
4. To identify the users perceptions of interventions which can make CAMH services more accessible

1.5: Primary outcome measures

1. To determine pathways used in access of the child and adolescent mental health services in Kenya
2. Identify future points and references to be used in the advocacy and promotion of CAMH services in Kenya.

(Word count: 1158)

CHAPTER TWO

LITERATURE REVIEW

2.1: Pathways to care definitions

Pathways to care in mental health can be defined as detailed and systematic description of sources of care used by patients before seeking help from mental health professionals and the factors that modify it (Gater *et al*. 1991). Rickwood & Thomas (2012) define pathways to care, (also known as help seeking pathways) in a mental health perspective as an adaptive coping process in an attempt to obtain external assistance to deal with a mental health concern. It can also be defined as the sequential ordering of contacts (individuals and organisations) prompted by the distressed person's efforts and those of his significant others to seek help as well the help supplied in the process. The pathway's course is not random and is influenced by psychosocial and cultural factors (Rogler & Cortes 1993; Anderson *et al*. 2010).

2.2: Theoretical models of pathways to care and their application to Mental Health and the Kenyan Health system

There are various theoretical models that have been designed to conceptualise the patient's decision-making process towards seeking help as well the factors that ultimately guide the client to a health care professional.

2.2.1: Common Sense Model of Self Regulation

This model, developed by Howard Leventhal and his colleagues, mainly looks at how a person identifies an illness threat (Leventhal *et al*. 2003). In this model, the individual uses the concrete and abstract sources of information available to them to

make sense of the illness and manage it, which is the first step in the help seeking process. The individual uses three sources of information to do this. The first source is the lay information that had already been assimilated by the individual from previous social communication and cultural knowledge of the illness. The second source is from the external social environment from perceived significant individuals such as a medical professional or a parent. The third source is the current experience with the illness, which is the symptomatic information based on the current perception and previous experiences with the illness. Information from all these three sources contributes to an individual the making sense of their condition (Hagger & Orbell 2003). This model has been used for various physical conditions such as cancer, hypertension and influenza as well as mental conditions such as depression, schizophrenia and dementia (Godoy-Izquierdo *et al*. 2007; Hamilton-West 2010).

2.2.2: The Andersen Model of Total Patient Delay

Patient pathways to presentation to health professionals are key determinants to treatment outcomes. The Andersen model comprises of 5 stages describing the decisional processes that account for the delay prior to treatment (Andersen & Cacioppo 1995). These are: Appraisal delay (time between which the patient first detects an unexplained symptom to the conclusion that he/she is ill), Illness delay (time between inferring illness and deciding to seek medical help), Behavioural delay (time between deciding an illness requires medical attention and deciding to act on this decision), Scheduling delay (time between deciding to act on the decision to seek help and actually attending the appointment) and Treatment delay (time between first appointment with healthcare provider and onset of treatment).

While the Andersen model has mostly been applied in relation to help seeking in cancer patients, (Walter *et al*. 2012; Lim 2011) it has also been demonstrated in mental health problems such as depression (Hosseini *et al*. 2014).

2.2.3: Goldberg and Huxley's Pathway to Care Model

This is a model created specific to psychiatric care and consists of 5 levels of care with four filters, also known as decision-making points (Wilkinson 2007). The first level looks at the prevalence of psychiatric and emotional disorders as measured by community surveys. While Kenya does not have child and adolescent mental health community prevalence surveys, school studies of mental health disorders place the prevalence rates at 26% in rural areas and 41% in urban areas (Mwangi 1996). The first filter is the decision made by the patient to seek help from a health professional. This first filter can be greatly influenced by various factors that include the quality and seriousness of the distress, social networks and cultural beliefs, stigma associated with psychiatric services, lack of information on available services, parental burden and problem recognition (McKay *et al*. 1996; Rogler & Cortes 1993; Wichstrøm *et al*. 2014).

The second level looks at patients with psychiatric morbidity presenting to the general practitioner. The prevalence of psychiatric morbidity in children and adolescents presenting in Kenyan primary care centres is in the range of 20-40 % (Kangethe 1988; Mulupi 2006). This brings us to the second filter, which is the primary care clinician's capacity to recognise psychiatric morbidity. The third level of care looks at conspicuous psychiatric morbidity the clinician is able to recognise and ultimately treat and refer. Unfortunately, there may be unrecognised or hidden morbidity and no appropriate intervention carried out for children and adolescents with mental health

problems. The third filter is the clinician's decision to refer. This is highly dependent on ability to recognise the disorder, treat and refer. Levels 4 and 5 involve the patient's entry into the psychiatric health service with the fourth filter being the decision to admit the patient for treatment where and when applicable.

2.2.4: Verhulst and Koot Model of Patient Referral

This model is an adaptation of the Goldberg and Huxley help-seeking model to psychiatric care described above, also consisting of five filters. The main difference lies in Filter 1, regarding the person who has to take action. While in the Goldberg and Huxley model the individuals seek help for themselves, in the Verhulst and Koot model, the parents and caregivers seek help for the child. The other filters remain the same (Cornelia & Douma 2006).

2.3: Studies on pathways to mental health services in adults

In 1988, the WHO in an effort to improve quality mental health care available in community settings conducted a multicentre study on pathways to mental health care (Gater *et al*. 1991). The study involved 11 countries and enrolled 1554 patients, mostly adults. In the study, the European centres (Granada, Manchester, Setúbal, Benesov-Kromeriz), Havana, Aden and Nairobi mainly followed medical pathways to mental health services with referrals either from the community or from the general practitioners. The centres in Mexico, India, Pakistan and Indonesia had native healers as important parts of the pathway.

A recent study in Jaipur India, predominantly of male adults, found that there were five major portals of care in that setting. Faith healers were found to be the most popular initial portal of care before presenting to the tertiary care psychiatry facility at

Jaipur. Other portals included non psychiatric registered medical care providers, alternative medicine care providers (ayurvedic, homeopathic, unani, siddh, acupuncture), other psychiatrists not based at the tertiary facility and direct entry into the psychiatry service (Jain *et al*. 2012). Findings in Malaysia and Cambodia also feature a traditional healer preference in the pathway to care (Razali & Najib 2000; Coton *et al*. 2008).

A household survey conducted in Singapore found that only 31.7 % of those with mental health disorders had sought help for their problem. However, the medical model was more popularly used than were the religious and spiritual healers. This study in addition indicated that 3.9 % consulted the Internet for their mental health problems and that 3.9 % also used medical hotlines to seek mental health advice (Chong *et al*. 2012).

A Pathways to psychiatric care study in Eastern Europe that involved eight centres in six countries (then Serbia-Montenegro, Romania, Bulgaria, Macedonia, Albania and Croatia) was conducted by Gater *et al*. (2005). Three main routes were identified: General practitioners, hospital doctors and direct access to services. Direct access to psychiatric services was the most popular route accounting for more than a third of new patients into psychiatric service, while general practitioners played a limited role in the pathway. Romania had 12% of their patients enter the psychiatric service through the police while in Macedonia, 10% of the patients had seen native and religious leaders.

Ghali *et al*. (2013) identified three pathways points prior to presentation to British mental health services for the management of psychosis. These were through the general medical practitioner (GP), emergency medical services and through the

criminal justice system (police, prison or probation services) Ethnic variation was demonstrated in the various pathways to care. British individuals were more likely to make contact with the GP and less likely to be seen in emergency settings, while black patients were more involved with the criminal justice system.

Some studies have looked at pathways to mental health care in the African continent and many of them show the significance of traditional and faith healers in mental health care pathways as highlighted in the following studies.

In a study involving 128 newly referred patients to mental health services at the three psychiatric units in Malawi, it was demonstrated that 22 % of them had seen a native healer as a first carer and only 41 % had sought care from general clinicians first. Nurses and police also played a role in the pathway. Native and religious healers formed a significant part of the health delivery system due to cultural and spiritual beliefs (Kauye *et al*. 2014). Similarly, Egyptian adults suffering from bipolar disorder were also shown to have sought care from traditional healers (40.8%) before access of mental services while Ethiopia demonstrated a religious healer preference of 50% compared to seeking help from the psychiatric facility in Jimma (Assad *et al*. 2015; Girma & Tesfaye 2011).

In Kumasi, Ghana however, Appiah-Poku *et al*. (2004) found that only 6% of new patients presenting for psychiatry services had seen a traditional healer and 14% had seen a pastor for their mental disorder before presentation to the facilities. The study was conducted in an urban setting and it was postulated that there might be fewer traditional healers in this setting. In a study on pathways to primary mental health care in Zimbabwe, medical providers were usually the first to be consulted for mental

health problems. The patient would then consult another medical provider or a traditional healer if the first treatment failed (Patel *et al*. 1997).

Andersson *et al*. (2013) found that 4.9 % of patients in South Africa with a lifetime prevalence of depression, had not experienced the need to seek help for their disorder, and the ones who had, reported that their first choice of the source for help would have been talking to a friend or relative followed by a health worker. Burns & Kirkbride (2012) looked at pathways to care and duration of untreated psychosis in South Africa. They found the pathway to care was shortened with police involvement and greater duration of age of onset.

Nairobi was among the centres picked for a WHO multi-centre pathway to care study referred to above (Gater *et al*. 1991). This was an adult study and the patients in this study were found to mainly use a medical pathway with 72% of the referrals being hospital based. Unlike in other African studies highlighted above, the Kenyan pathway did not have native healers playing a role in the pathway to care which contradicts reports of traditional healer presence and their involvement in the treatment of mental disorders in Kenya (Mbwayo *et al*. 2013). Some referrals to specialist mental health services were documented to come from the police and legal channels. The Nairobi centre demonstrated the shortest medium time between symptom onset and presentation to a medical facility (less than a week) compared to other centres included in the study including the European centres.

2.4: Pathways to mental health services in children

Parents and guardians are key in the recognition of the child's problematic behaviour and the subsequent decision on where and when to seek care for the children's mental health problems (Cornelia & Douma 2006) Teachers have also been identified as important focal points in recognising mental health problems in children and adolescents.

An Albanian based study on help seeking process among children and adolescents who have mental disorders is one of the few documented European studies that mentioned religious leader's role in care. They were however perceived as a barrier to child and adolescent mental health services as they do not act as referral agents. This study by Alikaj *et al*. (2011) pointed out that half the children with mental health disorders seen by general practitioners (GP) were not referred for mental health care due to failure to recognise the nature of the problem by the GP with the treatment revolving around physical symptoms. Other barriers identified in this study included the lack of parental awareness and demand for services.

One school based study on secondary school adolescents in Oman by Al Riyami *et al*. (2009) found that only 6-12% of those having a mental disorder were presented to medical facilities for treatment. This was related to the fact that in Oman, most things related to mental illness were viewed as spiritual possession or fate. Almost similar findings had been found by Pavuluri *et al*. (1996) in a study of a cohort of preschool American children. However their findings on unmet needs were related to the parent's ability to recognise the problem and seeking help from informal agencies and not viewing them as spiritual.

Farmer *et al*. (2003) examined the points of entry into the United States mental health service by following up 1420 youth who had previously been enrolled into the Great Smoky Mountain study over a period of three years. They found that the education system was the most common entry point for all age groups. The Juvenile justice system on the other hand was the commonest entry point for youth between 14 and 16 years of age, while the specialty mental health centre was the second most common for the youth up to 13 years. These disparities could not be accounted for.

Specialist child and adolescent mental health services are not available in many African countries resulting in a dearth of literature on pathways to mental health care specific to children and adolescents.

Two thirds of children and adolescents presented to a tertiary health facility in Northern Nigeria for treatment of mental problems were found to have been unwell for more than 6 months prior to presentation at the facility. Fifty nine per cent of the patients had received no care at all prior to presentation to the medical facility while 36.4% had received treatment from traditional and religious leaders (Abdulmalik & Sale 2012). The findings in this study were postulated to be due to beliefs in supernatural involvement in the causation of mental disorders. In contrast, a similar study conducted in South Eastern Nigeria involving children and adolescents found that 68% of the patients presented to medical facilities as first point of care, with most referrals being made by relatives, family and friends, and only 7.1% of the referrals originating from other hospitals. Alternative points of care in this study included prayer houses, faith healing centres, traditional healers, patent medicine stores and special schools.

There is a paucity of studies outlining pathways to child and adolescent mental health care in the Kenyan setting though this has been carried out in adults (Gater *et al*. 1991). Considering the prevalence of children and adolescents with mental health disorders, this is a major omission.

2.5: Determinants and barriers to utilisation of CAMH services

Several determinants and barriers to child and adolescent mental health care have been identified in various studies. Rates of mental health service use were found to be low among young children and increase substantially with age, a finding in a Dutch and an American study (Zwaanswijk 2005; Horwitz *et al*. 2012). This has been thought to be due to the involvement of other service sectors such as schools and primary care in the identification and referral of disordered children.

Increased parental burden experienced in raising children with mental health problems was found to influence parental problem recognition and subsequent help seeking and not the severity of the child's psychopathology (Wichstrøm *et al*. 2014). This was in contrast to the finding by Brown *et al*. (2014) from an American study involving parents of children with mental health problems, that showed that parental stress was a barrier to seeking mental health and community support services for children with behavioural problems. This had been echoed by Sayal *et al*. (2010) in a primary care focus group study based in the UK on parental help seeking for child and adolescent mental health services which found that the decision to enquire about mental health services for their children was influenced by the parent's perception of the problem, perceived ability to cope and parental knowledge of child mental health problems. The chance of concern and help seeking was also found to increase with the

presence of more than one mental disorders or coexisting physical illness in a child (Horwitz *et al*. 2012; Zwaanswijk 2005).

The effect of the child's gender has been identified as a determinant in help seeking in various studies. Female children and adolescents were less likely to receive mental health assistance probably due to the externalising symptom presentation in boys that makes it easier to recognise (Paula *et al*. 2014; Wichstrøm *et al*. 2014). The effect of the child's gender was also dependent on the age of the child, with more help being sought out for boys in childhood and adolescence while more help was sought for girls in late adolescence. This was explained by the finding that externalising problems, more prevalent in boys decreased with age while internalising problems, typical with girls increased with age (Zwaanswijk 2005).

Low socio economic status was found to have an independent effect on increased service use for mental health problems in Norway. These findings were however not explained in this study by Wichstrøm *et al*. (2014) as mental health services were free in Norway. Amone-P'Olak *et al*. (2010) however, found the exact opposite in the Netherlands, that a higher socio economic position along with an increased level of maternal education predicted specialty mental health service use independent of clinical severity and in Sweden, children living in high levels of socioeconomic deprivation were less likely to be referred to child and adolescent psychiatry clinics by their families (Ivert *et al*. 2011).

Countries that are multicultural usually report ethnicity as a barrier to care. A Swede study reported that children from a Swedish background were more likely to be referred and used mental health services than those with an immigrant background. In addition, social and legal avenues were utilised more by children with African and

Asian backgrounds while Asian or South American children were more likely to be referred by school and mental health agencies. The reason for the ethnic disparities in the findings was not explained in the study but three areas were highlighted as important in understanding mental health referrals: social networks, cultural contexts and beliefs about mental illness and the range of available care options (Ivert *et al*. 2011). Low service use rate was similarly found in children from other races or ethnic groups than white people in an American study (Horwitz *et al*. 2012).

A study conducted in rural Canada identified three main barriers to child and adolescent mental health care: personal barriers (stigma, lack of awareness on availability of the services, financial), systemic barriers (few mental health specialists, policy and funding issues, rigid intake criteria, and long waiting time for appointments) and environmental barriers (having to travel long distances for care) (Boydell *et al*. 2006).

Diminished mental health literacy has been identified as a barrier to mental health services in developing countries. Mental health literacy is the ability to recognise specific disorders, knowledge and beliefs about risk factors, self help interventions, professional help available and appropriate help seeking for mental health problems (Ganasen *et al*. 2008). Low mental health literacy among service users has been identified in Nigeria and other countries where mental health service use is low due to the belief that mental health disorders had a supernatural beliefs origin (Abdulmalik & Sale 2012). A study investigating nurses knowledge and attitudes towards mental illness in South Africa demonstrated low mental health literacy among health workers on finding that majority were not able to correctly diagnose the disorders on case vignettes (Hugo *et al*. 2003).

2.6: Overcoming barriers to CAMH service use

Developing a positive collaborative relationship with traditional healers would address the significant delay in modern psychiatric treatment in Egypt where most patients were seen to seek help from traditional healers according to Assad *et al*. (2015). For the same barrier, Girma & Tesfaye (2011) proposed improving public awareness about causes and treatment of mental illness in Ethiopia.

After a review of literature from developing countries that identified mental health literacy in the public and primary health care workers as a barrier to care, Ganasen *et al*. (2008) came up with the following recommendations for addressing the barrier bearing in mind the people's family values, cultural beliefs and education. i) Improve the mental health budgets of developing countries; ii) Effectively utilise existing mental health resources; iii) Identify resource barriers to mental health practice and policy; iv) Improve dissemination of mental health literacy among the general population and health care workers through awareness campaigns along with trainings for primary care workers to identify and deal with common mental disorders; v) Educate and update traditional healers on newly acquired knowledge in the field without being dismissive of their cultural beliefs and include them in appropriate referral systems.

The World Psychiatrist Association (WPA), the WHO and the International Association of Child and Adolescent Psychiatrists and Allied Professionals (IACAPAP) collaborated and conducted a pilot study aimed at assessing the level of change in awareness, knowledge, attitudes and beliefs of parents, teachers and students on mental health after using an Awareness manual. The study was conducted in 9 countries on 5 different continents. There were positive post awareness indicators

that demonstrated an increased willingness to discuss emotional problems freely (Hoven *et al*. 2008).

Provider and health systems barriers decreased in Brazil due to health system changes, the integration of mental health care into primary care and the consequent expansion of access to mental health care services (Fatori *et al*. 2012). Lack of parental recognition of mental disorders was identified as a significant barrier. Intervention programs aimed at increasing public awareness about mental health problems, sources of help available and how to access them was proposed to address this barrier (Paula *et al*. 2014).

Delivery of family centred care and enhancing family support may help decrease unmet needs as suggested in a study involving an American cohort where parental stress was found to be a barrier in help seeking and social support were found to promote help seeking (Brown *et al*. 2014).

Routine screening for physical and psychosocial problems by school physicians and nurses in most Dutch children during primary education has resulted in increased mental health service use due to early detection and referral according to Zwaanswijk (2005). In this light, Paula *et al*. (2014) proposed the use of training programs for teachers in Brazil to increase the capacity to recognise children in need of mental health services.

Singapore had a high rate of unmet mental health needs; with only 32% of those found to have mental health disorders in the community seeking help for their mental health needs (Chong *et al*. 2012). For this, the recommendation was to engage and work collaboratively with health care providers to improve the detection, assessment

and treatment of those with mental illness. They also recommended the incorporation of socio-cultural, religious and spiritual factors into mental health policies, services and medical education in order to break the barriers in mental health services.

Petterson *et al*. (2014) in an American study identified the need for an increased focus on patient centred care along with greater collaboration between primary care and mental health services to decrease the fragmentation of care and disparities in health outcomes.

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CHAPTER THREE

METHODOLOGY

3.1: Study location

The study was conducted at the Kenyatta National Hospital (KNH) child psychiatry and adolescent mental health outpatient clinics. Located in Kenya's capital city, Nairobi, the KNH was founded in 1901 and has grown to become the largest national referral (Level 6) hospital in Kenya providing highly specialised healthcare services in various disciplines such as mental health, intensive care, neonatal and paediatric services, oncology, neurology, radiology, cardiology and urology among others. It is also a teaching hospital affiliated with the University of Nairobi's Medical School. This site was picked as it is the largest centre that offers specialised child and adolescent services in Kenya.

The Department of Psychiatry at KNH provides child and adolescent mental health services to patients mainly from Nairobi and its environs, but also receives referrals from all over the country. There is no in-patient unit for psychiatry patients at the hospital that has a 1800 bed capacity, and there is no government institution in the country that has a child psychiatry inpatient unit. Patients above the age of 14 years with mental health problems deemed to require in-patient care are usually referred to the Mathari hospital, which is the country's psychiatry referral hospital. The psychiatry department however provides consultation liaison services for patients admitted in the wards for physical illnesses and found to have co-morbid psychiatric disorders. Four consultant psychiatrists and two clinical psychologists (affiliated with KNH or the University of Nairobi) provide mental health care at the KNH to

approximately 30 children and adolescents a week. The clinical psychology students in training and psychiatry registrars also provide care. They work closely with the occupational therapists, speech therapists and the educational assessment departments. There are two types of clinics providing services to children and adolescents in the hospital: The Child Psychiatry clinic that caters to children aged 0-13 years and the Youth Centre that caters to those aged between 14 and 24 years. Consultation services offered at the Youth Centre are free.

3.2: Study design

This was a cross sectional descriptive study investigating pathways to child and adolescent mental health services in Kenya and their determinants.

3.3: Study population

The study targeted children and adolescents aged 0-18 years receiving mental health services at the KNH mental health outpatient clinics and their guardians.

3.4: Sample size

The sample size was derived using the following formula for calculating sample size for proportions extracted from Israel (1992):

$$\mathbf{n= (1.96)^2 p\ (1-p)/d^2}$$

Where:

n = sample size

p = the hypothesised prevalence level from other prevalence studies set at 72%, being the percentage of patients presenting to medical facilities as first points of mental health care (Gater *et al*. 1991).

d =the desired level of precision set at 5% (0.05)

1.96 is the factor obtained from the normal distribution table at a setting of 95% confidence interval

On substitution of values:

$n= (1.96)^2 0.72\ (1-0.72)/0.05^2$

n= 309

Adjusting for finite population correction:

$$n' = \frac{n}{1 + \frac{n}{N}}$$

Where

$n^!$=adjusted sample size

n=sample size

N= population of interest (set to 360 as the KNH clinic population for 12 week period of data collection)

This resulted to an adjusted sample size of 166

3.5: Sampling technique

Purposive sampling technique was used on those who met the inclusion criteria over the eight weeks of data collection. Purposive sampling is a type of non- random sampling technique where the participants are selected based on their willingness to participate having met the inclusion criteria. This method was used in this study due to the short period allocated for data collection and the numbers of children attending the clinic were few.

3.5.1: Inclusion criteria

1. Children and adolescents under 1 year to 18 years
2. Children and adolescents whose guardians gave consent
3. Assent from children and adolescents after proxy consent from the guardian

3.5.2: Exclusion criteria

1. Children and adolescents whose guardians did not give consent
2. Youth aged more than 18 years attending the mental health clinic
3. Refusal by the child to participate in the research study despite proxy consent from the guardian

3.6: Study Instruments

3.6.1: Researcher designed socio-demographic questionnaire.

This questionnaire was designed to capture data such as age, gender, and educational background of the child and the guardian. It was administered to the guardian.

3.6.2: Modified WHO Encounter form.

The WHO Pathway Encounter form was first developed for use in a multicentre study on pathways to mental health care. It has been used before on the Kenyan adult population (Gater *et al*. 1991). It is designed to collect data on the sequence of points of care and referrals leading to the patient's presentation to the specialist mental health services.

In this study, the form was modified to add on questions on the guardian's belief as to the cause of the child's problem as well as barriers to care at the various care points on the pathway.

3.6.3: Kiddie- Schedule for Affective disorders and Schizophrenia- Present and Lifetime version (K-SADS-PL)

Psychiatric disorders were elicited using the K-SADS-PL 2009 Working Draft. This is a semi structured diagnostic screening instrument tool adapted from the K-SADS-PL (Kaufman *et al*. 1997; Pittsburgh n.d.). Its usage is freely permitted for research and clinical usage in Non-Profit organisations. It is designed for children and adolescents aged 6-18 years to assess current and past episodes of psychiatric morbidity according to DSM IV criteria. It covers most diagnosis on DSM IV in children except Learning disabilities, Intellectual disabilities and Somatoform disorders. It is also contains a section to assess for suicide risk and is used in tandem with the Children's Global Assessment Scale (CGAS) that is used to assess impairment of function on a continuous scale of 0-100 for children aged 4-18 years.

For those children below 6 years, the tool was still followed as a guide and the clinical DSM 4 diagnostic criteria applied. The somatoform range of diagnosis and intellectual disability were made clinically.

The tool has not been used previously on the Kenyan population but has been used in other African countries wholly or in part as a tool or as a gold standard to validate other screening instruments (Adewuya *et al*. 2007; Tunde-Ayinmode *et al*. 2012).

Although the study was conducted in a clinical setting, the K-SADS-PL was used to provide uniformity in the diagnosis. The demographic data in this tool was collected in the Socio-demographic questionnaire to avoid repetition.

The administration of the questionnaires by the researcher took an average of between 30 minutes to an hour and a half. All tools were directed to the parent/ guardian but the K-SADS was also directed to the child for confirmation for corroborative history.

3.7: Data collection procedure

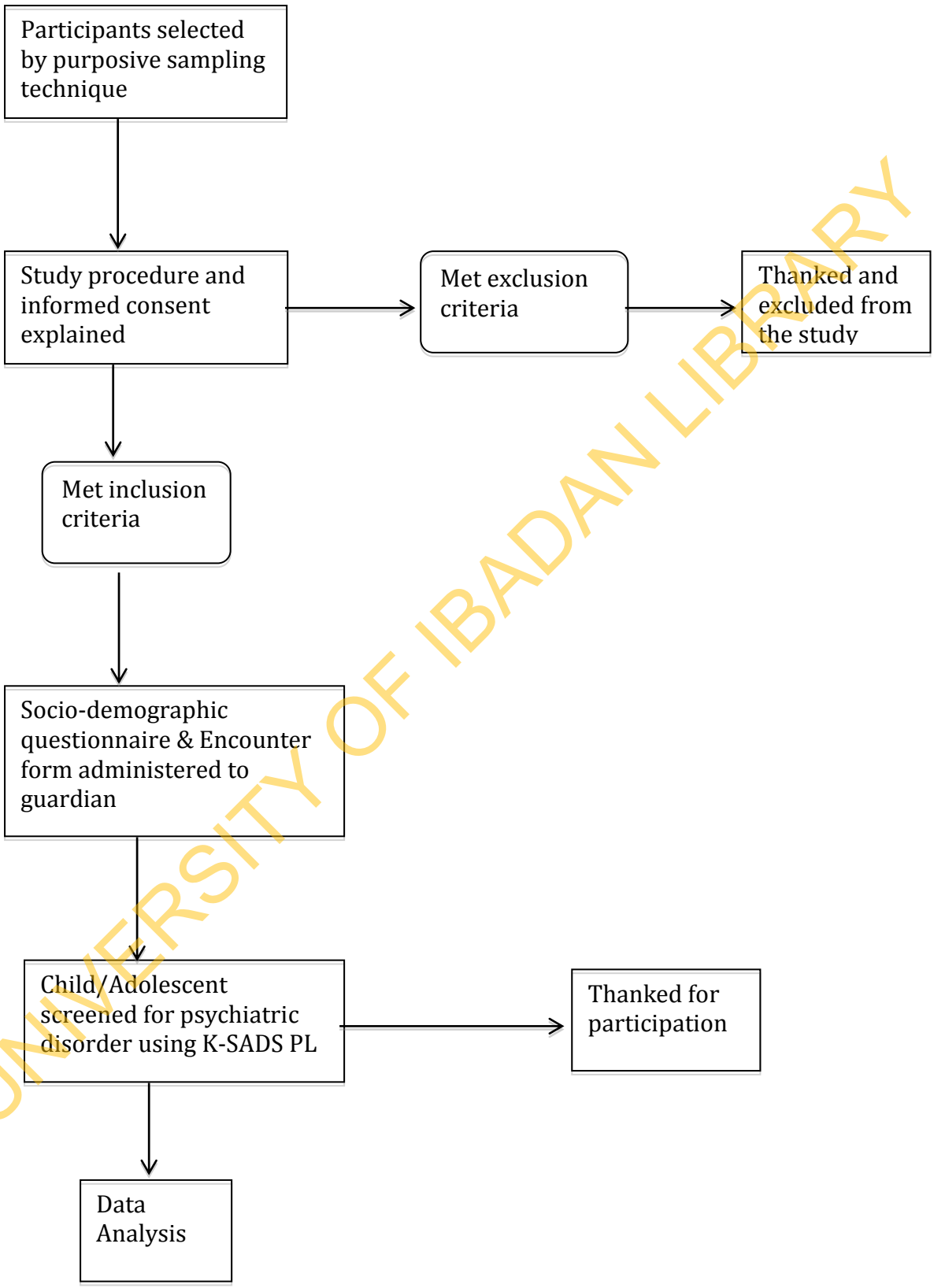
Data was collected on every clinic day from guardians and children who were eligible and consented. After signing the consent form, the researcher designed socio-demographic questionnaire, the modified encounter form and the K-SADS-PL screen were administered sequentially. The questionnaires were in the English language, as most of the study participants understood the English language. The researcher was also fluent in Kiswahili and Kikuyu languages.

Data collection began as early as 7.30 a.m. to maximise catchment as much as possible. Data was collected for a total of 10 weeks, and was mainly collected on the four days that the child and adolescent mental health clinics are run. Monday was

reserved for the Child Psychiatry clinic that attended to clients aged 0-13 years while data was collected from the Youth Centre (14-18 years) on Tuesday, Thursday and Friday. There were no refusals encountered during data collection.

The data collection procedure is summarised by the following flow chart.

Figure 3.1: Data Collection Procedure Flowchart



3.8: Data Management

Collected data was analysed using S.P.S.S (Statistical Package for Social Scientists) software version 20.

Socio demographic and clinical variables were analysed and presented in frequencies/percentages. The Chi Square test was used to determine association between categorical socio demographic and clinical variables and the type of pathway taken. Multiple logistic regression analysis was then conducted on the significant or almost significant variables on the bivariate analysis.

Kaplan Meier Survival analysis was applied for the analysis of time to event variable. In this study, the "Event" was the act of seeking help for the child's mental health symptoms by the caregiver, and exact times to seek help were determined. All the study participants sought help so the times to seek help were not censored. The Log rank test was used to look for an association between the socio demographic and clinical factors with the time taken to first intervention after the detection of symptoms (Bland & Altman 2004). Cox Proportional Hazards regression analysis was thereafter conducted on the significant or almost significant variables.

Computer assisted theme generation from the qualitative data was conducted using ATLAS. ti software.

The statistical level of significance was set at 5% ($p<0.05$).

3.9: Ethical considerations

Ethical approval to carry out this study was obtained from the Kenyatta National Hospital/University of Nairobi Ethics & Research Committee and after review and corrections, the permission to conduct the study was granted on 20th March 2015.

3.9.1: Consent

Informed written consent was sought from the parents/ guardians after careful explanation of the study.

3.9.2: Voluntariness

It was made clear to the guardians that participation was purely voluntary and the acquired information would only be used for research purposes and that failure to consent would not affect their treatment at the hospital in any way. None of the guardians approached to participate in the study failed to give consent.

3.9.3: Benefits and risks

The parents/ guardians were interviewed as they waited to receive services at the mental health clinic. They were not greatly inconvenienced, as the data collection process did not interfere with the clinic, and waiting time could sometimes go up to three hours. There was no material gain to them from the study, and the main benefit to the participant was the projected improvement of services after. It was made clear that one could withdraw from the interview at anytime if they so desired.

3.9.4: Confidentiality

The study participants were assured of anonymity and confidentiality. Their names did not appear anywhere on the questionnaires to maintain confidentiality.

(Word count: 1678)

CHAPTER 4

RESULTS

The findings from the study are presented in five sections. The first section gives a general description of the socio demographic and clinical factors of the study participants, while the second section describes the characteristics of the pathways to care. The third section presents the associations between pathways to care and clinical, social and demographic factors. Section four and five describe the perceived challenges experienced by patients and caregivers during the health care seeking process and their suggested interventions to improve child and adolescent mental health (CAMH) services respectively.

4.1: General description of the study sample

4.1.1: Socio demographic characteristics

One hundred and sixty six participants were enrolled into the study. The ages of the children and adolescents ranged from 2 to18 years with a mean of 13.6 ± 4.16 years. Ninety-three (56%) were male, with a female: male ratio of 1:1.2. Out of the 32 children below 10 years, 25 of them (78.1%) were male while 7 were female. Among the 134 adolescents in the sample, 68(50.7%) were male and 66(49.3%) were female. This difference in gender across the ages at presentation was found to be statistically significant (p=0.005)

Seventeen (10.2%) of the children and adolescents were not in school for various reasons. Two (1.2%) had dropped out of school, 5 (3%) had been expelled from

school, 5(3%) were not in school due to the mental disability and 5 (3%) were not yet of school age.

The personal socio-demographic characteristics of the study participants are displayed in Table 1 below.

Table 1: Personal Socio demographic characteristics of the study participants

N=166

Variables	**n (%)**
Age (years)	
0-4	8(4.8)
5-9	24(14.5)
10-14	37(22.3)
*15-18	97(58.4)
Total	**166 (100)**
Gender	
Male	93(56.0)
Female	73(44.0)
Total	**166 (100)**
[a]School status/grade	
Pre primary	12 (7.2)
Primary	35 (21)
Secondary	89 (53.6)
Post-secondary	4 (2.4)
Special school	9 (5.4)
Not in school	17 (10.2)
Total	**166 (100)**

[a]: Pre primary (4-6 years of age) Primary [8 years of schooling (class 1-class 8)] Secondary [four years of schooling (form 1-form 4)]

*: Range of ages restricted by scope of survey (under 1 year to 18 years)

Forty six (27.7%) of the participants were from single parent households, while 9 (5.4%) were double orphans. Of the non-parent guardians, 16 (9.6%) of them were blood relatives. The family characteristics of the study participants are displayed in table 2 below.

Table 2: Family Characteristics of the Study Participants

Variables	n (%)
Primary guardian	
Biological parent	147(88.6)
Blood relative	16(9.6)
Non relative	3(1.8)
Total	**166 (100)**
Parental status	
Married	111(66.9)
Separated or divorced	37(22.3)
Maternal orphan	1 (0.6)
Paternal orphan	8 (4.8)
Both parents dead	9 (5.4)
Total	**166 (100)**
Educational status of father	
No formal education	3 (2.7)
Primary school	13 (11.6)
Secondary school	43 (38.4)
Tertiary	54 (47.3)
Total	**112 (100)**
[a]Occupational status of father	
Professional	41 (36.60
Non-professional	69 (61.6)
No employment	2 (1.8)
Total	**112 (100)**
Educational status of mother	
No formal education	3 (1.9)
Primary school	30 (19.2)
Secondary school	70 (44.9)
Tertiary education	53 (34.0)
Total	**156 (100)**
[a]Occupation status of mother	
Professional	32 (20.5)
Non-professional	96 (61.5)
No employment/ homemaker	28 (18.0)
Total	**156 (100)**
Geographical area (province)	
Eastern	9(5.4)
Central	39(23.5)
Rift valley	10(6.0)
Nyanza	4(2.4)
Nairobi (site of study)	104(62.7)
Total	**166 (100)**
Religion	
Christianity	165(99.4)
Islam	1(0.6)
Total	**166 (100)**

[a]:Professional: requires tertiary education; Non professional: requires little or no formal education

4.1.2: Mental and physical disorders in the study sample

Table 3a and table 3b display the clinical characteristics of the study sample. Substance use disorders related to cannabis use were the most common psychiatry diagnosis followed by major depression. Intellectual disability was diagnosed in 17 (10.2%) of the children and adolescents while seizure disorders 18(10.8%) were the most common of the physical conditions. Other physical conditions found in the sample were cerebral palsy 1(0.6%), HIV 1(0.6%), headache 1(0.6%) and hearing difficulties 2(1.2%). Twenty three (13.7%) of the children and adolescents in the study reported experiencing suicidal ideation, and 7(4.2%) of them reported having attempted suicide at least once.

Out of the 166 children and adolescents enrolled in the study, 69 (41.6%) met the diagnostic criteria for more than one disorder and 16(9.6%) of the study participants had used more than one substance of abuse.

Table 3a: Frequency Distribution of Mental and Physical Disorders in the Study Sample N=166

Disorders	Number	%
Psychotic disorders and bipolar disorders		
Schizophrenia	9	5.4
Schizoaffective disorder	1	0.6
Schizophreniform disorder	3	1.8
Brief psychotic disorder	1	0.6
Bipolar disorder	7	4.2
Depression, Anxiety and related disorders		
Major Depression and Dysthymia	23	13.9
Anxiety disorders	11	6.6
Somatoform disorders	10	6.0
Adjustment disorders	6	3.6
Disruptive disorders		
Attention Deficit Hyperactivity Disorder (ADHD)	20	12.1
Conduct disorder	12	7.2
Oppositional Defiant Disorder	9	5.4
Disruptive disorder not otherwise specified	2	1.2
Substance related disorders		
Tobacco use	10	6.0
Alcohol use (abuse &dependence)	12	7.2
Cannabis use (abuse & dependence)	24	14.5
Stimulant abuse	3	1.8
Cocaine dependence	1	0.6
Autism spectrum disorders	21	12.7
Physical disorders		
Seizure disorder	18	10.8
HIV	1	0.6
Cerebral palsy	1	0.6
Others (headache and hearing)	3	1.2
Suicidality	23	13.9
Intellectual disability	18	10.8
Others		
Tic disorders	2	1.2
Enuresis	3	1.8
Other conditions that may be a focus of clinical attention (related to social environment, social support and school problems)	18	10.8

N.B. Due to presence of comorbidities, the total n(%) will be more than 100%

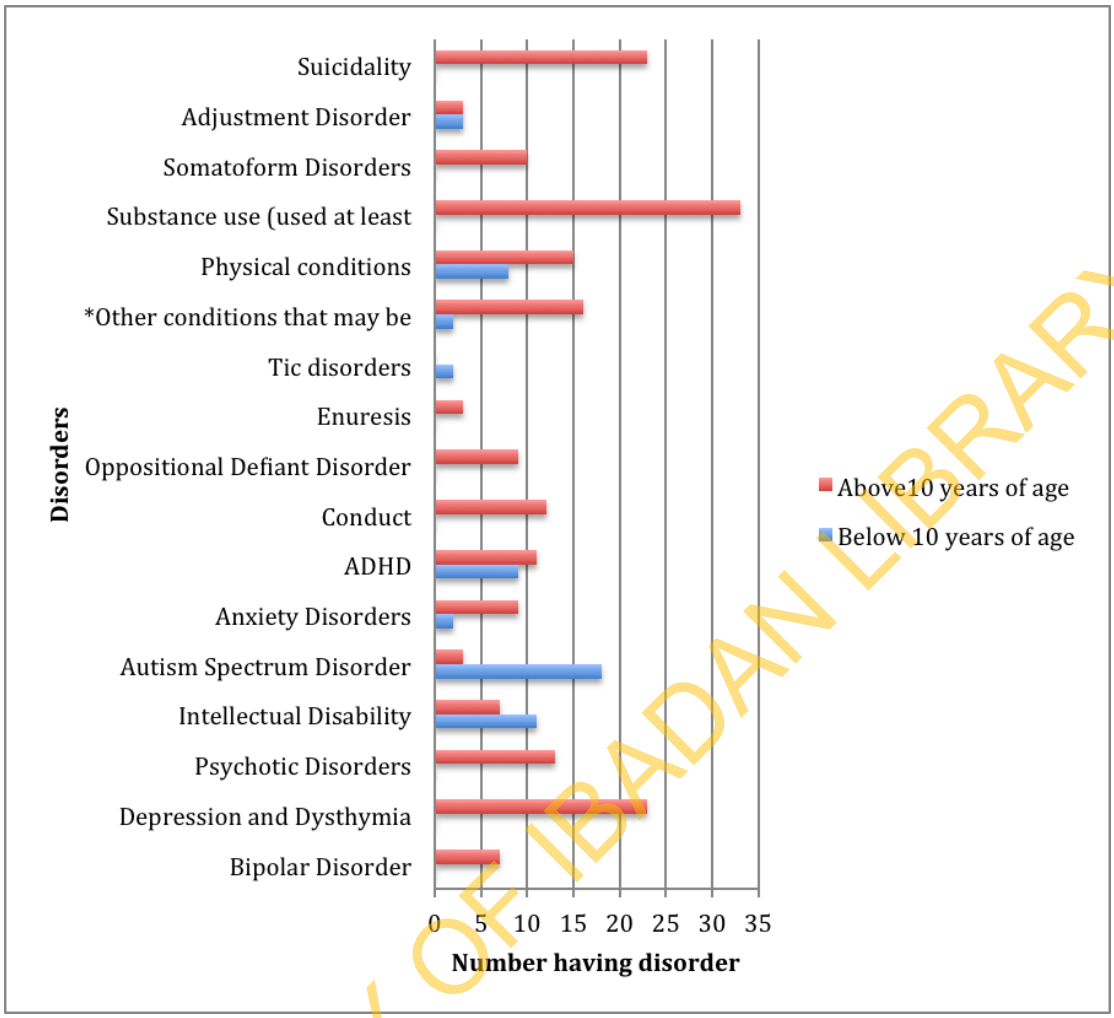
Table 3b: Frequency Distribution of Mental and Physical Disorders in the Study Sample

N=166

Disorders	**Number**	**%**
Psychotic disorders and bipolar disorders	21	12.6
Depression, anxiety, somatoform and adjustment disorders	50	30.1
Disruptive disorders	43	25.9
Substance related disorders	33	19.8
Autism spectrum disorders	21	12.7
Physical disorders	23	13.9
Suicidality	23	13.9
Intellectual disability	18	10.8
Others: Tic disorders, Enuresis and Other conditions that may be a focus of clinical attention	23	13.9

N.B. Due to presence of comorbidities, the n(%) will be more than 100%

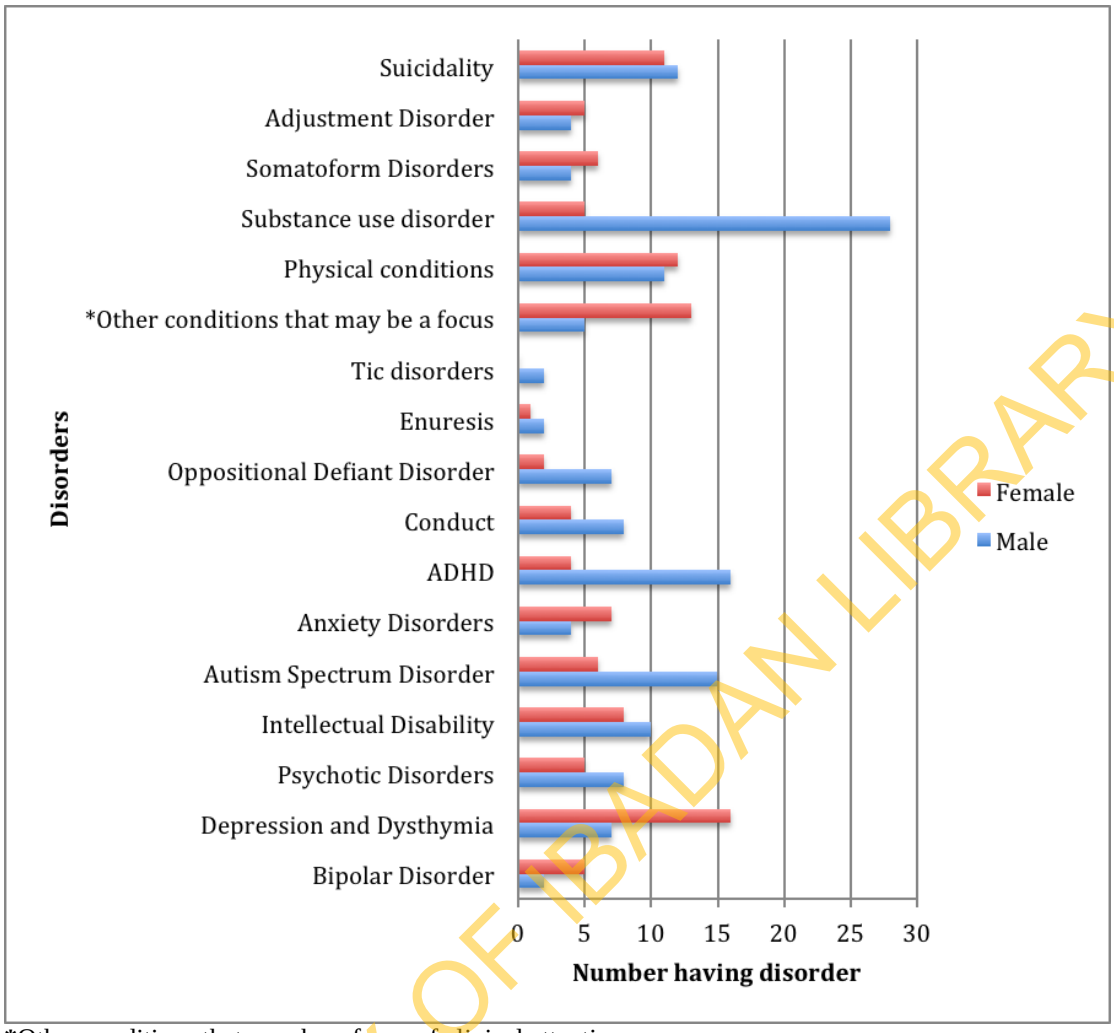
Figure 4.1: Comparison graph of disorders in participants below 10 years versus those above 10 years



*Other conditions that may be a focus of clinical attention

Figure 4.1 above displays the prevalence of the disorders by age group, comparing those below 10 years to those above 10 years. Autism spectrum disorders were highest in the lower age group while there were no substance use disorders in the lower age group.

Figure 4.2: Comparison graph of disorders presenting in males versus females



***Other conditions that may be a focus of clinical attention**

More female participants had depression (n=16) compared to the male participants (n=7) while 28 males had a substance abuse problem compared to females (n=5). This is displayed on figure 4.2 above.

The Children's Global Assessment scale was used to assess 162 children aged above four years. More than half of them 89(54.9%) were grouped into the severe impairment of function category, see Table 4.

Table 4: Impairment of function according to Children's Global Assessment Scale (CGAS)

N=162

Score	**n (%)**
Normal function (>70)	32 (17.8)
Mild impairment - moderate (69-51)	41 (25.3)
Severe impairment <50	89 (54.9)

4.2: Pathways into child and adolescent mental health services

4.2.1: Interventions by primary caregiver after onset of mental symptoms

The medical facilities were the most popular portals in help seeking after the detection of symptoms with 82(49.8%) going to the Kenyatta National Hospital (KNH), a tertiary care facility, directly without referral from another medical facility. Some primary guardians opted to change the child's environment after the detection of symptoms by moving the child to a relative or changing to a different school 7(4.2%)

For the second intervention, the medical setting was still the most popular with 75(72.1%) seeking help from the Kenyatta National Hospital. Three caregivers (29%) sought help for their children's mental problems from consultant psychiatrists in private practice as the second intervention, while one sought help from a traditional healer (1%).

Fifty two caregivers went on to pursue a third intervention for their children's mental health problems, with most going to the Kenyatta National Hospital 48(92.3%). Only 2 (3.8%) sought help from a nonmedical setting.

Only ten participants in the study sample were taken for a fourth intervention in the study and they all went to the mental health clinic at the Kenyatta National Hospital.

Table 5 summarises the various interventions sought by the caregivers for their children's mental health problems. As noted above, the number of participants decreases sequentially with each intervention.

Table 5: Interventions sought by the primary caregivers after onset of symptoms

Variables	First Intervention N=166 n(%)	Second Intervention N=104 n(%)	Third Intervention N=52 n(%)	Fourth Intervention N=10 n(%)
Sought help in Hospital setting				
Kenyatta National Hospital	82 (49.4)	75 (72.1)	48 (92.3)	10 (100)
Casualty	*2 (1.2)*	*3 (2.9)*	-	-
Paediatrician	*6 (3.6)*	*9 (8.7)*	*2 (3.8)*	-
Neurologist	*5 (3.0)*	*1 (1.0)*	-	-
Mental health	*60 (36.1)*	*54 (51.9)*	*42 (80.8)*	*10 (100)*
Occupational therapy	*3 (1.8)*	*3 (2.9)*	*1 (1.9)*	-
Physician	*1 (0.6)*	*2 (1.9)*	*3 (5.8)*	-
ENT	*5 (3.0)*	*2 (1.9)*	-	-
Ophthalmologist	-	*1 (1.0)*	-	-
Psychiatry Referral Hospital (Mathari)	5 (3.0)	-	-	-
Psychiatrist in private practice	-	3 (2.9)	-	-
Other hospitals and clinics	50 (31.9)	14 (13.5)	2 (3.8)	-
Primary care	*14 (8.4)*	*4 (3.9)*	-	-
Secondary and tertiary hospitals	*31(18.7)*	*5(4.8)*	*2 (3.8)*	-
Private consultant clinics (specialist)	*5(3.0)*	*5(4.8)*	-	-
Pharmacy	1 (0.6%)	-	-	-
Sought help in a non medical setting				
Juvenile justice system	1 (0.6%)	2 (1.9)	-	-
Visited religious leader (pastor)	10 (6%)	5 (4.8)	1 (1.9)	-
Visited traditional healer	-	1 (1.0)	1 (1.9)	-
Sought help from counsellor	6 (2.6%)	4 (3.9)	-	-
Private counsellor/ psychologist	*3 (1.8%)*	*3 (2.9)*	-	-
School counsellor	*2 (1.2%)*	*1 (1.0)*	-	-
Drug rehabilitation centre counsellor	*1 (0.6%)*	-	-	-
Sought help from a school assessment centre	3 (1.8)	-	-	-
Change in environment	7 (4.2%)	-	-	-
Sought help from relatives	1 (0.6%)	-	-	-
Total	**166 (100%)**	**104 (100%)**	**52(100%)**	**10 (100%)**

The information on where to seek the first intervention mainly came from the caregiver 81(48.8%). The child's teacher also directed 50(30.1%) caregivers on where to go.

Most of the caregivers 43(41.3%) were directed towards the second intervention by medical practitioners while 2 of the caregivers (1.9%) were directed towards the second intervention by education assessment officers.

For the third intervention, medical practitioners initiated care for most of the caregivers 33(63.5%). The child's teacher initiated contact for three (5.8%) of the caregivers while a lawyer initiated contact for one (1.9%) caregiver.

Most caregivers got information about the fourth intervention after detection of symptoms from medical practitioners 8(80%). However, one caregiver got the information about the fourth intervention from the media 1(10%), while the other was directed by a pastor (10%).

Table 6 summarises who referred to the various intervention points.

Table 6: Initiator of contact for the various interventions after onset of symptoms

Who initiated contact	First Intervention N=166 n (%)	Second Intervention N=104 n (%)	Third Intervention N=52 n (%)	Fourth Intervention N=10 n (%)
Primary caregiver	81 (48.8)	23 (22.1)	6 (11.5)	-
Relative/friend	28 (16.9)	18 (17.3)	11 (21.2)	-
Childs teacher	50 (30.1)	12 (11.5)	12 (11.5)	-
Medical practitioner	5 (3.0)	43 (41.3)	33 (63.5)	8 (80)
Media (Radio)	1 (0.6)	-	-	1 (10)
Child's request	1 (0.6)	-	-	-
Police	-	2 (1.9)	-	-
Probation officer	-	-	1 (1.9)	-
Counsellors	-	3 (2.9)	-	-
Education assessors	-	2 (1.9)	-	-
Court order/ lawyer	-	1 (1.0)	1 (1.9)	-
Pastor	-	-	-	1 (10)
Total	**166 (100%)**	**104 (100%)**	**52 (100%)**	**10 (100%)**

4.2.2: Time taken between interventions by primary caregiver after onset of mental symptoms

4.2.2.1: Time between onset of symptoms and the first intervention of the study sample

Most caregivers seeking help for their children and adolescents did so within a week after the onset of symptoms. The mean time between onset of symptoms and seeking the first intervention was 11 months, (SD: 23.2), while the median time to the first intervention was one month. See table 7a and table 7b.

Table 7a: Time between the detection of symptoms and the first intervention

N=166

Time between symptoms and first intervention	N (%)
Within a week	60 (36.1)
Less than a month	20 (12.0)
1-6 months	39 (23.5)
7-12 months	11 (6.6)
13-24 months	16 (9.6)
25-36 months	8 (4.8)
37-48 months	4 (2.4)
49 months/more	8 (4.8)

Table 7b: Summary statistics of time between detection of symptoms and first intervention

Summary statistics	Time
Mean:	11 months
Median	1 month
Inter quartile range	11.5 months
Mode	1 week

4.2.2.2: Time between first and second intervention of the study sample

One hundred and four caregivers went on to seek a second intervention. Forty six of them (44.2%) took between one to six months to seek the second intervention. Overall, the mean time taken between the first and second intervention was 8 months (SD: 18.19) with a median time of 2 months.

Out of the 52 caregivers who went on to seek a third intervention for their children, most took 1-6 months 21(40.4%) between the second and third interventions. Only one (1.9%) took more than four years. The mean time taken between second and third intervention was 8 months (SD: 12.5), with a median time of 2 months.

Only 10 caregivers went on to seek a fourth intervention for their children's mental problems, and most took 1-6 months between the third and fourth interventions. The mean time between the third and fourth intervention was 4 months (SD: 4.89).

Tables 8a and 8b summarise the times taken between the various interventions

Table 8a: Time taken between the various interventions

Time	Between 1st and 2nd intervention N=104	Between 2nd and 3rd intervention N=52	Between 3rd and 4th intervention N=10
Within a week	17 (16.3)	6(11.5)	1(11.1)
Less than a month	14 (13.5)	9(17.3)	1(11.1)
1-6 months	46 (44.2)	21(40.4)	5(55.6)
7-12 months	13 (12.5)	6(11.5)	1(11.1)
13-24 months	5 (4.8)	5(9.6)	1(11.1)
25-36 months	4 (3.9)	3(5.8)	-
37-48 months	1 (1.0)	1 (1.9)	-
49 months/more	3 (2.9)	1(1.9)	-

Table 8b: Summary statistics of time taken between the various interventions

Summary statistics	Between 1st and 2nd intervention N=104	Between 2nd and 3rd intervention N=52	Between 3rd and 4th intervention N=10
Mean	8.0 months	8.0 months	4.35 months
Median	2.0 months	2.0 months	2.5 months
Inter quartile range	6.5 months	10.5 months	7 months
Mode	1 week	1 week	1 month

4.2.2.5: Time between onset of symptoms and getting to the child and adolescent mental health clinic

The longest time taken between onset of symptoms and finally reaching the child and adolescent mental health clinics was 183 months (15.25 years). The mean time taken was 16.6 months (SD: 26.03). Most of the caregivers took 1-6 months to get to the mental health clinic after onset of symptoms. See table 9a and table 9b.

Table 9a: Time between onset of symptoms and getting to the CAMH clinic

N=166

Time between third and fourth intervention	n (%)
Within a week	29(17.5)
Less than a month	7(4.2)
1-6 months	50(30.1)
7-12 months	22(13.2)
13-24 months	24(14.5)
25-36 months	14(8.4)
37-48 months	8(4.8)
49 months/more	12(7.2)

Table 9b: Summary Statistics of Time between onset of symptoms and getting to the CAMH clinic

Summary statistics	Time
Mean	16.6 months
Median	6.0 months
Interquartile range	22.6 months
Mode	1 week

4.3: Socio-demographic and clinical factors associated with the first intervention

4.3.1: Socio-demographic and clinical factors of the study participants associated with the type of first intervention

For analysis purposes, the intervention points were divided into medical (involving hospital settings) and non-medical interventions (involving non hospital settings of such as seeking an intervention from a religious leader, traditional healer or the juvenile justice system). Gender was found to significantly affect the pathway of care with more females (90.4%) being taken through the medical pathway by their caregivers than males (77%), (p=0.027). The association between the personal socio demographic characteristics of the study sample and the type of intervention are displayed on Table 10 below.

Table 10: Relationship between socio-demographic variables and the pathway

N=166

Variable	Medical Intervention	Non medical Intervention	X^2	p value
Age (years)				
0-9years	29 (90.6%)	3 (9.4%)		
10-18	109 (81.3)	25 (18.9%)	1.587	0.208
Gender				
Male	72 (77%)	21 (22.6%)		
Female	66 (90.4)	7 (9.6%)	4.923	***0.027**
Child's education				
Primary school	54 (84.4%)	10 (15.6%)		
Special school	9 (100%)	0 (0%)		
Secondary school	75 (80.6%)	18 (19.4%)		‡0.401

*: p<0.05 ‡: Fisher's exact test applied

Overall, there was no significant association between the type of first intervention and family information. A higher proportion of participants whose parents were married were taken through a medical intervention after detection of symptoms compared to the single or double orphans (78.2%) but this finding was not significant (p=0.242). A higher proportion (87.1%) of the respondents whose care was initiated by others sought the medical pathway compared to those whose care was initiated by the primary guardian. This was not statistically significant (p=0.166) as displayed on table 11.

Table 11: Relationship between family characteristics of the study participants and choice of first intervention

Variable	Medical intervention	Non medical intervention	X^2	p value
Type of Primary guardian				
Parent	125 (85.0%)	22 (15.0%)		
Non-parent	13 (68.4%)	6 (31.6%)		‡0.098
Parental status				
Parents married	95 (85.6%)	16 (14.4%)		
Single/ double orphan	43 (78.2%)	12 (21.8%)	1.438	0.242
Area of origin				
Out of Nairobi	83 (78.8%)	21 (20.2%)		
Nairobi	55 (88.7%)	7 (11.3%)	2.197	0.138
Father's education				
Up to secondary	55 (88.7%)	7 (11.3%)		
Tertiary	41 (82,0%)	9 (18.0%)	1.018	0.313
Mother's education				
Up to secondary	89 (85.6%)	15 (14.4%)		
Tertiary	41 (78.8%)	11 (21.2%)	1.131	0.288
Father's occupation				
Professional	35 (85.4%)	6 (14.6%)		
Non-professional	61 (85.9%)	10 (10%)	0.006	0.936
Mother's occupation				
Professional	27 (84.4%)	5 (15.6%)		
Non-professional	103 (83.1%)	21 (16.9%)	0.031	0.859
Initiator of care				
Primary guardian	64 (79%)	17 (21%)		
Others	74 (87.1%)	11 (12.9%)	1.915	0.166

‡ Fisher's exact test applied

Among the mental and physical disorders in the study sample, Disruptive disorders (p=0.019) and physical conditions (p=0.015) were found to be significantly related to the type of pathway to care. Participants without disruptive disorders (87%) were more likely to seek the medical pathway compared to those who had a disruptive disorder. These findings are displayed in Table 12 below.

Table 12: Relationship between mental and physical disorders in the study sample and choice of first intervention

N=166

Diagnosis	Medical intervention	Non medical intervention	X^2	p value
Psychotic & Bipolar				
Present	16 (76.2%)	5 (23.8%)		
Absent	122 (84.1%)	23 (15.9%)		‡0.358
Depression and Anxiety related				
Present	35(87.5%)	5 (12.5%)		
Absent	103(81.7%)	23 (18.3%)	0.717	0.397
Disruptive disorders				
Present	30 (71.4%)	12(28.6%)		
Absent	108 (87%)	16 (12.9%)	5.493	***0.019**
Substance use disorders				
Present	25 (75.8%)	8 (24.2%)		
Absent	113 (85 %)	20 (15.0%)	1.598	0.215
Autism spectrum				
Present	19 (90.5%)	2 (9.5%)		
Absent	119(82.1%)	20 (15.0%)		‡0.534
Physical disorders				
Present	23 (100%)	0 (0%)		
Absent	115 (80.4%)	28 (19.6%)		‡***0.015**
Suicidality				
Present	16 (69.6%)	7 (30.4%)		
Absent	122 (85.3%)	21 (14.7%)		‡0.075
Intellectual disability				
Present	16 (88.9%)	2 (11.1%)		
Absent	122 (82%)	26 (17.6%)		‡0.741
[a]Others				
Present	20 (87%)	3 (13.0%)		
Absent	118 (82.5%)	25(17.5%)		‡0.429

‡ Fisher's Exact test applied * $p<0.05$

[a] Others: Tic disorders, Enuresis and other conditions that may be a focus of clinical attention

Children and adolescents with severe impairment of function (79.8%) were less likely to be taken for a medical intervention compared to their counterparts who had normal functioning and mild impairment of function (86.3%). This finding was however not statistically significant (p=0.274), see table 13 below.

Table 13: Relationship between impairment of function according to the Children's Global Assessment scale and choice of first intervention

N=162

Clinical severity	Medical intervention	Non medical intervention	X^2	p value
Normal to mild	63 (86.3%)	10 (13.7%)		
Moderate to severe	71 (79.8%)	18 (20.2%)	1.195	0.274

4.4.2: Logistic Regression Analysis of Socio demographic and Clinical factors Independently associated with Medical and Non medical Intervention

Socio demographic and clinical factors significantly ($p<0.05$) or almost significantly ($p<0.1$) associated with type of first intervention on bivariate analysis were entered into a logistic equation. The odds ratio and 95% confidence intervals from multiple logistic regression of the medical intervention on gender, type of guardian and clinical conditions (disruptive disorders, suicidality) are shown on table 14 below.

After adjusting for type of guardian, disruptive disorders and suicidality, females were three times more likely to be taken for medical care compared to males (OR 2.9, 95% CI =1.17-7.77).

Table 14: Logistic regression analysis of seeking medical intervention on gender type of guardian, disruptive disorders and suicidality

Variable	Odds ratio	95% [a]CI	P value
Gender			
†Male	1	1.08-7.84	***0.034**
Female	2.96		
Type of guardian			
Parent	0.35	0.11- 1.11	0.075
†Non parent	1		
Disruptive disorders			
†Present	1	0.81-4.86	0.133
Absent	1.97		
Suicidality			
†Present	1	0.96-7.88	0.059
Absent	2.75		

[a] CI. : Confidence interval *: p <0.05 †: reference variable

4.3.3: Socio-demographic and clinical factors of the study participants associated with the time taken between onset of symptoms and first intervention

Kaplan Meier's Log rank survival test was used to look for an association between the socio-demographic and clinical factors with the time taken to seek care for the first time after the detection of symptoms. In this study, first intervention was taken to be the event during analysis.

Children enrolled in special school were likely to take longer to be taken for the first intervention (median time = 3.00 months) than those in primary school or secondary school. This finding was not statistically significant (p=0.097) as displayed on table 15.

Table 15: Relationship between time taken to initially seek care and personal socio demographic characteristics of the study participants (Event: First intervention)

N=166

Variable	Median time to event (months)	Range	§X^2	p value
Age (years)				
0-9years	2.0	56.87		
10-19	1.0	161.87	0.074	0.786
Gender				
Male	2.0	63.87		
Female	0.25	161.87	0.196	0.658
Child's education				
Primary school	2.0	161.87		
Special school	3.0	119.87		
Secondary school	0.5	155.62	4.668	0.097

§ X^2=Median test statistic

Table 16 displays the relationship between time to first intervention after detection of symptoms by the caregiver and the family information of the study participants. Residing out of Nairobi was associated with a longer duration of seeking the first intervention after onset of symptoms (median time=2 months) compared to living in Nairobi (median time<1 week). This finding was not statistically significant (p=0.369). Having the first intervention initiated by someone who was not a primary caregiver was found to result in a longer time to seek initial help after the detection of symptoms than if the care was initiated by the primary caregiver (p<0.005).

Table 16: Relationship between time taken to first intervention and the family characteristics of the study participants (Event: seeking care for the first time)

Variable	Median time to event (months)	Range	§X^2	p value
Area of origin				
Nairobi	0.25	155.62		
Out of Nairobi	2.0	161.87	0.806	0.369
Type of Primary guardian				
Parent	1.00	161.87		
Non-parent	2.00	63.87	0.929	0.335
Parental status				
Parents married	0.5	161.87		
Single parent/orphan	2.0	59.87	0.160	0.689
Father's education				
Up to secondary	0.5	161.87		
Tertiary	0.5	155.62	0.126	0.723
Mother's education				
Up to secondary	0.5	161.87		
Tertiary	2.0	155.62	0.030	0.863
Father's occupation				
Professional	1.75	155.62		
Non-professional	0.5	161.87	0.057	0.811
Mother's occupation				
Professional	1.0	37.87		
Non-professional	1.0	161.87	0.697	0.404
Initiator of care				
Primary guardian	1.3	59.87		
Others	3	161.87	13.0	***0.005**

§: X^2= Median test statistic

*: $p<0.05$

Disruptive disorders were found to have a significant relationship ($p<0.005$) with the time taken to seeking care among the clinical variables. Those with a disruptive disorder (median time=17.5 months) were predicted to take longer to be taken for the first intervention after detection of symptoms than those who did not have a disruptive disorder (median time<1 week), see table 17.

Table 17: Relationship between mental and physical disorders in the study sample and time to first intervention (Event: First intervention)

Disorder	Median time to event (months)	Range	§X^2	p value
Psychotic & Bipolar				
Present	1.30	161.87		
Absent	1	155.62	1.754	0.185
Depression, Anxiety, Somatoform and Adjustment				
Present	0.5	155.62		
Absent	1.0	161.87	0.008	0.929
Disruptive disorders				
Present	17.5	155.62		
Absent	0.25	161.87	16.126	***<0.005**
Substance use disorders				
Present	2.0	63.87		
Absent	1.0	161.87	0.074	0.785
Autism spectrum				
Present	3.0	161.87		
Absent	1.0	155.62	1.046	0.306
Physical disorders				
Present	0.13 (< a week)	155.62		
Absent	1.0	161.87	0.031	0.843
Suicidality				
Present	0.25	47.87		
Absent	1.0	161.87	1.889	0.169
Intellectual disability				
Present	3.0	43.87		
Absent	0.5	161.87	0.421	0.516
[a]Others				
Present	1.00	21.87		
Absent	1.00	161.87	3.625	0.057

$p<0.05$ [a] Others: Tic disorders, Enuresis and other conditions that may be a focus of clinical attention

§: X^2= Median test statistic

The median time taken to seek the first intervention by the caregiver after the detection of symptoms was similar in those who had severe impairment of function and those who had mild impairment. The relationship between impairment of function and the time to the first intervention after detection of symptoms was not statistically significant (p=0.685), see table 18.

Table 18: Relationship between time taken to first intervention and impairment of function (Event: seeking care for the first time)

N=166

[a]Illness severity	Median time to event (months)	Range	[§]X^2	p value
Normal/mild (100-61)	1.0	155.62		
Mod/ severe (<60)	1.0	161.87	0.164	0.685

[a] Measured by CGAS (Children's Global Assessment Scale)

[§]: X^2= Median test statistic

4.3.4: Cox regression analysis of socio demographic and clinical factors independently associated with the time taken to the first intervention after detection of symptoms

Socio demographic and clinical factors significantly or almost significantly associated with the time taken to seek help after the detection of symptoms on survival analysis were taken through Cox regression analysis. Hazards ratio and 95% confidence intervals from cox regression for these factors are shown on table 19.

After adjusting for the initiator of care and the clinical diagnosis of the disorders falling into the others category, it would take a participant having a disruptive disorder 1.8 times longer (HR 1.8 95% CI=1.26-2.64) to be taken for the first intervention than one without a disruptive disorder. Similarly, care being initiated by another party other than the primary guardian would result in the participant taking 1.6 times longer (HR 1.6 95% CI=1.16-2.19) to be taken for the first intervention after the detection of symptoms than when the care is initiated by the primary caregiver after adjusting for the respective covariates. See table 19 below. Figure 4.3 is the graphical presentation of the Hazard Function.

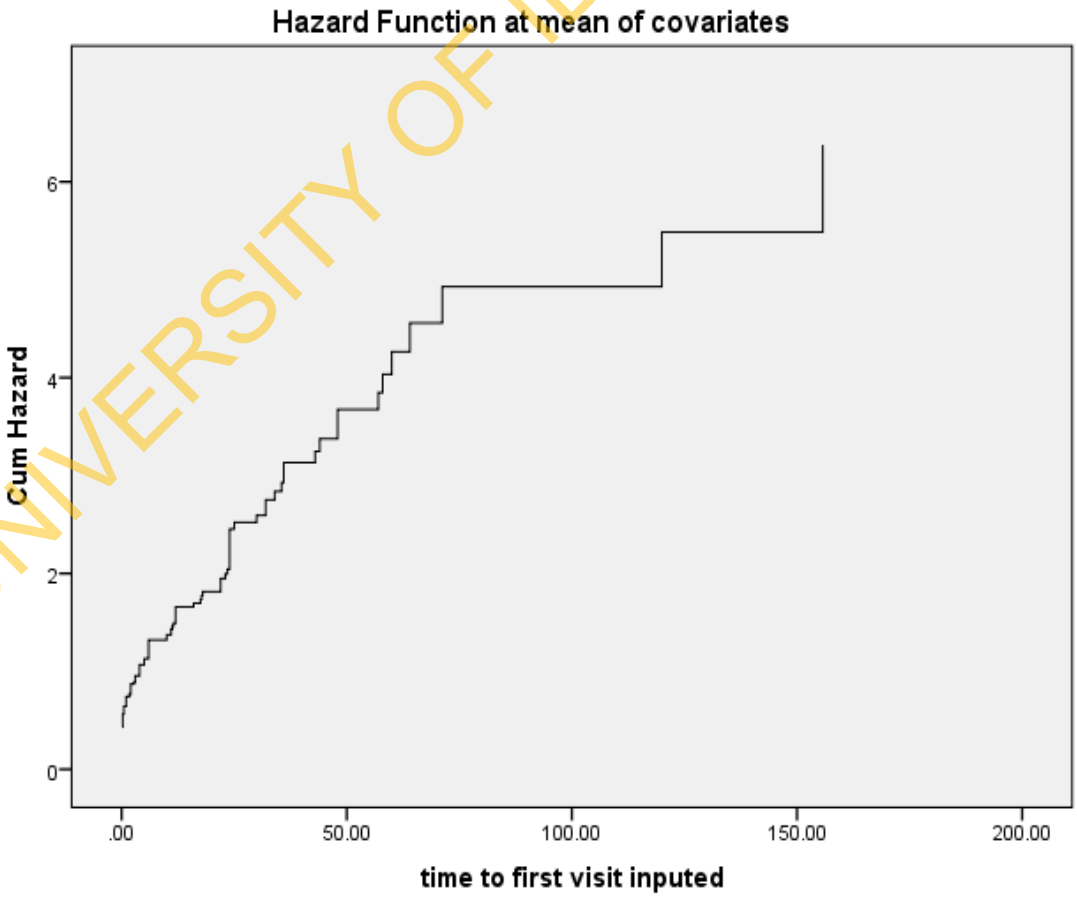
Table 19: Cox regression analysis of median time to help seeking after detection of symptoms on disruptive disorders, other disorders and the initiator of care

Variable	Hazards ratio	95% [a]c.i.	p value
Disruptive disorders			
†Present	1.82	1.26-2.64	***0.001**
Absent	1		
[a]Others			
Present	1.30	0.82-2.04	0.265
†Absent	1		
Initiator of care			
Primary guardian	1.60	1.16-2.19	***0.004**
†Others	1		

p<0.05 †: reference variable

[a] Others: Tic disorders, Enuresis and other conditions that may be a focus of clinical attention

Figure 4.3: Graphical representation of the Hazard Function (Time in Months)



4.4: Barriers to accessing child and adolescent mental health services.

4.4.1: Perceived causes attributed to the symptoms of the mental and physical disorders presenting to the mental health clinic

Many of the caregivers thought the symptoms displayed by the patient were normal childhood and adolescent behaviour 18(10.8%), while others attributed a curse or spiritual cause 20(12.0%) to the symptoms. Twenty five (15%) did not recognise the symptoms as a problem until it was pointed out to them by someone else. Only 7(4.2%) thought it was due to a mental disorder or that the symptoms were hereditary 2 (1.2%).

A summary of the perceived causes and beliefs are displayed on table 20

Table 20: Perceived causes attributed to the symptoms of the mental and physical disorders presenting to the CAMH clinic

N=166

Theme	Number of mentions n(%)	Examples
Peer Influence	39(23.5)	'*Bad associations at school*' '*Peer pressure*' *'Bad influence by the matatu (transport) boys… bad crowd*' '*Lesbianism in school*'
Physical Illness	30(18.1)	**'***Previous ringworm infection*' '*Pneumonia has gone to the head*' **'***The child has a hearing problem. It is not mental*'
Don't Know the cause	25(15.1)	*'Did not know it was a problem until teacher referred her*' *Didn't even know the child had a problem until a doctor pointed it out*' '*Didn't know what to think. Was puzzled*'
Spiritual/ family curse	20(12.0)	'*He was like a person possessed by demons'* '*Jealousy in the family'* '*Spiritual: house girl was from a different tribe'* '*Clan problems on husband's side'* '*Bewitched so that head doesn't work'*
Normal childhood /adolescent behaviour	18(10.8)	*'Thought it was childhood behaviour*' '*Child is not unwell. She just reacted normally*' '*Not an illness. The child was provoked*'

(Table 20 continued)

Table 20: Perceived causes attributed to the symptoms of the mental and physical disorders presenting to the CAMH clinic

N=166

Theme	Number of mentions n(%)	Examples
Others	8(4.8)	**'***Related to emotions after discipline (had previously been slapped by the grandmother)*' '*Laziness; self-neglect*' '*Didn't want school'* '*Blamed self, maybe she had wronged the daughter*' '*At some point thought she was faking it'*
Poor upbringing / Indiscipline	8(4.8)	*'Thought it was just indiscipline or he was broke'* '*Rebellion due to lack of a father'* '*Just bad mannered'* *Did not know, but teacher thought it was poor upbringing*'
Mental Disorder	7(4.2)	'*Brain problem*' '*Autism. Had heard of it*' **'***Psychological, parent is a counsellor*'
Stress	7(4.2)	'*Was releasing stress (had some family problems)'* **'***Stress from school'*
Trauma	6(3.6)	**'***Previous head injury* *'Brain injury. She also had convulsions'* *'Rape'*

(Table 20 continued)

Table 20: Perceived causes attributed to the symptoms of the mental and physical disorders presenting to the CAMH clinic

N=166

Theme	Number of mentions n(%)	Examples
Bullying		*'Bullying at new school'*
	4(2.4)	*'Child was being victimised'*
Developmental Delay		**'***Just a delay that would pass*'
	4(2.4)	'*Just a late bloomer*'
Drug abuse		**'***Believed he was using drugs. Had been caught with cigarettes in 2012*'
	4(2.4)	'*Cerebral malaria or drug abuse*'
False Allegation		**'***Not clear if son actually used alcohol at school*'
	3(1.8)	'*The school was witch hunting*'
Person's Nature		*'Her personality'*
	3(1.8)	*'It was his trait'*
Hereditary		**'***Birth family problem'*
	2(1.2)	**'***Characteristics in the family. The father's sister is odd'*
Rite of Passage		**'***Not coping well with young ones after circumcision, hence keeping to self'*
	2(1.2)	*'After circumcision, he felt he was a man'*

The most common themes were cross-tabulated with the disorders in the study sample. Table 21 demonstrates that caregivers of children presenting with substance related disorders thought peer influence was the cause, while those whose children presented with psychotic disorders thought the symptoms had a spiritual cause.

Table 21: Perceived cause of the mental health problem by the caregiver matched with the disorder

	Perceived causes n(%)					
Disorders	**Peer influence**	**Physical illness**	**Didn't know**	**Spiritual**	**Normal behaviour**	**Poor upbringing**
Psychotic disorders and bipolar disorders	2 (9.5)	6(28.6)	1(4.8)	8(38.1)	0	0
Depression, anxiety, somatoform and adjustment disorders	4 (10%)	9(22.5)	10(25)	3(7.5)	1(2.5)	3(7.5)
Disruptive disorders	10(23.8)	1(2.4)	9(21.4)	4(9.5)	5(11.9)	4(9.5)
Substance related disorders	24(72.7)	2(6.1)	4(12)	1(3)	2(6.1)	3(9.1)
Autism spectrum disorders	0	6(28.6)	5(23.8)	3(14.3)	0	0
Physical disorders	0	9(39.1)	6(26.1)	2(8.7)	0	0
Intellectual disability	0(0%)	4(22.2)	4(22.2)	4(22.2)	0	0
Others: Tic disorders, Enuresis and Other conditions that may be a focus of clinical attention	5(21.7%)	2(8.7)	1(4.3)	1(4.3)	8(34.7)	1(4.3)

4.4.2: Reasons for not taking the child for an intervention immediately after detection of symptoms

Eighty three care givers did not take the child for an intervention immediately after the detection of symptoms. Various reasons were given for this. Majority of the caregivers 39(47%) thought that the problem would resolve without any intervention, 17 (20.4%) reported that they did not know it was a problem and 24 (28.9%) did not know what to do or where to go after they detected the symptoms. See table 22 below.

Table 22: Reasons for not seeking help within a week of recognition of symptoms

N=83

Theme	Number of mentions n(%)	Example
Thought Child would get better	39(47.0)	*'Thought that it was a bad habit that would pass'* *'Thought problem would subside by itself'* *'Was not sure whether it was a phase or not'*
Lack of awareness	24(28.9)	*'Was not sure where to go or what to do'* *'Has had to change schools for son thinking its peer pressure'* *'Didn't know of the clinic. Happened upon it during a visit to the hospital'* *'Didn't know where to go'*
Did not know it was a problem	17(20.5)	*'They thought it was exam stress and the child was pretending to avoid consequences'* *'Thought it was normal'* *'Thought it was his nature'*
Others	4(4.8)	*'Thought it was adjustment to the children's home and her personality'* *'She had just come under their care'* *'Child had several physical illnesses as well. Rickets, pneumonia'*
Hospital is not a right choice	3(3.6)	*'Parent used corporal punishment first'* *'first changed schools'*
Child was not available for immediate help seeking	2(2.4)	*'Daughter was in boarding school when she found out. Waited for her to come home from school'* *'Waited for the school term to end'*

Fifty per cent of the study participants were not taken for an intervention within a week of detection of symptoms. Caregivers of 31% of the children who had a disruptive disorder did not seek help immediately as they thought the child would get better, while 27% of caregivers to children with substance use related disorders did not do so as they did not know where to go. See table 23

Table 23: Reasons given for not seeking help within a week by the caregivers matched with disorders

N=83

	Reason for not seeking help immediately n(%)		
Disorders	**Thought would get better**	**Lack of awareness**	**Didn't know it was a problem**
Psychotic and bipolar disorders	3(14.3)	2(9.5)	3(14.3)
Depression, anxiety, somatoform and adjustment disorders	7(7.5)	2(5.0)	3(7.5)
Disruptive disorders	13(31.0)	8(19)	5(11.9)
Substance related disorders	4(12.1)	9(27.3)	5(15.2)
Autism spectrum disorders	9(42.9)	2(9.5)	0
Physical disorders	3(13.0)	2(8.7)	0
Intellectual disability	10(55.6)	1(5.6)	0
Others: Tic disorders, Enuresis and Other conditions that may be a focus of clinical attention	5(21.7)	3(13)	0

4.4.3: Barriers encountered while seeking help for the child

These were divided into personal barriers, barriers related to the medical facilities and barriers related to the staff working at the medical facilities.

4.4.3.1: Personal barriers

Having financial problems was the most common personal barrier cited by the caregiver while seeking help for the child's mental health problem (n=30). Fourteen of the caregivers reported having experienced conflict about the cause and treatment of their child's disorder. This is further demonstrated on table 24 below.

Table 24: Personal barriers encountered while seeking help for the child

Theme	Number of mentions	Examples
Financial	30	**'***Financial problems, drugs are expensive'* '*Financial: fare, buying drugs'* '*Financial -medication, fare'*
Lack of awareness	21	**'***Not knowing what is wrong with the child'* '*Not knowing of this facility before'* '*Not knowing what to do'* *'For a long time didn't understand what was wrong'*
Problems related to school	12	**'***Teachers don't understand. She has changed schools twice; once due to expulsion.'* '*Problems looking for a school'* *'Special school she went to didn't categorise to ability and child started regressing*' *'Has lost school time has changed schools because the teachers were afraid when he gets unwell in school'*
Conflict over nature of problem	14	**'***Confusion over cause, people telling her its demons, drugs and that it's not a doctor's disease'* '*Believes teachers might be wrong'* '*Is wondering about the school management. Something not right with them'* '*Has been told its not normal illness, people have brought her herbal remedies'* '*Has received all sorts of advice: family problems, birth problems, he is bewitched and it will stop on its own'*
Perceived stigma/Self blame	13	**'***Can't believe it. Wonders if he did something wrong in the daughters upbringing'* '*Feels judged when child acts out in public. She can be very friendly to strangers, talks loud. It's embarrassing*' '*Mother feels judged. Has been told its poor parenting'* '*People think it's her fault'*

4.4.3.2: Staff related barriers

Regarding staff working in the medical facilities, some caregivers cited that they perceived some of their previous providers to be inexperienced or that they lacked the necessary knowledge (n= 17) see table 25.

Table 25: Barriers encountered while seeking help for the child relating to medical staff

Theme	Number of mentions	Examples
Lack of knowledge or inexperience	17	**'***Personnel not knowing where to refer'* *'Some previous doctors had said he was pretending and the mother believed and ignored the problem'* *'She was discharged with no diagnosis from the ward'* *'Out of town clinicians don't understand her problem'* *'Some of the psychiatric nurses in the district are not knowledgeable'* *'Some previous doctors told her it was not an illness'*
Others	2	**'***Son reports wants a younger person he can comfortably talk to'* *'Had difficulties finding a counsellor for the son's age'*

4.4.3.3: Barriers related to the hospital facilities

The main problem mentioned regarding the hospital facilities was the long waiting time (n=25), however, inadequate facilities were also cited by six of the caregivers as displayed in table 26.

Table 26: Barriers related to hospital facilities encountered while seeking help for the child

Theme	Number of mentions	Examples
Long waiting time	25	*'Takes too long to be seen and the child gets bored and impatient and starts disturbing'* *'Long waiting times everywhere. The clinic, for invoice generation'* *'Long waiting time and people have to go to work after clinic'* *'It takes too long to get an appointment. Two months'*
Distance	7	**'***The distance and traffic jam* *'Hospital far. Daughter has to travel by night bus to get to the doctor'*
Inadequate facilities	6	**'***Not enough rooms to see patients'* *'Drug stock outs'* *'Some hospitals have no medications'* *'There is not enough room for the counsellors to use'*

4.5: Suggested interventions by the service user towards improving child and adolescent mental health service delivery

Table 27 demonstrates that increasing awareness about the child and adolescent mental health services was suggested by nine of the service users, while five caregivers requested for the formation of support groups to help them cope.

Table 27: Suggested interventions towards improving child and adolescent mental health service delivery

Theme	Number of mentions	Example
Make facilities /specialists more accessible	13	**'***Avail the medication in the hospital. There is no Ritalin at Kenyatta Hospital and its difficult to get'* '*Open more centres and have youth camps run by psychologists and psychiatrists'* '*Create a mental unit for children (for admission)'* '*Have similar centres out of Nairobi'* '*Have a help line. She would like to call in for assistance'*
Modify clinic set up	10	**'***Bored at the waiting bay. Provide entertainment at the waiting bay'* *'Have privacy'* '*Get bigger clinic space and more rooms'* '*Add more consultation rooms to the clinic'*
Increase awareness about the clinic	9	**'***Create awareness about clinic. Not many people know about the clinic'* '*Have a fun day to promote the clinic* '*We should take our services to schools and talk to youths*' '*Advertise the clinic'*
Get more staff/doctors	7	**'***Have more staff at the pharmacy and clinic*' '*Get younger counsellors*.' '*Add more staff for patient reviews'*
Improve on time keeping	6	**'***Doctors should work faster'* '*Need more room at the clinic to serve clients faster and decrease waiting time'* '*Decrease the waiting time'*
Support group	5	**'***Call parents for seminars on how to cope'* '*Get a group for children with autism and get special toys and materials for children with autism'* '*Form an autism support group for the clinic and have a help line. She would like to call in for assistance'*
Support with drugs and fare	2	**'***Support with fare and medication'* '*Free medication'*
Home follow-up	1	**'***Have home visits. Follow-up at home would help'*

CHAPTER V

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1: Discussion

This study of 166 children looked at the various interventions utilised and the pathways taken by their caregivers as they sought help for their children's mental health problems and eventually arrived at the child and adolescent mental health clinic at the Kenyatta National Hospital, a tertiary health facility. Various socio demographic and clinical characteristics of the study participants and their caregivers were related to factors in the pathway such as the type of intervention used and the time interval between the onset of symptoms and the intervention.

Information about the caregiver's beliefs as to the cause of mental health problems, perceived barriers to care and their suggested interventions to improve services are also discussed.

The study participants were aged 2-18 years with a mean age of 13.6 years (SD=4.16), with the males predominating the sample at all age groups. The gender characteristics observed in this study are similar to what has been reported in other child clinic populations (Omigbodun 2004; Sarwat *et al*. 2009; Jayaprakash 2012). A similar study of 127 children and adolescents referred to a tertiary care facility in Ibadan, Southwest Nigeria, had a mean age of 12.7 years and a higher proportion of males (62%) presenting at the child and adolescent mental health clinic (Omigbodun 2004).

Compared to the lower age groups (<10 years) the proportion of females using the mental health service in this study was noticed to increase in the adolescent age group. This observation is similar to findings in child psychiatry clinic populations in South Africa and the United States of America (Raman & van Rensburg 2013; Merikangas *et al*. 2010). Epidemiological studies reveal a preponderance of depression in females around the age of 13 years resulting in the increased proportion of girls in mental health facilities (Merikangas & Nakamura 2011), a finding that was consistent with the current study. In the youngest age group, the reasons for the much larger proportion of males observed can be accounted for by the well established fact that all developmental disorders are commonly found in boys (Chakrabarti & Fombonne 2005).

Most of the study participants who came to the child and adolescent mental health service at the Kenyatta National Hospital, Nairobi were from Nairobi and its environs within an 80km radius. The fewest came from Nyanza province, which is furthest from the Kenyatta National Hospital. The presence of Moi Teaching and Referral Hospital, (Kenya's second national referral hospital after Kenyatta National Hospital) 313 km North west of Nairobi and whose immediate catchment area covers Rift Valley, Western and Nyanza provinces would explain why a low proportion of participants came from this distant area. There were no participants from the Coast Province, which is more than 400 km from Nairobi. This region however has mental health services manned by psychiatrists, which the community is able to access. There were no participants from North Eastern province, which has no psychiatrists and is far from both Kenyatta National Hospital and Moi Teaching and Referral Hospital (367km and 650 km respectively). This region of Kenya is fraught with conflict and

instability as a result of terrorist attacks and may account for the lack of psychiatrists and mental health services in a region with much need.

There was only one Muslim among the study participants while the rest were Christians, probably because the predominant religion in Kenya is Christianity (82%), and the few Muslims predominantly live in the Coastal and North Eastern provinces, far from the site of the study (The Office of the President: Republic of Kenya 2010).

Individuals suffering from psychiatric disorders are more likely to have a truncated education due to the disability from the disorder (Kessler *et al*. 1995). More than 90% of the participants of school going age in the study were attending either mainstream or special school. This proportion of in-school attendees at the child and adolescent mental health service is much higher when compared to findings from similar studies in West Africa. Omigbodun (2004) reported that over a quarter (27.6%) of children who presented in a child and adolescent mental health clinic at a tertiary health facility in Ibadan, Southwest of Nigeria were not attending school. Similarly, a study of children presenting to a tertiary health facility study in Maiduguri, Northeast of Nigeria revealed that over half of their study participants with a mean age of 12.3 years were not in school (Abdulmalik & Sale 2012). A reason for this difference may be that service users presenting to these tertiary facilities in both North and South of Nigeria had more severe and disabling disorders than in the Kenyan clinical setting, where substance abuse disorders were the most prevalent while psychotic disorders were found to be more prevalent in the Nigerian clinical settings as described below. A recent report from UNICEF revealed that the West African region had the lowest primary school enrolment rates in the world and this could have contributed to the

higher proportion of participants not in school in the Nigerian clinical setting (UNICEF 2015).

A five year survey of children and adolescents referred to a neuropsychiatry hospital in Lagos, Southwest Nigeria revealed that psychotic disorders (38%), were most prevalent disorders in that clinical setting closely followed by seizure disorders (34%) but very low depressive disorder rates (1.3%) (Omigbodun & Ogun 2005). Similarly, a study conducted at a child and adolescent mental health clinic also in the Southwest region of Nigeria revealed high rates of psychotic disorders (32.3%), low depressive disorder rates (1.6%) and seizure disorders at 11% (Omigbodun 2004). Conversely, Raman & van Rensburg (2013), found ADHD (24%) and depressive (17.8%) disorders were the most prevalent diagnosis in an urban child mental health clinic at a tertiary children's hospital in Johannesburg, South Africa. A study featuring 100 participants aged between 13 and 18 years attending a psychiatry clinic at a tertiary care hospital in Nepal found depressive disorders were most prevalent at 20%, followed by anxiety disorders (16%) (Shakya 2010). In the current study, mental disorders most diagnosed were substance use related disorders, specifically cannabis use followed by depressive disorders. Cultural contexts and beliefs may be associated with parental differences in tolerance thresholds and their perceptions on whether or not a problem behaviour is mental health related (Ivert *et al*. 2011).

The high presentation of substance use disorders to the child and adolescent mental health clinic in the Kenyan setting could be due to the intensified public and media campaign against drugs and alcohol in the country by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA 2015).

This study identified medical pathway as the most used first portal of care sought out by caregivers after the detection of the child's symptoms. Half of the caregivers in the study sought for help at the Kenyatta National hospital, a tertiary facility as a first intervention, with more than a third of them accessing the mental health service directly. A very small proportion of the caregivers sought help from primary care as a first intervention. There is a dearth of psychiatrists in Kenya, where the estimated ratio is one psychiatrist to half a million people (Kiima & Jenkins 2010; Ndetei *et al*. 2007) explaining why the caregivers would seek help from secondary medical facilities, where they expect to find a mental health specialist.

The WHO recommends equipping primary health care workers with the knowledge to recognise and treat mental health disorders, leaving the specialists to deal with the more severe disorders and act in a supervisory capacity (WHO 2010). The Mental Health Gap Action Programme (mhGAP) which entails the scaling up of services for mental, neurological and substance use disorders has been identified as useful in this regard, as it brings the mental health services to the people (WHO 2010). Primary care services in Kenya are mainly offered by nurses and clinical officers (non-physician clinicians). A programme to train primary care workers on mental health care was rolled out in 2005. The Kenyan Ministry of Health, the Kenya Psychiatrists Association, WHO collaborating centre and the Kenya Medical Training Centre ((KMTC) the body that overseas the training of nurses and clinical workers) embarked on a collaborative project to train primary care and community health workers about mental health and integrate mental health in their routine work (Jenkins, *et al.* 2010). The training was delivered through KMTC and integrated into their regular training curriculum of general nurses and clinical officers, while for the already qualified nurses and clinical officers in practice, it was offered on CPD

(Continuous Professional Development) credit. The training was found to have positive impact on the 1671 primary care workers trained over the five year period, indicating high mean change in knowledge scores and an impact on attitudes as qualitative observations after training indicated improved assessment and diagnosis of individuals with mental health problems (Jenkins, *et al.* 2010). It was however recognised that it was challenging to scale up services to deal with mental health disorders in primary care in the already constrained human and financial resources (Jenkins, *et al.* 2010). Creating awareness on the existence of mental health services in primary care would be beneficial to the community.

Traditional and religious leaders have been identified in several studies as playing a key role as a first intervention in the pathway to care for mental health disorders (Gater *et al.* 2005; Kauye *et al*. 2014; Girma & Tesfaye 2011; Razali & Najib 2000; Coton *et al.* 2008; Bakare 2013). A pathways to care study conducted at an out patient psychiatry clinic at a tertiary health care facility in Maiduguri, Northeast Nigeria, revealed that 34% of the participants had been taken for care to traditional and religious leaders before presenting at the tertiary facility (Abdulmalik & Sale 2012). Similar observations were made in an adult based study at a tertiary mental health facility in Jaipur India, where 39.5% of the study participants had visited a faith healer and 4% had visited alternative medicine providers (Ayurveda and acupuncture practitioners) before visiting the health facility (Jain *et al.* 2012). These findings are however not consistent with the current study conducted in an African setting, where only 6% of the caregivers sought care from a religious leader as a first intervention and only 1.2% of the caregivers reported having taken their child to a traditional healer at one point in the pathway. In Kumasi, Ghana only 6% of the 322 adult patients presenting for psychiatry services at the four mental health clinics in the city

had seen a traditional healer and only 32% had seen a pastor for their mental health needs before visiting the medical facilities (Appiah-Poku *et al.* 2004). The authors of the study proposed that there might have been fewer traditional healers in the urban setting where the study was conducted accounting for the low numbers of patients who visited a traditional healer.

Of interest however, Mbwayo *et al*. (2013) demonstrated traditional healer presence and their involvement in the treatment of mental disorders in the city of Nairobi Kenya (where the current study was conducted) after interacting with 59 traditional healers and 305 of their adult patients in a Nairobi slum settlement. Ninety five per cent of those who went to traditional healers reported that they were satisfied with the services. Almost half of the patients in that study visited traditional healers because they felt they were not adequately treated at hospitals, while others thought hospitals were too expensive. Although this was an adult study, the implications resonate in child and adolescent mental health. It is probable that many children are being taken to traditional healers and not finding their way into the mental health services, also emphasised by the fact that 12% of the caregivers in the current study reported associating a spiritual problem or a curse with the child's presenting symptoms.

Ganasen *et al.* (2008) proposed educating and updating traditional healers of newly acquired knowledge in the mental health field without being dismissive of their cultural beliefs and including them in appropriate referral system as a way of facilitating the patient's access to mental health care. This recommendation was also proposed by Assad *et al.* (2015) after observing that 40.8% of 350 adult patients sought help from traditional healers before and after seeking psychiatry services for bipolar disorder treatment in three different private and government psychiatry

hospitals in Cairo, Egypt. This concept of developing a positive collaborative relationship with traditional healers could be challenging to enforce. In two focus group discussions involving 70 traditional healers in Maseno, Western Kenya, traditional healers expressed their desire to collaborate with formal health services as they recognised their limitations in treating conditions such as tuberculosis, meningitis, malaria and HIV. However, they also believed that they could treat patients whom doctors and nurses could not treat such as those bewitched and possessed by demons and in turn also requested a base in primary care to assist in treatment (Okonji *et al.* 2008).

The females in this study were predicted to be three times more likely to be taken for a medical intervention after the onset of symptoms compared to their male counterparts. Zwaanswijk (2005) who found that more help was sought for girls in late adolescence, while it was sought more for boys in early childhood. This finding was explained by the fact that externalising problems more prevalent in boys decreased with age while internalising problems that were more common in girls increased with age. In the current study, the numbers of girls presenting to mental health care increased in the older age group, and there was indeed a higher prevalence of depressive disorders in females than males as well as somatoform disorders and a higher proportion of males having disruptive disorders. Along the same lines, it emerged from the current study that having a disruptive disorder would result in the caregiver taking almost two times longer to seek a first intervention than if the disorder was not disruptive in nature, and in addition, the intervention was more likely to be non medical in nature. Findings from a study in Croydon, United Kingdom that looked at 127 children (5-11 years) who had ADHD compared those who had passed though a mental health service with those who had not. The study revealed that

presenting complaints to medical facilities are more likely to be physical rather than behavioural (Sayal *et al*. 2002). This would explain why girls in the current study would be more likely to present to a medical facility given the nature of the presenting complaints. Further more, parental concern about being blamed may contribute to the reluctance to identify the behaviour as a complaint for children with disruptive disorders in a clinical setting (Sayal *et al*. 2002). Children and adolescents having conduct disorders may also not present to medical facilities, as they are more likely to be found in conflict with the law. Maru *et al*. (2003) found a psychiatric morbidity of 44% among 90 criminal offenders (aged 8-18 years) presenting at a juvenile court in Nairobi, Kenya. Conduct disorders accounted for nearly half of the psychiatric disorders in that cohort.

Children with chronic physical conditions in a longitudinal American study of participants aged 2-17.5 years were found to be twice as likely to receive mental health services than those who did not (Horwitz *et al*. 2012). This was thought to be due to the additional contact with a medical practitioner who would recognise the need for mental health services. Zwaanswijk (2005) in addition found help seeking increased with the presence of more than one mental disorder, probably due to increased parental burden. While comorbidity rate in this study was placed at 41.6%, this relationship was not examined. However, the presence of a physical disorder was associated with seeking a medical intervention as opposed to a non-medical intervention.

Parents and guardians are key in the recognition of the child's problematic behaviour and making the subsequent decision on where to seek care for the child's mental health problem (Cornelia & Douma 2006). In the current study, the primary caregiver

was the key initiator of care to any first intervention after detection of symptoms and was significantly associated with a shortened duration to help seeking. However, overall, medical practitioners (clinical officers, general practitioners and specialists such as paediatricians, neurologists and Ear Nose and Throat specialists) were the main referral agents into the child and adolescent mental health service. This was mainly because most of the participants were already receiving a medical intervention before going into the mental health service.

Farmer *et al*. (2003) in a study involving a cohort of American youth found that rates of mental health service use were lower among young children and increased substantially with age. They found that fewer youth entered the services before the ages of 5 or after 13 years, with 89% entering the service between the ages 5 and 13 years. This has been thought to be due to the involvement of the education sector as the child grows older indicating the importance of teachers in the identification and referral of disordered children into mental health services (Farmer *et al*. 2003; Zwaanswijk 2005). Conversely, a pathways to care study of children aged 3-18 years conducted at a federal neuropsychiatric hospital in Enugu Southeast Nigeria, revealed that only 0.3 % of 393 participants were referred from a school, while in an Albanian cohort of 162 children and adolescents, only two participants were referred from a school (Bakare 2013; Alikaj *et al*. 2011).

An encouraging finding in the current study was that teachers played a role in the ultimate referral of more than a quarter of the study participants to the child and adolescent mental health clinic. While this demonstrates some form of mental health literacy on the part of the teachers referring the students in this study, a needs assessment would be key to assess the baseline knowledge and attitudes of teachers

towards mental health problems and there after plan for programmes to address the resultant gap identified. This is especially in view that severe mental health problems such as psychotic disorders appear to present at much lower proportions in the current study's clinical setting compared to other African settings (Omigbodun 2004; Omigbodun & Ogun 2005). For example, knowledge and attitudes of 103 elementary school teachers in rural and urban schools in Ibadan, Southwest Nigeria attending an in service training workshop in child and adolescent mental health was assessed. In this needs assessment study for developing a training program for teachers, Bella *et al*. (2011) found that the teachers knowledge on mental health problems in students was deficient with only a third answering knowledge questions correctly. In addition, an intolerant attitude to children with mental health problems was revealed when only fewer than half of the teachers gave appropriate attitude responses.

Despite being visited by more than 6% of the study participants in the pathway, religious leaders were hardly involved in the referral process, which is similar to the findings by Bakare (2013) in a South-eastern Nigerian cohort of 393 participants where only 0.3% were referred from prayer houses despite 22% of the participants visiting the establishments. This was identified as a barrier to care by Alikaj *et al*. (2011) in an Eastern European study conducted in Albania where it was identified that 4.5% of the 100 study participants had visited traditional healers but with hardly any referrals from there.

The median duration taken by the caregiver to seek any type of intervention was 1 month, while the longest duration was more than four years in the current study. Delays to seeking help in this study can be attributed to the inability of the caregiver to recognise the symptoms as abnormal, as explained in findings by Maniadaki *et al*.

(2007) in a study exploring parental beliefs about the nature of ADHD behaviour and relationship to referral intentions in pre school children. The study revealed that parents who thought that the disruptive behaviours in ADHD were normal were more likely to suspend the referral to child and adolescent mental health services.

On the other hand, almost half of the caregivers in the current study sought help within a month. This finding could have been influenced by two factors. Referrals from teachers especially in substance related disorders, conduct and oppositional defiant disorders were attached to a disciplinary caveat, of suspension from school unless they sought help. The other factor, also a speculation was that the parents were unable to recognise the salient prodromal symptoms of mental disorders as abnormal and only presented in crises.

The mean time taken from the onset of symptoms to finally getting into contact with the mental practitioner was almost one and a half years. Considering that most of the patients were already seeking a medical intervention, it highlights delays within the medical pathways that may arise when the clinician is unable to diagnose and promptly refer. This is in keeping with the finding that non recognition of symptoms by the general practitioner was the main barrier to accessing specialist mental health care in a community based study in the United Kingdom (Sayal *et al*. 2002). In that study featuring 18 general practitioners, it was found that the general practitioner recognised mental disorder in 28% of primary care attendees, when 74% of the children in the community identified to have ADHD had seen the general practitioners in the previous year.

Other socio demographic factors (parental education, parental employment and religion) were not found to be significantly related to service use in the current study

probably because of the general similarities in the socio-demographic variables of the study participants in the current study. Low socioeconomic status was however related to increased service use in Norway, where mental health services are free. This was the finding in a study of 995 participants followed up from the age of four years (Wichstrøm *et al*. 2014). Contrary to this, Amone-P'Olak *et al*. (2010) found that socioeconomic status and higher maternal education were linked to high mental service use in an American study. These contradictory findings could not be explained by either of the authors.

The first step in help seeking for child and adolescent mental problems is the ability of the primary caregiver to recognise that the child has a problem. The inability to recognise the symptoms has been cited as a barrier to seeking services in a number of studies. Sayal *et al*. (2010) conducted a primary care focus group of 34 parents of children whose ages ranged from 2-15 years in the United Kingdom. The authors found that the parents' decision to enquire about mental health services for their children was influenced by the parents' perception of the problem. This was echoed by Fatori *et al*. (2012) in a follow up epidemiological study of 345 children aged between 6-13 years in Brazil. In the study, only 19 out of 32 mothers whose children were identified to have a disorder thought about help seeking, identifying stigmatising beliefs and poor knowledge about mental health problems and treatment as the barrier for not seeking help. Poor problem recognition as a barrier was also acknowledged by Pavuluri *et al*. (1996) in an American study of 320 pre school children. In that study, only 19 % of those who had a disorder sought help with the most common barrier identified being that the problem would resolve or that the parents should be strong enough to handle them. The inability of the parent to recognise the symptoms of the mental disorder as a barrier barrier is also identified in the current study where almost

a third of the caregivers thought symptoms were in keeping with normal childhood or adolescent behaviour, and some reported not knowing it was a problem until someone pointed it out.

After symptom recognition, decisions made by the caregiver regarding where to seek help can be influenced by various factors, which can act as barriers to seeking care. These have been identified in various studies and include cultural beliefs, stigma associated with psychiatry services, lack of information on available services and parental burden (McKay *et al*. 1996; Rogler & Cortes 1993; Wichstrøm *et al*. 2014). Almost half of the caregivers in this study who did not seek help immediately thought the problem would resolve on it's own and only came when perhaps when their ability to cope with the problem proved difficult. This was also identified by Sayal *et al*. (2003) when looking for predictors of parental perception of hyperactivity as a serious problem in a community sample of 93 children aged 5-11 years with ADHD. In the study, children whose parents perceived ADHD as a serious problem were compared to those who did not. The authors found that parental perception was the strongest predictor of service use and it was in turn influenced by the financial impact of the child's behaviour or the parent's work, with mental health service use increasing when these impacts reached a threshold.

Relating supernatural forces such as spiritual possession or evil eye, witchcraft and the wrath of god to the aetiology of mental disorders is the reason behind patronizing traditional and religious healer establishments in African and Asian countries (Chadda *et al*. 2001; Razali & Najib 2000; Kauye *et al*. 2014; Abdulmalik & Sale 2012). It is interesting to note that in the current study, despite 12% of the caregivers thinking that the child's problem was spiritual in nature, they still brought their children for

care in medical settings. Some caregivers cited conflict towards the cause of the problem as a personal barrier to accessing child and adolescent mental health services, and this could have a negative impact on the child's treatment if the conflicts are not addressed.

It emerges in this study that lack of awareness of the existence of mental health services is a major barrier to care. A third of the caregivers reported that they did not know where to go for help for their child problem after the recognition of symptoms. This finding further illustrates poor mental health literacy among the caregivers in the study. Mental health literacy refers to the knowledge and beliefs about mental disorders, which aid their recognition, management and prevention (Ganasen *et al*. 2008). By not viewing the mental disorders as medical conditions, the caregiver is less likely to visit a medical facility for an intervention (Maniadaki *et al*. 2007). Surprisingly, this barrier is not only unique to low income countries where child and adolescent mental health services are scarce but it has also been reported in high income countries such as Canada and the United States (Boydell *et al*. 2006; Busko 2008), indicating that the need to create awareness about child and adolescent mental health services is a global.

Awareness campaigns would be useful in improving parental ability to recognise mental disorders, decrease stigma and promote mental health (Ganasen *et al*. 2008). A collaborative pilot study by the WHO, World Psychiatrist Association and the International Association of Child and Adolescent Psychiatrists and Allied Professionals sought to assess the level of change in awareness, knowledge, attitudes and beliefs of parents, teachers and students on mental health before and after an awareness campaign. This study was conducted in nine countries (Armenia,

Azerbaijan, Brazil, China, Egypt, Georgia, Israel, Russia and Uganda. The study yielded positive post awareness indicators. The participants were more knowledgeable on mental health matters and reported a willingness to discuss their emotional problems freely (Hoven *et al*. 2008).

While the current study relied on the caregivers perspective in help seeking for their children's mental health needs, the role of the adolescent in recognising their mental health needs cannot be overemphasised. In the current study, only one adolescent identified his problem and initiated the help seeking process. One hundred and sixty four students (ages 10-18years) from rural and urban schools in the Ibadan, Southwest Nigeria were enrolled in a study seeking to find out young people's perspectives on mental illness (Dogra *et al*. 2012). In that needs assessment study, a tool modified to the cultural setting was used to assess knowledge and attitudes towards mental health problems as well as social distance (stigma). On evaluation, the study revealed that the Nigerian children who participated in the study lacked adequate knowledge of mental health and illness and demonstrated negative attitudes towards mentally ill people.

As a follow up to the needs assessment study described above, a mental health program aimed at improving mental health literacy in schools was developed and evaluated in a quasi experimental designed study involving 78 students (mean age 15.3 years) on the intervention arm and 78 students (mean age 14.3 years) on the control arm (Bella-Awusah *et al*. 2014). The intervention was the mental health programme that addressed views on general mental health, how to recognise mental illness and how to access support for themselves and others in need. Six months post intervention, the study revealed significant changes in knowledge items. This

intervention, although on a small scale highlighted the adolescents mental health needs in the community and a possible way to meet them.

Financial challenges were cited as a barrier in the current study as well as in other studies. Ambikile & Outwater (2012) conducted in depth interviews on two focus group comprising parents of children with mental disorders in Tanzania. Financial challenges due to cost of drugs were high on the participants list. Similarly, Boydell *et al*. (2006) in a study involving 30 caregivers of children with mental health needs in rural Canada found that, financial difficulties as a result of long distances travelled to seek care, and taking time off work were a barrier to care. In an American setting, lack of adequate health insurance was a barrier to access of services in a follow up study examining points of entry into the mental health service in a sample of 1420 youth aged 11 or 13 years at study entry (Farmer *et al*. 2003). In the current study, similar concerns were raised. Most Kenyans pay out of pocket for their health needs. Health insurance coverage is still low and the National Hospital Insurance Fund (NHIF) by the government mainly caters for inpatient care in government hospitals. The services offered at the youth clinic (14-24 year olds) at the Kenyatta National Hospital are free and the financial constraints voiced are mainly due to travel and filling out prescriptions. Increase in the coverage by the NHIF would be a step in the right direction.

Patient satisfaction is a useful indicator of quality in healthcare. (Barber *et al*. 2006; Kitts *et al*. 2013) Caregivers influence the use of child and adolescent mental health services by their children and parental satisfaction is predicted by the degree to which the clinics are able to meet the parents' desires (Holmboe *et al*. 2011). In turn, a high level of satisfaction with health care delivery is associated with better alliance with

staff, follow up and continuity of care. (Druss *et al*. 1999; Bulow *et al*. 1987) Service user informed interventions to improve service delivery are ideal as they are tailored to the needs of the service users. While not all the study participants reported clinic and staff related barriers, this cannot be directly translated to mean a high patient satisfaction rate as some of the service users were new to the clinic and had only started using the services. The major area of dissatisfaction with services at the Kenyatta National Hospital in this study was the long waiting time, that would go up to three hours and inadequate facilities due to drug stock-outs, inadequate clinic space.

5.2: Conclusion

This study revealed that for children and adolescents who were eventually seen at the Kenyatta National Hospital's child and adolescent mental health clinic, the most frequently used intervention was to access care in a hospital setting. It also points to the existence of non-medical interventions and brings to light the possibility that some children in Kenya with severe mental disorders may not be exposed to the medical practitioners at all. They could be under the care of traditional healers or in their homes as one of the barriers identified was the caregiver not knowing what to do after the recognition of symptoms.

The study findings suggest that service user delays were mainly caused by inability of the caregiver to recognise symptoms, not identifying the symptoms as having a possible medical cause and not knowing where to seek help. As there were delays after initiating the medical pathway, this indicates delays in referrals or problem recognition on the part of the medical practitioners in the medical pathway.

The caregivers in the study identified various interventions to address the barriers that they perceived and if addressed, they would improve service delivery and encourage the service users to further utilise the current services.

Study limitations

This was a cross sectional descriptive study that relied on information on events that had already happened; recall on the part of the guardian may have been affected.

The study also depended on the willingness of the participants to acknowledge previous points of care.

This study was conducted in an urban setting, where there is access to specialists and the findings cannot be applied wholly to rural settings. For example, it would be of interest to know where teachers refer students who do not reside in Nairobi.

5.3: Recommendations

Based on the study findings, the following recommendations are made:

1. Increase mental health literacy in the community. This could be done through the Ministry of Health in collaboration with non-governmental organisations by increasing community awareness on the causes of mental disorders, how to recognise them and where to seek help.
2. Inter-sectorial collaboration between the Ministries of Health and Education, and in particular, the Division of Mental health. Developing teacher-training programs after identifying their baseline needs to enhance the recognition and referral of children with mental problems would be key in facilitating help seeking.
3. Implications on research: This was a hospital-based study. A community based study identifying children with mental health problems and seeking to find out if

they seek help and where they seek help for their mental health needs would be more informative on the pathways to child and adolescent mental health services in Kenya.

(Word count: 5,730)

CHAPTER SIX

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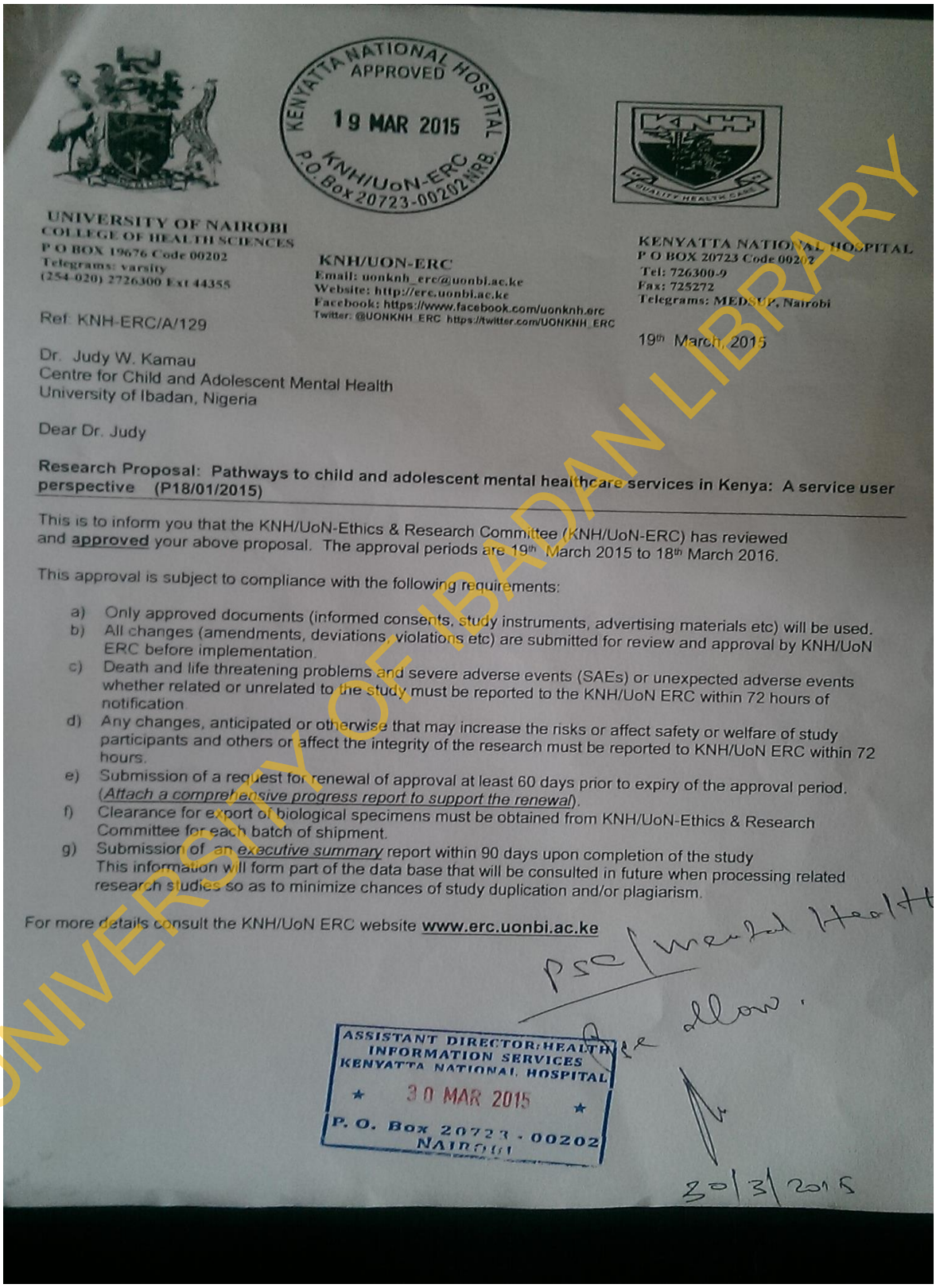
APPENDICES

APPENDIX A: Approval letter from the Ethical Committee



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Ref: KNH-ERC/A/129

19th March, 2015

Dr. Judy W. Kamau
Centre for Child and Adolescent Mental Health
University of Ibadan, Nigeria

Dear Dr. Judy

Research Proposal: Pathways to child and adolescent mental healthcare services in Kenya: A service user perspective (P18/01/2015)

This is to inform you that the KNH/UoN-Ethics & Research Committee (KNH/UoN-ERC) has reviewed and **approved** your above proposal. The approval periods are 19th March 2015 to 18th March 2016.

This approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH/UoN ERC before implementation.
c) Death and life threatening problems and severe adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH/UoN ERC within 72 hours of notification.
d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH/UoN ERC within 72 hours.
e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
f) Clearance for export of biological specimens must be obtained from KNH/UoN-Ethics & Research Committee for each batch of shipment.
g) Submission of an *executive summary* report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

For more details consult the KNH/UoN ERC website **www.erc.uonbi.ac.ke**

ASSISTANT DIRECTOR: HEALTH INFORMATION SERVICES
KENYATTA NATIONAL HOSPITAL
30 MAR 2015
P. O. Box 20723 - 00202
NAIROBI

30/3/2015

APPENDIX B: CONSENT

B1: INFORMED CONSENT EXPLANATION

My name is Dr Judy Kamau, a Psychiatrist, currently undergoing further training to better look after children and adolescents. I am conducting a study to find out how children and adolescents with mental health problems come to be seen at the Kenyatta National Hospital.

I am therefore asking for your permission as the parent/guardian to allow me to ask questions mainly regarding your child's illness and where you have sought for help for his problem before coming to Kenyatta National Hospital. This will be done using a series of as a guide and will take about 30 minutes to an hour to administer

Other than the information about your child, there will be no other procedures carried out, such as drawing of blood or performing other tests, but I will need to look at the doctor's notes to see what he/she is being treated for.

The information obtained from you will not be disclosed to anyone, and your identity or that of your child will not be recorded anywhere on the question forms.

There will be no financial gain to you during this study. Answer the questions asked to the best of your ability and hopefully, this study will help improve the management of children with mental health problems.

You are not being forced to participate and you are free to withdraw if you so wish during the interview.

For any questions or clarifications, you can contact me on +254722489273, one of my supervisors, Dr. Kuria at the University of Nairobi or the University of Nairobi-Kenyatta National Hospital Ethics review board on +2540202726300 Ext 44355

B2: CONSENT FORM

As a Parent/ Guardian to a child attending this clinic, I hereby volunteer to participate in this study whose nature and purpose has been fully explained to me.

Guardian's name: _____

Guardian's signature: _____ Date_____

Witnessed by:

Name: _____

Signature_____ Date_____

Researcher: Dr Judy Kamau; +254722489273

University of Nairobi-Kenyatta National Hospital Ethics review board: +2540202726300 Ext 44355

APENDIX C: QUESTIONNAIRES

C1: RESEARCHER DESIGNED SOCIO-DEMOGRAPHIC QUESTIONNAIRE

Pathways to child and adolescent mental health care services in Kenya: a service user perspective

Date…….

1. Allocated research number……..
2. Date of birth of child (day, month, year) …….
3. County of residence (Code 1 to 47)

1. Mombasa	2. Kwale	3. Kilifi	4. Tana River	5. Lamu
6. Taita – Taveta	7. Garissa	8. Wajir	9. Mandera	10. Marsabit
11. Isiolo	12. Meru	13. Tharaka-Nithi	14. Embu	15. Kitui
16. Machakos	17. Makueni	18. Nyandarua	19. Nyeri	20. Kirinyaga
21. Muranga	22. Kiambu	23. Turkana	24. West Pokot	25. Samburu
26. Trans Nzoia	27. Uasin Gishu	28. Elgeyo Marakwet	29. Nandi	30. Baringo
31. Laikipia	32. Nakuru	33. Narok	34. Kajiado	35. Kericho
36. Bomet	37. Kakamega	38. Vihiga	39. Bungoma	40. Busia
41. Siaya	42. Kisumu	43. Homa Bay	44. Migori	45. Kisii
46. Nyamira	47. Nairobi			

4. Age of child ……
5. Gender a) Male b) Female
6. Attending school a) Yes b) No
7. If No, why? …….
8. Grade in school…….....
9. Age appropriate a) Yes b) No
10. If No, why?.....
11. Primary Guardian
    a) Biological parent
    b) Relative adult Specify relationship…….
    c) Non-relative adult Specify……

d) Self

e) Other (specify)……

12. Parental status

a) Both parents alive

b) Single parent Mother Father

c) Orphan

13. Level of Father's Education

a) No formal education

b) Primary school

c) Secondary school

d) Post Secondary, (Not University)

e) University degree & above

14. Father's occupation ……..

15. Level of Mother's Education

a) No formal education

b) Primary school

c) Secondary school

d) Post Secondary, (Not University)

e) University degree & above

16. Mother's occupation……

17. Do you practice any religion? a) Yes b) No

18. If yes, please specify which ……

C2: MODIFIED WHO ENCOUNTER FORM

Pathways to child and adolescent mental health care services in Kenya: a service user perspective

Form filled at Kenyatta National Hospital

1. Basic information

Date:……

Allocated research number…….

1.1. Date first seen at the Patient support centre/ Adolescent clinic at KNH.

…….

1.2. Before your child got unwell, did you think mental health problems could affect children and adolescents?.....

1.3. What was the first symptom developed by the patient?

.....

1.4. How long ago? (Months) .....

1.5. State your child's Diagnosis (if known)

……..

1.6 If diagnosis unknown by guardian, why?

……

2. The decision to first seek help

2.1. When your child first got unwell, what did you believe was the cause of the illness?

……

2.2. Who was first seen?

a) Pastor b) Traditional healer c) KNH d) Mathari Hospital

e) Other hospital/ Clinic……

f) Special school g) Paediatrician h) Chemist i) Medical Laboratory

j) Psychiatrist k) Police l) Other

2.3. How long ago? (Months)……

2.4. Who initiated first contact? (Who adviced you on where to go?)

a) Self b) Relative /Friends c) Patient d) Neighbours

e) Child's teacher f) Medical practitioner g) Workmates/Colleagues

h) Media (TV, Radio, Newspapers, Internet) i) Police

j) Other……

2.5. What symptom caused decision to seek care?.....

2.6. If did not seek help immediately (within a week), why? .....

…….....

2.7. What were you told was the child's diagnosis?

.....

2.8. What treatment(s) was offered?

.....

3. The first referral

3.1. Who was next seen?

a) Pastor b) Traditional healer c) KNH d) Mathari Hospital

e) Other hospital/ Clinic……

f) Special school g) Paediatrician h) Chemist i) Medical Laboratory

j) Psychiatrist k) Police l) Other

3.2. How long ago? (months)…….

3.3. Decision taken by whom? (Who decided/ adviced you to see this person?)

a) Parent/ Guardian b)Relative /Friends c) Patient d) Neighbours

e) Child's teacher f)Medical practitioner g) Workmates/Colleagues

h) Media (TV, Radio, Newspapers, Internet) i) Police

j) Other …….

3.4. What symptom caused you to see first referral?

.....

3.5. What were you told was the child's diagnosis?.....

3.6. What treatment (s) was offered?

.....

4. Second referral

4.1. Who was next seen?

a) Pastor b) Traditional healer c) KNH d) Mathari Hospital

e) Other hospital/ Clinic……

f) Special school g) Paediatrician h) Chemist i) Medical Laboratory

j) Psychiatrist k) Police l) Other ……

4.2. How long ago? (months)…….

4.3. Decision taken by whom? (Who decided/ adviced you to see this person?)

a) Parent/ Guardian b) Relative /Friends c) Patient d) Neighbours

e) Child's teacher f) Medical practitioner g) Workmates/Colleagues

h) Media (TV, Radio, Newspapers, Internet) i) Police

j) Other: ……..

4.4. What symptoms caused decision to seek 2nd referral?

.....

4.5. What were you told was the child's diagnosis?

.....

4.6. What treatment (s) was offered?

.....

5. Concurrent treatments.

5.1. Are you still seeking other previous treatments? a) Yes b) No

5.2. If Yes, which ones?

……..

5.3. Is your child being treated for another condition? a) Yes b) No

5.4. If Yes, What?

……

5.5. Does the other doctor know that your child attends this clinic?

a) Yes b) No

If No, Why? ……

……..

6. Perceived barriers and challenges to the current child mental health services

6.1. What are the main problems you have encountered while seeking help for your child?

6.1.1: Personal

……

……

6.1.2: Hospital facilities

……

……..

6.1.3: Staff

……

……

6.1.4: Others

……

……

6.2. How do you think we can improve the provision of medical care to children with mental disorders?

a) …….

b) ……..

c) ……..

C3: KIDDIE- SCHEDULE FOR AFFECTIVE DISORDERS AND SCHIZOPHRENIA- PRESENT AND LIFETIME VERSION (K-SADS-PL 2009 WORKING DRAFT) SCREEN INTERVIEW & THE CHILDREN'S GLOBAL ASSESSMENT SCALE (C-GAS)

Due to the bulky nature of the tool, only the screen interview section is attached.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present. Not at all or less than once a week.
( )	( )	( )	**2 -** Subthreshold: Depressed mood at least 2-3 days/ week, for much of the day.
( )	( )	( )	**3 -** Threshold: Depressed mood, nearly every day (5-7 days/week), most of the day (or > 1/2 of awake time).

PAST: ☐ P ☐ C ☐ S

Duration of Depressed Mood: (current) ☐☐☐

Duration of Depressed Mood: (most severe past) ☐☐☐

1. Depressed Mood

Refers to subjective feelings of depression based on verbal complaints or feeling depressed, sad, blue, gloomy, very unhappy, down, empty, bad feelings, feels like crying. Do not include ideational items (like discouragement, pessimism, worthlessness), suicide attempts or depressed appearance. Some children will deny feeling "sad" and report feeling only "bad" so it is important to inquire specifically about each dysphoric affect. Do not count feelings of anxiety or tension.
Irritability without any other persistent dysphoric affect should not be rated here.
In the interview with parent, mother's "gut feeling" (empathic sensing) that child frequently feels depressed can be taken as positive evidence of child's depressive mood *if parent is not concurrently depressed*.

Have you ever felt sad, blue, down, or empty?
Did you feel like crying? When was that?
Do you feel _____ now?
Was there ever another time you felt _____?
Did you have any other bad feelings?
Did you have a bad feeling all the time that you couldn't get rid of?
Did you cry or were you tearful? Did you feel (_____) all the time, some of the time? (Percent of awake time: summation of % of all labels if they do not occur simultaneously).
(Assessment of diurnal variation can secondarily clarify daily duration of depressive mood)
Did it come and go?
How often? Every day?
How long did it last?
What do you think brought it on?
(Assess relationship between depressed mood and separation from caregiver.)
Did you feel sad when your mother was away?
If separation from mother is given as a cause: Did you feel (_____) when mother was with you?
Did you feel a little better or was the feeling totally gone?
Could other people tell when you were sad?
How could they tell? Did you look different?

NOTE: SOMETIMES THE CHILD WILL INITIALLY GIVE A NEGATIVE ANSWER AT THE START OF THE INTERVIEW BUT WILL BECOME OBVIOUSLY SAD AS THE INTERVIEW GOES ON. THEN THESE QUESTIONS SHOULD BE REPEATED ELICITING THE PRESENT MOOD AND USING IT AS AN EXAMPLE TO DETERMINE ITS FREQUENCY. SIMILARLY, IF THE MOTHER'S REPORT IS THAT THE CHILD IS SAD MOST OF THE TIME AND THE CHILD DENIES IT, THE CHILD SHOULD BE CONFRONTED WITH THE MOTHER'S OPINION AND THEN ASKED WHY HE THINKS HIS MOTHER BELIEVES HE FEELS SAD SO OFTEN.

NOTE: WHEN A CHILD OR PARENT REPORTS FREQUENT SHORT PERIODS OF SADNESS THROUGHOUT THE DAY, IT IS LIKELY THAT THIS CHILD IS ALWAYS SAD AND ONLY REPORTS THE EXACERBATIONS, IN WHICH CASE THE RATING OF DEPRESSIVE MOOD WILL BE 4. THUS, IT IS ALWAYS ESSENTIAL TO ASK ABOUT THE REST OF THE TIME: "Besides these times when you felt (_____), during the rest of the time, did you feel happy or were you more sad than your friends?"

2. Irritability and Anger

Subjective feeling of irritability, anger, crankiness, bad temper, short tempered, resentment or annoyance, whether expressed overtly or not. Rate the intensity and duration of such feelings.

Was there ever a time when you got annoyed, irritated, or cranky at little things?
Did you ever have a time when you lost your temper a lot? When was that?
Are you like that now? Was there ever another time you felt _____?
What kinds of things made you _____?
Were you feeling mad or angry also (even if you didn't show it)?
How angry?
More than before?
What kinds of things made you feel angry?
Did you sometimes feel angry and/or irritable and/or cranky and didn't know why?
Did this happen often?
Did you lose your temper?
With your family?
Your friends?
Who else?
At school?
What did you do?
Did anybody say anything about it?
How much of the time did you feel angry, irritable, and/or cranky?
All of the time?
Lots of the time?
Just now and then?
None of the time?

When you got mad, what did you think about?
Did you think about killing others or hurting yourself? Or about hurting them or torturing them? Whom? Did you have a plan? How?

NOTE: IRRITABILITY MAY BE DUE TO OTHER DISORDERS, e.g., BIPOLAR DISORDER, ADHD, ODD, CD, SUBSTANCE ABUSE, PDD.

P	C	S	
( )	( )	( )	**0 -** No information
( )	( )	( )	**1 -** Not present. Not at all or less than once a week.
( )	( )	( )	**2 -** Subthreshold: Feels definitely more angry or irritable than called for by the situation at least (2-3 days/week), for much of the day.
( )	( )	( )	**3 -** Threshold: Feels irritable/angry daily, or almost daily, at least 50% of awake time.

PAST: ☐ P ☐ C ☐ S

Duration of Irritable Mood (current) ☐☐☐

Duration of Irritable Mood (most severe past) ☐☐☐

P	C	S
( )	( )	( )
( )	( )	( )
( )	( )	( )
( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Several activities definitely less pleasurable or interesting. Or bored or apathetic at least 3 times a week during activities.

3 - Threshold: Most activities much less pleasurable or interesting. Or bored or apathetic daily, or almost daily, at least 50% of the time.

PAST: ☐ P ☐ C ☐ S

3. Anhedonia, Lack of interest, Apathy, Low Motivation, or Boredom

Boredom is a term all children understand and which frequently refers to loss of ability to enjoy (anhedonia) or to loss of interest or both. Loss of pleasure and loss of interest are not mutually exclusive and may coexist.

What are the things you do for fun? Enjoy?
(Get examples: nintendo, sports, friends, favorite games, school subjects, outings, family activities, favorite TV programs, computer or video games, music, dancing, playing alone, reading, going out, etc.).

Has there ever been a time you felt bored a lot of the time? When?
Do you feel bored a lot now?
Was there another time you felt bored a lot?
Did you feel bored when you thought about doing the things you usually like to do for fun? (Give examples mentioned above).
Did this stop you from doing those things?
Did you (also) feel bored while you were doing things you used to enjoy?

Anhedonia refers to partial or complete (pervasive) loss of ability to get pleasure, enjoy, have fun during participation in activities which have been attractive to the child like the ones listed above. It also refers to basic pleasures like those resulting from eating favorite foods and, in adolescents, sexual activities.

Did you look forward to doing the things you used to enjoy? (Give examples)
Did you try to get into them?
Did you have to push yourself to do your favorite activities?
Did they interest you?
Did you get excited or enthusiastic about doing them? Why not?
Did you have as much fun doing them as you used to before you began feeling (sad, etc.)?
If less fun, did you enjoy them a little less? Much less? Not at all?
Did you have as much fun as your friends?
How many things are less fun now than they used to be (use concrete examples provided earlier by child)?
How many were as much fun? More fun?
Did you do _____ less than you used to? How much less?

In adolescents: (if sexually active) *Do you enjoy sex as much as you used to? Are you less sexually active than you used to be?*

This item does not refer to inability to engage in activities (loss of ability to concentrate on reading, games, TV, or school subjects)

Two comparisons should be made in each assessment: Enjoyment as compared to that of peers and/or enjoyment as compared to that of child when not depressed. The second is not possible in episodes of long duration because normally children's preferences change with age. Severity is determined by the number of activities which are less enjoyable to the child, and by the degree of loss of ability to enjoy.

Do not confuse with lack of opportunity to do things which may be due to excessive parental restrictions.

Duration of Anhedonia: (current)

☐☐☐

Duration of Anhedonia: (past)

☐☐☐

4a. Recurrent Thoughts of Death

Sometimes children who get upset or feel bad, wish they were dead or feel they'd be better off dead.
Have you ever had these type of thoughts? When?
Do you feel that way now?
Was there ever another time you felt that way?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Infrequent thoughts of death (e.g. less than once per month, vague, non-specific).
( )	( )	( )	**3 -** Threshold: Recurrent thoughts of death, "I would be better off dead" or "I wish I were dead."

PAST: ☐ P ☐ C ☐ S

4b. Suicidal Ideation

This includes preoccupation with thoughts of death or suicide and auditory command hallucinations where the child hears a voice telling him to kill himself or even suggesting the method.
Do not include mere fears of dying.

Sometimes children who get upset or feel bad think about dying or even killing themselves.
Have you ever had such thoughts?
How would you do it?
Did you have a plan?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not at all.
( )	( )	( )	**2 -** Subthreshold: Infrequent or vague thoughts of suicide (e.g., less than once per month).
( )	( )	( )	**3 -** Threshold: Recurrent thoughts of suicide.

PAST: ☐ P ☐ C ☐ S

4c. Suicidal Acts - Intent

Judge the seriousness of suicidal intent as expressed in his suicidal act like: Likelihood of being rescued; precautions against discovery; actions to gain help during or after attempt; degree of planning; apparent purpose of the attempt (manipulative or truly suicidal intent).

Have you actually tried to kill yourself? When?
What did you do?
Any other things?
Did you really want to die?
How close did you come to doing it?
Was anybody in the room? In the apartment?
Did you tell them in advance?
How were you found? Did you really want to die?
Did you ask for any help after you did it?

NOTE: CODE SELF-HARMING BEHAVIOR WITH NO INTENT TO DIE AS NON-SUICIDAL, SELF-INJURIOUS BEHAVIOR - NOT AS SUICIDAL BEHAVIOR.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** No attempt.
( )	( )	( )	**2 -** Subthreshold: Preparations with no actual intent to die (e.g., held pills in hand) or planned attempt but did not follow through or engage in self harming behavior.
( )	( )	( )	**3 -** Threshold: Self injurious behavior with ANY suicidal intent. (If subject endorses even a 1% intent to die, code as threshold here).

PAST: ☐ P ☐ C ☐ S

Ever attempted suicide: ○ Yes ○ No

Number of lifetime attempts meeting threshold of (3): ☐☐☐

	P	C	S	
4d. Suicidal Acts - Medical Lethality	( )	( )	( )	**0 -** No information.
	( )	( )	( )	**1 -** No attempt or engaged in behavior with no intent to die (e.g., held pills in hand). No medical damage.
	( )	( )	( )	**2 -** Subthreshold: superficial cuts, scratch to wrist, took a couple of extra pills.
	( )	( )	( )	**3 -** Threshold: Medical intervention occurred or was indicated; or significant cut with bleeding, or took more than a couple of pills.

Actual medical threat to life or physical condition following the most serious suicidal act. Take into account the method, impaired consciousness at time of being rescued, seriousness of physical injury, toxicity of ingested material, reversibility, amount of time needed for complete recovery and how much medical treatment needed.

How close were you to dying after your (most serious suicidal act)?
What did you do when you tried to kill yourself?
What happened to you after you tried to kill yourself?

NOTE: CODE SELF-HARMING BEHAVIOR WITH NO INTENT TO DIE AS NON-SUICIDAL, SELF-INJURIOUS BEHAVIOR - NOT AS SUICIDAL BEHAVIOR.

PAST: ☐ P ☐ C ☐ S

	P	C	S	
4e. Non-suicidal, Self-Injurious Behavior	( )	( )	( )	**0 -** No information.
	( )	( )	( )	**1 -** Not present.
	( )	( )	( )	**2 -** Subthreshold: Once. Has engaged in the behavior on 1 occasion. Has never caused serious injury to self.
	( )	( )	( )	**3 -** Threshold: Repetitive. Has engaged in the behavior more than 1 time and/or has engaged in the behavior with significant injury to self (e.g., burn left scar, cut required stitches).

Refers to self-mutilation, or other acts done **without intent** of killing himself.

Did you ever try to hurt yourself?
Have you ever burned yourself with matches/candles?
Or scratched yourself with needles/ a knife? Your nails?
Or put hot pennies on your skin?
Anything else?
Why did you do it?
How often?
Do you have many accidents?
What kind?
How often?

Some kids do these types of things because they want to kill themselves, and other kids do them because it makes them feel a little better afterwards. Why do you do these things?

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED A SCORE OF 3 ON CURRENT RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE DEPRESSIVE/DYSTHYMIC DISORDERS (CURRENT) SECTION OF THE AFFECTIVE DISORDERS SUPPLEMENT, AFTER FINISHING THE SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON PAST RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE DEPRESSIVE/DYSTHYMIC DISORDERS (PAST) SECTION OF AFFECTIVE DISORDERS SUPPLEMENT, AFTER FINISHING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF DEPRESSIVE/DYSTHYMIC DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST DEPRESSIVE DISORDERS).

Introduction to the Mania/Hypomania Section

The identification of manic symptomatology and diagnosis of bipolar disorder in children and adolescents is difficult. There is considerable controversy about whether aspects of the DSM-IV criteria for a Manic, Mixed or Hypomanic episode are appropriate to use in youth. Issues that have been particularly difficult include whether: (1) distinct episodes of abnormally elevated/irritable mood are required or if chronic irritability is sufficient; (2) (hypo)manic symptoms must be clearly associated with the onset and offset of abnormal elevated/irritable mood; (3) the duration criteria for a manic/hypomanic/mixed episode are appropriate; and (4) complex cycling patterns between mania and depression exist and are clinically significant. The Mania/Hypomania section of KSADS-PL 2009 Working Draft applies the DSM-IV criteria strictly for issues 1, 2, and 3 but allows for identification of episodes of shorter duration. It does not directly address issue 4, but instead helps to determine whether the (hypo)manic symptomatology meets the threshold for a Manic or Hypomanic episode irrespective of the intensity of depressive symptoms that occur concurrently with manic or hypomanic symptoms. If full criteria are met for a Manic Episode, then the interviewer is prompted to assess concomitant depressive symptomatology to determine whether DSM-IV criteria are met for a Mixed Episode.

Potential (hypo)manic symptoms should be rated as positive only if they are associated with the abnormal mood (either the onset is temporally associated with the abnormal mood, or if the symptom is present chronically, then it intensifies or is exacerbated with the onset of the abnormally elevated/elated/irritable mood). If the symptom is only questionably associated with the abnormal mood, then it should be rated as subthreshold. The DSM-IV frequency/duration criteria for (hypo)manic symptoms are that the symptom has been persistent and present to a significant degree during the period of abnormal mood. This is much less specific than the most of the day, nearly everyday criteria for symptoms of a major depressive episode. Interviewers must use clinical judgment to determine whether the symptom meets the frequency/duration criteria, but reasonable guidelines would be that the symptom must be present intermittently during most the mood episode or the symptom is very prominent during a shorter proportion of the abnormal mood episode. If the symptom exists but does not meet the persistent/present to significant degree criteria, then it is rated as subthreshold.

	P	C	S
1. Elevated, Elated, or Expansive Mood	( )	( )	( )

0 - No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Definitely elevated and optimistic outlook that is somewhat out of proportion to the circumstances (above and beyond what is expected in a child of the subject's age). Occurs less than 4 hours in a day and/or for fewer than 3 separate days.

( ) ( ) ( ) **3 -** Mood and outlook are clearly out of proportion to circumstances. Noticeable to others and perceived as odd or exaggerated. Occurs for at least 4 hours out of a day for at least 2 consecutive days or on at least 3 separate days.

PAST: ☐ P ☐ C ☐ S

Elevated mood and/or excessively optimistic attitude which is out of proportion to circumstances and above and beyond what is expected in children of the same age or same developmental level. **Differentiate from normal mood in chronically depressed subjects. Do not rate positive if mild elation is reported in situations like Christmas, birthdays, going to amusement parks, which normally overstimulate and make children very excited.**

NOTE: DO NOT SCORE POSITIVELY IF ELATED MOOD IS EXCLUSIVELY DUE TO MEDICATIONS OR ANY OTHER PSYCHIATRIC OR MEDICAL CONDITION.

Has there ever been a time when you felt super happy or on top-of-the world? Way more than your normal happy feeling?
Did the super-happy feeling seem to come out of the blue?
Have there been times when you were super silly, much more silly than everyone else around you?
Were you laughing about things that normally you would not find funny?
Did it feel like you couldn't stop laughing?
Did it seem like you were drunk or high, even though you weren't taking drugs or alcohol?
Did other people notice?
Have your friends ever said anything to you about being way too happy, too silly or too high?
Did you feel super-positive, like nothing could go wrong?
Did you have the feeling that everything was terrific and would turn out just the way you wanted?
Did you feel really excited or full of enthusiasm but there really was not a reason to feel this way?
Can you give me some examples?
How long did this feeling usually last?
Would it come and go throughout the day?
Did you ever have problems or get in trouble for being too happy or high?

Ask Parent/Caregiver: *Was this above and beyond what you would see in his/her friends or other kids of the same age or developmental level in the same circumstances?*

	P	C	S
2. Explosive Irritability / Anger	( )	( )	( )

0 - No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Definite periods of excessively irritable/angry mood. Anger / Irritability is out of proportion for the situation and occurs for much of the day or intensely for a brief period (< 1 hour).

( ) ( ) ( ) **3 -** Threshold: Episodes of explosive irritability / anger that are far out of proportion to any stressor or stimuli - has associated aggressive behavior (e.g. threats, property destruction or physical aggression). Occurs on at least 2 consecutive days or on at least 3 separate days.

PAST: ☐ P ☐ C ☐ S

Was there ever a time you were so irritable and angry that you exploded?
When you are feeling really mad, do you throw things or break things?
Tear your room apart?
Have you ever punched a hole in the wall when you were angry?
When you got really angry, did you ever threaten or actually hurt a parent or a teacher? What about other kids or pets?
What was going on at the time when this happened? What set you off?
Have there been times when you got super angry without knowing why or over little things that you normally would not get upset about?

P C S

3. Episodes of Unusual Energy/Activity

( ) ( ) ( )

Has there ever been a time where you had much more energy than usual, so much energy that it felt like too much? What kinds of things were you doing when that happened?
Was there a change in how much you were doing or how fast you were moving?
Did it seem like you were doing too many things or were super hyper? How long did that feeling last? Did other people notice it?
Was it different than other people around you?
Did anything seem to cause that feeling?
Was there anything else different about you during the time of high energy - your speed of talking, thinking, any thing else?

NOTE: IF THE CHILD HAS ADHD OR IS VERY ACTIVE AND ENERGETIC AT BASELINE, ONLY RATE POSITIVE IF THIS IS A DISTINCT PERIOD OF SUBSTANTIAL INCREASE IN ENERGY.

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** Subthreshold: Brief period(s) of increased energy, or mild intensification from baseline (or) likely caused by environmental stimulus; of questionable clinical significance.

( ) ( ) ( ) **3 -** Threshold: Definite episodes of clear increased energy, well beyond baseline or far in excess of same age peers in the same situation. Occurs for a total of at least 4 hours in a day, for either 2 consecutive days or on 3 separate days.

PAST: ☐ P ☐ C ☐ S

P C S

4. Decreased Need for Sleep

( ) ( ) ( )

Less sleep than usual yet still feels rested (average for several days when needs less sleep).

Have you ever needed less sleep than usual to feel rested?
How much sleep do you ordinarily need?
How much had you been sleeping?
Did you stay up because you felt especially high or energetic? Were you with friends or by yourself? Had you taken any drugs? Were you up busy doing things?
What time did you wake up?
Were you tired the next day, or did you have plenty of energy and did not seem to need the sleep?

NOTE: DO NOT SCORE POSITIVELY IF DECREASED NEED FOR SLEEP TRIGGERED BY SOCIAL EVENT OR DRUG USE, OR REFLECTIVE OF TYPICAL IRREGULAR ADOLESCENT SLEEP PATTERN.

( ) ( ) ( ) **0 -** No information.

( ) ( ) ( ) **1 -** Not present.

( ) ( ) ( ) **2 -** At least 1 1/2 hours less than usual without feeling tired, for at least 2 consecutive days, or at least 3 separate days.

( ) ( ) ( ) **3 -** At least 3 hours less than usual because he/she felt energetic or high and did not feel tired. Occurs for at least 2 consecutive days, or on at least 3 separate days.

PAST: ☐ P ☐ C ☐ S

	P	C	S
5. Hypersexuality	( )	( )	( )

0 - No information.

1 - Not present.

2 - Isolated, brief incidents of mildly inappropriate sexual behavior, of questionable clinical significance.

3 - Definite episodes of clearly inappropriate sexual behavior.

PAST: ☐ P ☐ C ☐ S

NOTE: HYPERSEXUALITY IN THE ABSENCE OF SEXUAL ABUSE OR INAPPROPRIATE EXPOSURE TO SEXUAL BEHAVIOR OR MEDIA IS A SYMPTOM FAIRLY SPECIFIC TO MANIC/HYPOMANIA. IT IS NOT A SEPARATE DSM-IV DIAGNOSTIC CRITERION, BUT WHEN PRESENT, IT CAN POTENTIALLY FULFILL EITHER BOTH THE INCREASED GOAL-DIRECTED ACTIVITY AND THE RISKY, PLEASURE-SEEKING BEHAVIOR B CRITERION.

For younger children ask parent/caregiver:
Have there been times when your child was excessively focused on sex, nudity, his/her private parts or touching others' private parts?
Did your child show an unusual increase in touching their privates in public or dressing in an inappropriate or sexual manner?
Would your child kiss or touch you in a sexual way or be way too affectionate instead of their usual way of showing affection?
What was his/her mood like during these times?
Did anything happen to cause these changes?

For adolescents:
Have there been times when you suddenly got much more interested in sex than usual or that your sex drive seemed to go way up?
Did you do anything differently when this happened (dress in a revealing way, talk about sex a lot or ask other people to be intimate / have sex with you)?
Were there times when you were driven to have sex much more than usual or with many different partners?

NOTE: IF ENDORSED POSITIVE, NEED TO RULE OUT SEXUAL ABUSE OR INAPPROPRIATE EXPOSURE TO SEXUAL MATERIAL OR BEHAVIOR.

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS FOR ELEVATED / ELATED MOOD OR EXPLOSIVE IRRITABILITY AND ANGER, OR A SCORE OF 2 ON BOTH ELEVATED / ELATED MOOD AND EXPLOSIVE IRRITABILITY / ANGER COMPLETE THE CURRENT MANIA/HYPOMANIA SECTION OF THE AFFECTIVE DISORDERS SUPPLEMENT.**

_ **IF THE CURRENT RATINGS FOR UNUSUAL ENERGY, DECREASED NEED FOR SLEEP, HYPERSEXUALITY ARE RATED A 3, BUT NOT ELEVATED / ELATED MOOD OR EXPLOSIVE IRRITABILITY AND ANGER, RE-INQUIRE CAREFULLY ABOUT ABNORMALLY ELEVATED / ELATED MOOD OR EXPLOSIVE IRRITABILITY AND ANGER THAT MAY HAVE OCCURRED WITH THE SYMPTOM.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS FOR ELEVATED / ELATED MOOD OR EXPLOSIVE IRRITABILITY AND ANGER, OR A SCORE OF 2 ON BOTH ELEVATED / ELATED MOOD AND EXPLOSIVE IRRITABILITY / ANGER COMPLETE THE PAST MANIA/HYPOMANIA SECTION OF THE AFFECTIVE DISORDERS SUPPLEMENT.**

_ **IF THE PAST RATINGS FOR UNUSUAL ENERGY, DECREASED NEED FOR SLEEP, OR HYPERSEXUALITY ARE RATED A 3, BUT NOT ELEVATED / ELATED MOOD OR EXPLOSIVE IRRITABILITY AND ANGER, RE-INQUIRE CAREFULLY ABOUT ABNORMALLY ELEVATED / ELATED MOOD AND EXPLOSIVE IRRITABILITY AND ANGER THAT MAY HAVE OCCURRED WITH THE SYMPTOM.**

_ **NO EVIDENCE OF (HYPO) MANIA**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST HYPOMANIA OR MANIA).

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Suspected or likely.
( )	( )	( )	**3 -** Threshold: Definitely present.

PAST: ☐ ☐ ☐
P C S

1. Hallucinations

Has there ever been a time when your mind played tricks on you?
Sometimes children might hear voices or see things, or smell things that other people cannot hear, see or smell.
Has this ever happened to you? Tell me about it.

Has there ever been a time when you heard voices that other people could not hear?
What did you hear? What kind of things did you hear?
Did you ever hear music which other people could not?

Has there ever been a time when you saw things like people or figures that other people could not see? If yes ... can you tell me about it?
What did you see? How often did it happen? When did it happen?
Did this only happen at night while you were trying to sleep, or did it happen in the daytime too?

Has there ever been a time when you smelled things that other people can't smell or felt things that weren't there?

NOTE: IF HALLUCINATIONS POSSIBLY PRESENT, PRIOR TO SCORING THIS ITEM, ASSESS THE SUBJECT'S CONVICTION OF THE REALITY IF THE HALLUCINATIONS WITH THE PROBES BELOW.

What did you think it was?
Did you think it was your imagination or real?
Did you think it was real when you (heard, saw, etc.) it?

What did you do when you (heard, saw, etc.) it?
These voices you heard (or other hallucinations), did they occur when you were awake or asleep? Could it have been a dream?
Did they happen when you were falling asleep? Waking up? Only when it was dark? Did they happen at any other time also?
Were you sick with fever when they occurred?
Have you ever been drinking beer, wine, liquor? Or taking any drugs when it happened?
Was it like a thought or more like a voice (noise) or a vision?

NOTE: IF HALLUCINATIONS ARE PRESENT, *CAREFULLY ASSESS* TIMELINE TO DETERMINE IF IN RELATION TO MOOD SYMPTOMS OR INDEPENDENT OF MOOD SYMPTOMS. THIS WILL FACILITATE DIFFERENTIAL DIAGNOSIS.

NOTE: DO NOT RATE AS POSITIVE IF ONLY ENDORSES HAVING HEARD SOMEONE CALLING THEIR NAME OCCURRING ONLY ONCE OR TWICE.

DON'T RATE ILLUSIONS POSITIVELY. Illusions are defined as false perceptions based on a real sensory stimuli which is momentarily transformed. They frequently occur due to poor perceptual resolution (darkness, noisy locale) or inattention and they are immediately corrected when attention is focused on the external sensory stimulus or perceptual resolution improves.

NOTE: TAKE INTO ACCOUNT CULTURAL BACKGROUND OF THE SUBJECT.

NOTE: IT IS IMPORTANT TO NOTE IF THE CHILD IS ACTING ON HALLUCINATIONS.

	P	C	S
2. Delusions	( )	( )	( )
Have you ever had any ideas about things that you didn't tell anyone because you were afraid they might not understand?	( )	( )	( )
What were they? *Do you have any secret thoughts? Tell me about them.*	( )	( )	( )
Have you ever believed in things that other people didn't believe in? Like what?	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Suspected or likely delusional.

3 - Threshold: Definite delusions.

PAST: ☐ ☐ ☐
P C S

Ask about each of the delusions surveyed below:

Has there ever been a time you felt that someone was out to hurt you or that someone was following you or spying on you? Who? Why?
Does anyone control your mind or body (like a robot)?
Did you ever think you were an important or great person?
Do you have any special powers?
When you are with people you do not know, do you think that they are talking about you?
Was there ever a time when you felt something was happening to your body? Like believing it was rotting from the inside, or that something was very wrong with it?
Did you ever feel convinced that the world was coming to an end?
How often did you think about _____?

NOTE: IF DELUSIONS ARE PRESENT, CAREFULLY ASSESS THE TIMELINE TO DETERMINE IF IN RELATION TO MOOD SYMPTOMS OR INDEPENDENT OF MOOD SYMPTOMS. THIS WILL FACILITATE THE DIAGNOSIS.

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE CURRENT SECTION OF THE PSYCHOTIC DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE PAST SECTION OF THE PSYCHOTIC DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF PSYCHOSIS.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST HALLUCINATIONS AND DELUSIONS).

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: At least 1 unanticipated attack. No persistent worry about future attacks, and no effect on behavior related to the attacks.
( )	( )	( )	**3 -** Threshold: Recurrent unexpected attacks with persistent worry for at least one month about having another attack or significant change in behavior related to the attacks.

PAST: ☐ P ☐ C ☐ S

1. Panic Attacks

Have you ever had a time when, all of a sudden, out of the blue, for no reason at all, you suddenly felt anxious, nervous, or frightened? Tell me about it.
The first time you had an attack like this, what did you think brought it on?
Did the feeling come from out of the blue?
Wha t was it like?
How long did it last?
After the first time this happened, did you worry about it happening again?

If specific symptoms are not elicited spontaneously when describing attacks, ask about each of the following symptoms:

Associated Symptoms: Shortness of breath, palpitations, chest pains, nausea, flushes, chills, choking or smothering sensation, dizziness, numbing of hands or feet, sweating, faintness, trembling or shaking, depersonalization or derealization, fear of dying, fear of losing control.

NOTE: DO NOT COUNT IF LASTS ALL DAY OR DIRECTLY CAUSED BY DRUGS OR MEDICATIONS.

_ **IF A SCORE OF 3 ON CURRENT RATING OF PANIC ATTACK ITEM, COMPLETE THE PANIC DISORDER (CURRENT) SECTION OF THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF SCORE OF 3 ON PAST RATING OF PANIC ATTACK ITEM, COMPLETE THE PANIC DISORDER (PAST) SECTION OF THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF PANIC DISORDER.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST PANIC DISORDER).

1. Agoraphobia

Have you ever been really afraid of being in a crowded place or going outside in public alone?
Were you ever afraid to go to the mall or any other places?
What about being on a bridge or traveling in a car, bus or train?
What were you afraid would happen?
Were you afraid of having a panic attack? Of being unable to escape?

NOTE: RATE POSITIVELY ONLY IF BEHAVIOR IS ABOVE AND BEYOND WHAT WOULD BE EXPECTED IN CHILDREN OF SAME AGE AND DEVELOPMENTAL LEVEL.

Do not rate positively if exclusively accounted for by other psychiatric disorders (i.e. psychosis, depression) separation anxiety, social phobia or medical problems.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Fear of stimuli or situation more severe than a typical child his/her age.
( )	( )	( )	**3 -** Threshold: Persistent anxiety about being in a place or situations from which escape might be difficult (or embarassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic like symptoms. Fear of stimuli or situation clearly out of proportion to circumstances.

PAST: ☐ P ☐ C ☐ S

2. Distress / Avoidance

How scared did ____ make you?
Did it make your stomach upset or your heart race? How long did ___ last?
Are you more scared of ____ than any of your friends?
Has there ever been a time when your fear of ____ kept you from doing anything?
Did you try to avoid ____?
Were there times you could ____?
If someone was with you, could you ____?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Associated with only mild transient symptoms of distress. Minimal or inconsistent avoidance.
( )	( )	( )	**3 -** Threshold: Feared stimuli or situations associated with moderate to severe symptoms of distress. Stimuli or situations consistently avoided.

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE AGORAPHOBIA (CURRENT) SECTION OF THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS ON EITHER OF THE PREVIOUS ITEMS, COMPLETE THE AGORAPHOBIA (PAST) SECTION OF THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF AGORAPHOBIA.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST AGORAPHOBIA)

NOTE: KEEP IN MIND THE DEVELOPMENTAL LEVEL OF THE CHILD. RATE POSITIVELY ONLY IF SYMPTOM IS ABOVE AND BEYOND WHAT WOULD BE EXPECTED IN A CHILD OF THE SAME AGE AND DEVELOPMENTAL LEVEL.

1. Fears Calamitous Event that will Cause Separation

Did you ever worry that something bad might happen to you where you would never see your parents again? Like getting lost, kidnapped, killed, or getting into an accident?
How much do you worry about this?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasionally worries. Worries more severely and more often than a typical child his/her age.
( )	( )	( )	**3 -** Threshold: Frequently worries in separation situations. Persistent and excessive worry that an untoward event will lead to separation from major attachment figure.

PAST: ☐ P ☐ C ☐ S

2. Fears Harm Befalling Attachment Figure

Has there ever been a time when you worried about something bad happening to your parents? Like what?
Were you afraid of them being in an accident or getting killed?
Were you afraid that they would leave you and not come back?
How much did you worry about this?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasionally worries. Worries more severely and more often than a typical child his/her age.
( )	( )	( )	**3 -** Threshold: Frequently worries in separation situations. Persistent and excessive worry about losing, or about possible harm befalling major attachment figure.

PAST: ☐ P ☐ C ☐ S

3. School Reluctance/Refusal

Was there ever a time when you had to be forced to go to school?
Did you have worries about going to school? Tell me about those feelings.
What were you afraid of?
Had you been going to school?
How often did you miss school or did you leave school early?

NOTE: ONLY COUNT IF SCHOOL AVOIDED IN ORDER TO STAY WITH ATTACHMENT FIGURE OR AT HOME.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Frequently somewhat resistant about going to school but usually can be persuaded to go, missed no more than 1 day in 2 weeks.
( )	( )	( )	**3 -** Threshold: Protests intensely about going to school, or sent home or refuses to go at least 1 day per week. Persistent reluctance or refusal to go to school.

PAST: ☐ P ☐ C ☐ S

P C S

4. Fears Sleeping Away From Home/Sleeping Alone

Has there ever been a time after the age of four, when you were afraid of sleeping alone?
Did you get scary feelings if you had to sleep away from home without your parents being with you?
Do you move to your parent's bed in the middle of the night?
Or do you need your parent to sleep in your bedroom?
Do you avoid sleepovers?

( ) ( ) ( )

( ) ( ) ( )

( ) ( ) ( )

( ) ( ) ( )

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally fearful. Fears of sleeping away or alone more severe and more frequent than a typical child his/her age.

3 - Threshold: Frequently fearful, some avoidance of sleeping alone or away from home. Persistent refusal to go to sleep without being near a major attachment figure or to sleep away from home.

PAST: ☐ ☐ ☐
P C S

P C S

5. Fears Being Alone at Home

Was there ever a time, after the age of 4, when you used to follow your mother wherever she went?
Did you get upset if she was not in the same room with you?
Did you cling to your mother?
Did you check up on your mother a lot?
Did you always want to know where your mother was?
How afraid were you?
How often did this happen?

( ) ( ) ( )

( ) ( ) ( )

( ) ( ) ( )

( ) ( ) ( )

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally fearful. Fears of being alone more severe and more frequent than a typical child his/her age.

3 - Threshold: Clings to mother; fearful, some avoidance of being alone. Persistent and excessively fearful or reluctant to be alone or without major attachment fugures at home.

PAST: ☐ ☐ ☐
P C S

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE SEPARATION ANXIETY DISORDER (CURRENT) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE SEPARATION ANXIETY DISORDER (PAST) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF SEPARATION ANXIETY DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST SEPARATION ANXIETY DISORDER)

	P	C	S
1. Fear of Social Situations	( )	( )	( )
Are you a very shy person?	( )	( )	( )
Have you ever felt nervous, self-conscious or shy around people that you didn't know very well? *Have you ever felt so shy that you just couldn't say anything? Even to another kid?* *Is it difficult for you to be with other kids - even kids you know?* *What kind of situations make you feel uncomfortable?*	( )	( )	( )
__ *Speaking in front of others (e.g. answering questions in class, giving oral reports, show & tell)?* __ *Eating in front of others (e.g. school cafeteria, fast food restaurant)?* __ *Writing in front of others (e.g. at chalkboard, taking tests)?* __ *Using public bathrooms when others are around?* __ *Performance situations (e.g., gym class, recess, sports activities)?* __ *Changing clothes when others are present (e.g., in gym/pool locker room)?* __ *Going to parties or social events?*	( )	( )	( )
How old were you when you first started to feel this way? *For how long have you been feeling this way?*			

NOTE: SHYNESS AND FEAR OF SOCIAL SITUATIONS MUST BE SIGNIFICANTLY AFFECTING THE CHILD. DO NOT RATE POSITIVELY IF EXCLUSIVELY ACCOUNTED FOR BY ANOTHER PSYCHIATRIC DISORDER (i.e., PDD/ASPERGER'S DISORDER)

0 - No information.

1 - Not present.

2 - Subthreshold: Clearly self-conscious and uncomfortable in social performance situations; avoids only 1 or 2 activities that are not critical to the child's well being (e.g. avoiding large parties where child knows no one).

3 - Threshold: Considerable self-consciousness that makes the child uncomfortable in several social settings; at least 1 activity is avoided (e.g., repeatedly and persistently refusing to give presentation at school, avoiding gatherings where child does not know everyone). A marked and persistent fear of social performance situations - fears acting in a way (or showing anxiety symptoms) that will be humiliating or embarrassing. **DO NOT CODE AS THRESHOLD IF THE CHILD'S ONLY FEAR IS GIVING ORAL PRESENTATIONS AT SCHOOL.**

PAST: ☐ P ☐ C ☐ S

__ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF EITHER OF THE PREVIOUS ITEMS, COMPLETE THE SOCIAL PHOBIA (CURRENT) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

__ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF EITHER OF THE PREVIOUS ITEMS, COMPLETE THE SOCIAL PHOBIA (PAST) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

__ **NO EVIDENCE OF SOCIAL PHOBIA**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST SOCIAL PHOBIA)

Only rate most intense phobia.

	P	C	S
1. Specific Phobias	( )	( )	( )
Are you very afraid of anything?	( )	( )	( )
Are you really, really scared to death of crowds, being outside alone, being on a bridge or traveling in a bus, train or automobile?	( )	( )	( )
*Has there ever been a time when you were really scared to death of dogs, horses, insects, heights, elevators, subway, the dark... (*ask about all situations listed*).*	( )	( )	( )
Were you afraid of any other things?			

0 - No information.

1 - Not present.

2 - Subthreshold: Fear of stimuli or situation more severe than a typical child his/her age.

3 - Threshold: Marked and persistent fear that is excessive and unreasonable, cued by the presence or anticipation of a specific object or situation.

PAST: ☐ ☐ ☐
P C S

	P	C	S
2. Distress/Avoidance	( )	( )	( )
How scared did ___ make you?	( )	( )	( )
Did it make your stomach upset or your heart race?			
How long did ___ last?	( )	( )	( )
Are you more scared of ___ than any of your friends?			
Has there ever been a time when your fear of ___ kept you from doing anything?			
Did you try to avoid ___?	( )	( )	( )
Were there times you could ___?			
If someone was with you, could you___?			

0 - No information.

1 - Not present.

2 - Subthreshold: Associated with only mild transient symptoms of distress. Minimal or inconsistent avoidance.

3 - Threshold: Fear of stimuli or situation associated with moderate to severe symptoms of distress. Feared stimuli or situation consistently avoided.

PAST: ☐ ☐ ☐
P C S

Specify most intense phobia:

Specify other phobias:

_ **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF EITHER OF THE PREVIOUS ITEMS, COMPLETE THE SPECIFIC PHOBIA (CURRENT) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF EITHER OF THE PREVIOUS ITEMS, COMPLETE THE SPECIFIC PHOBIA (PAST) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF SPECIFIC PHOBIAS**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST SPECIFIC PHOBIC DISORDERS)

1. Excessive worries

	P	C	S
	( )	( )	( )
Are you a worrier? *Do you worry too much?*	( )	( )	( )
Do you worry more than other kids your age? *Have people said you worry too much?* *Are you nervous a lot?* *Can you give me some examples?*	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Frequently worries somewhat excessively (at least 3 times per week) about anticipated events or current behavior.

3 - Threshold: Most days of the week is excessively worried about at least two different life circumstances or anticipated events or current behavior.

PAST: ☐ P ☐ C ☐ S

NOTE: IF THE ONLY WORRIES THE CHILD BRINGS UP RELATE TO THE ATTACHMENT FIGURE OR A SIMPLE PHOBIA, DO NOT SCORE HERE. ONLY RATE POSITIVELY IF THE CHILD WORRIES ABOUT MULTIPLE THINGS.

In order to rate positively, child must worry above and beyond other children of the same age. Worries must be exaggerated and out of context.

2. Somatic Complaints

	P	C	S
	( )	( )	( )
Was there ever a time when you got sick a lot? *Did you miss school, gym or other activities a lot because you didn't feel well?*	( )	( )	( )
Was there ever a time when you got aches and pains a lot? *Did you get headaches, stomachaches, aches in your legs, backaches?* *Any other types of problems? Everyday? Once in a while?* *When did you get a _____? In the morning, evening, weekends? Only on school days?*	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: occasional symptoms /complaints. Symptoms/complaints more severe and more often than experienced by a typical child his/her age.

3 - Threshold: Frequent symptoms /complaints (more than 1 time per week), somewhat of a problem.

PAST: ☐ P ☐ C ☐ S

NOTE: DO NOT COUNT IF ONLY RELATED TO SEPARATION SITUATION OR SCHOOL REFUSAL.

NOTE: DO NOT COUNT IF SYMPTOMS ARE KNOWN TO BE CAUSED BY A REAL MEDICAL ILLNESS.

Look especially for repetitive vague symptoms (i.e., stomach ache/headache).

	P	C	S	
3. Marked Feeling of Tension/Unable to Relax	( )	( )	( )	**0 -** No information.
Was there ever a time when you felt "up-tight" or tense a lot?	( )	( )	( )	**1 -** Not present.
Like you couldn't relax even if you tried?				
Did you get so nervous that you couldn't sit still?	( )	( )	( )	**2 -** Subthreshold: Frequently nervous /anxious (more than 1 time per week), somewhat of a problem.
Did you often feel jumpy or "on edge"?	( )	( )	( )	**3 -** Threshold: Most days of the week is nervous / anxious.

PAST: ☐ ☐ ☐
P C S

- **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE GENERALIZED ANXIETY DISORDER (CURRENT) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**
- **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE GENERALIZED ANXIETY DISORDER (PAST) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**
- **NO EVIDENCE OF GENERALIZED ANXIETY DISORDER.**

NOTES: RECORD DATES OF POSSIBLE CURRENT AND PAST GENERALIZED ANXIETY DISORDER).

	P	C	S
1. Obsessions	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Suspected or likely.

3 - Threshold: Definite obsessions, causes some effect on functioning or distress.

PAST: ☐ P ☐ C ☐ S

Recurrent and intrusive thoughts, impulses, or images that, are distressing and debilitating and over which the person has little control.

Has there ever been a time when thoughts popped into your mind over and over and you couldn't get rid of them?
Has there ever been a time when you were bothered by thoughts, "pictures" or words which kept coming into your head for no reason and that you couldn't stop or get rid of?
Did you ever worry a lot about having dirt or germs on your hands, or worry that you might get ill from dirt or germs?
Did you ever worry about doing things perfectly or about making things even or arranging things in a certain way?
What about thoughts that something bad might happen, or that you did something terrible, even though you knew it wasn't true?
Any other types of thoughts that kept running around your mind?
What about silly thoughts, words, or numbers which wouldn't go away?
How often did you think about them?
Were they like a hiccup that won't go away, just kept coming again and again?
Are these thoughts annoying to you?
Did they not seem to make any sense?
Do these thoughts get in your way or stop you from doing things?

NOTE: DO NOT SCORE OBSESSIONS ITEMS POSITIVELY IF IDEAS / THOUGHTS ARE DELUSIONAL, OR ARE EXCLUSIVELY DUE TO ANOTHER AXIS I DISORDER (e.g. thoughts of food in the presence of an eating disorder; thoughts that parents will get harmed in the presence of a separation anxiety disorder; increased worries from GAD). DO NOT RATE POSITIVELY IF SAYS, "I cannot stop thinking about boy/girlfriend or music."

	P	C	S
2. Compulsions	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Suspected or likely.

3 - Threshold: Definite compulsions, causes some effect on functioning or distress.

PAST: ☐ P ☐ C ☐ S

Recurrent intrusive, repetitive, purposeful behaviors performed in response to an obsession, according to certain rules, or in stereotyped fashion that are distressing and debilitating and over which the person has little control.

Has there ever been a time when you found yourself having to do things that seemed silly over and over, or things which you could not resist repeating like touching things, or counting or washing your hands many times, or checking locks or other things?
Have you ever found yourself having to repeat certain actions over and over?
Did you feel you had any control over them? Did these things bother you?
Were there things you always felt you had to do exactly the same way or in a special way?
Did you ever have trouble finishing your school work because you had to read parts of an assignment over and over or because you were writing and re-writing your homework over and over again?
Did you ever have trouble making it to school on time because it takes too long to get ready in the morning?
If you made a mistake on your school work, did you have to start at the beginning?
What about when you went to sleep, did you have to check something several times before you fell asleep?
Or did you have to arrange things in your room in a particular way?
Have other people ever commented about these habits?

NOTE: DO NOT RATE POSITIVELY IF BEHAVIOR IS EXCLUSIVELY ACCOUNTED FOR BY ANOTHER DISORDER (e.g., PDD, Asperger's, tics, psychosis, eating disorder).

_ **IF RECEIVED A SCORE OF 3 ON CURRENT RATINGS OF EITHER OBSESSIONS OR COMPULSIONS ITEM, COMPLETE OBSESSIVE COMPULSIVE DISORDER (CURRENT) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON PAST RATINGS OF EITHER OBSESSIONS OR COMPULSIONS ITEM, COMPLETE OBSESSIVE COMPULSIVE DISORDER (PAST) SECTION IN THE ANXIETY DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

_ **NO EVIDENCE OF OBSESSIVE COMPULSIVE DISORDER.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST OBSESSIVE COMPULSIVE DISORDER).

1. Repeated Voiding

A lot of kids sometimes have accidents and wet their beds when they sleep at night. Has there ever been a time when this happened to you?
Did you ever have accidents during the day?
What about if you laughed or sneezed real hard?

a. Night time

How often did this happen at night?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** At least one to four times a month for three or more months.
( )	( )	( )	**3 -** At least two times a week for three consecutive months.

PAST: ☐ P ☐ C ☐ S

b. Daytime

How often did this happen during the day?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** At least one to four times a month for three or more months.
( )	( )	( )	**3 -** At least two times a week for three consecutive months.

PAST: ☐ P ☐ C ☐ S

c. Total

Estimate frequency of combined nighttime and daytime accidents.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** At least one to four times a month for three or more months.
( )	( )	( )	**3 -** At least two times a week for three consecutive months.

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 2 OR ABOVE ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF RECEIVED A SCORE OF 2 OR ABOVE ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF NO EVIDENCE OF ENURESIS, GO TO ENCOPRESIS SECTION ON PAGE 24.**

Distress

What did you usually do when you had an accident? Did you tell your mom? Your teacher? What did they do? Did the kids at school know you sometimes had accidents? How much did it bother you when you had an accident?

Impairment: (home, school, peers)

Duration: (specify)

2. Evidence of Enuresis

DSM-IV Criteria

A. Repeated voiding of urine into bed or clothes (whether involuntary or intentional);
B. The behavior is clinically significant as manifested by either a frequency of twice a week for at least three consecutive months, the presence of clinically significant distress or functional impairment in social, academic (occupational), or other important areas of functioning;
C. Chronological age is at least 5 years (or equivalent developmental level);
D. The behavior is not due exclusively to the direct physiological effect of a substance (e.g., a diuretic) or a general medical condition (e.g., diabetes, spina bifida, a seizure disorder).

__ **MEETS DSM-IV CRITERIA FOR ENURESIS (CURRENT). (Scored 3 OR 2 plus impairment).**

__ **MEETS DSM-IV CRITERIA FOR ENURESIS (PAST). (Scored 3 OR 2 plus impairment)**

NOTES: (RECORD DATES OF CURRENT AND PAST ENURESIS).

1. Repeated Passage of Feces

Some kids have accidents and soil their beds when they sleep at night. Did this ever happen to you?
Has there ever been a time when you had accidents and went to the bathroom in your pants during the day?
What about when you were really scared, or for some reason couldn't get to a bathroom when you needed to?
What kinds of accidents were you having?
Number one or number two?

NOTE: ONLY RATE POSITIVELY IF THERE ARE STOOLS IN THE PATIENT'S UNDERWEAR.

a. Night time

How often did this happen at night?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2** - Subthreshold: Less than 1 time a month.
( )	( )	( )	**3 -** Threshold: 1 or more times a month for at least 3 months.

PAST: ☐ P ☐ C ☐ S

b. Daytime

How often did this happen during the day?

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Less than 1 time a month.
( )	( )	( )	**3 -** Threshold: 1 or more times a month for at least 3 months.

PAST: ☐ P ☐ C ☐ S

c. Total

Estimate total number of nighttime and daytime accidents.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Less than 1 time a month.
( )	( )	( )	**3 -** Threshold: 1 or more times a month for at least 3 months.

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 2 OR ABOVE ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF RECEIVED A SCORE OF 2 OR ABOVE ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE QUESTIONS ON THE FOLLOWING PAGE.**

_ **IF NO EVIDENCE OF ENCOPRESIS, GO TO ANOREXIA NERVOSA SECTION ON PAGE 26.**

Distress

What did you usually do when you had an accident? Did you tell your mom? Your teacher? What did they do? Did the kids at school know you sometimes had accidents? How much did it bother you when you had an accident?

Impairment: (home, school, peers)

Duration: (specify)

2. Evidence for Encopresis

DSM-IV Criteria

A. Repeated passage of feces into inappropriate places (e.g. clothing or floor) whether involuntary or intentional;
B. At least one such event a month for at least 3 months;
C. Chronological age is at least 4 years (or equivalent developmental level);
D. The behavior is not due exclusively to the direct physiological effect of a substance (e.g., laxatives) or a general medical condition except through a mechanism involving constipation.

_ **MEETS DSM-IV CRITERIA FOR ENCOPRESIS (CURRENT).**

_ **MEETS DSM-IV CRITERIA FOR ENCOPRESIS (PAST).**

NOTES: (RECORD DATES OF CURRENT AND PAST ENCOPRESIS).

Begin this section with a brief (2-3 minute) semi-structured interview to obtain information about eating habits:

Do you think you are too fat?
Has there ever been a time when you wished you were thinner?
Were you on any kind of diet?
What was your weight? What did you want your weight to be?
If you got down to that weight, what difference do you think it would have made in your life?

1. Fear of Becoming Obese

Has there ever been a time when you were afraid of getting fat?
Did you believe you were fat?
Have you ever been really overweight?
Did you watch what you ate and think about what you ate all the time?
Were you afraid of eating certain foods because you were afraid they'd make you fat? What foods?
How much time did you spend thinking about food and worrying about getting fat?
If you saw that you had gained a pound or two, did you change your eating habits?
Fast for a day or do anything else?

NOTE: KEEP IN MIND DIFFERENTIAL DIAGNOSES OF ANXIETY DISORDER, OCD, AND PSYCHOSIS.

	P	C	S
0 - No information.	( )	( )	( )
1 - Not present.	( )	( )	( )
2 - Subthreshold: Intense and persistent fear of becoming fat, which defies prior weight history and/or present weight, reassurance, etc. Fears have only moderate impact on behavior and/or functioning (e.g., weight loss methods utilized at least once a month, but less than once a week).	( )	( )	( )
3 - Threshold: Intense and persistent fear of becoming fat, that has severe impact on behavior and/or functioning (e.g., constantly pre-occupied with weight concerns; or use of weight loss methods 1 time a week or more).	( )	( )	( )

PAST: ☐ P ☐ C ☐ S

2. Emaciation

Weight is proportionally lower than ideal weight for height (see table).

If, by observation, there is any suspicion of emaciation, you must weigh the child, and look at the table (see attached). If in doubt do not ask, just weigh the child.

NOTE: DO NOT RATE POSITIVELY IF WEIGHT LOSS IS DUE TO A MEDICAL CONDITION OR MOOD DISORDER.

	P	C	S
0 - No information.	( )	( )	( )
1 - Not present.	( )	( )	( )
2 - Subthreshold: Weight below 90% of ideal.	( )	( )	( )
3 - Threshold: Weight below 85% of ideal.	( )	( )	( )

PAST: ☐ P ☐ C ☐ S

_ **IF RECEIVED A SCORE OF 3 ON CURRENT RATINGS OF EITHER OF THE PRECEDING ITEMS, COMPLETE THE ANOREXIA NERVOSA SECTION (CURRENT) IN THE EATING DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON PAST RATINGS OF EITHER OF THE PRECEDING ITEMS, COMPLETE THE ANOREXIA NERVOSA SECTION (PAST) IN THE EATING DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

_ **NO EVIDENCE OF ANOREXIA NERVOSA.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST ANOREXIA NERVOSA).

1. Weight Loss Methods

Have you ever used diet pills to control your weight?
How about laxatives, or water pills to lose weight?
Did you sometimes make yourself throw up?
Did you exercise a lot, more than was usual for you, in order to lose weight? How much? How many hours a day?
Did you have periods of at least 1 week during which you had nothing but liquids with no calories (teas, diet sodas, coffee, water)?

Criteria
0 = No Information
1 = Not present
2 = Less than one time a week
3 = One or more times a week

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
a. using diet pills	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
b. taking laxatives	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
c. taking water pills	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
d. throwing up	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
e. exercising a lot	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
f. taking only non-caloric fluids for a week or more	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
g. combined frequency weight loss methods	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )

P	C	S	
( )	( )	( )	**0 -** No information
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Eating binges that occur less than once a week.
( )	( )	( )	**3 -** Threshold: Eating binges once a week or more.

PAST: ☐ ☐ ☐
P C S

2. Eating Binges or Attacks

Recurrent discrete episodes of uncontrollable excessive rapid eating of high caloric, easily ingested foods, lasting at most a few hours, during which the patient usually hides, and which terminate by abdominal pain, throwing up, or falling asleep, and which may be followed by depressed mood and low self esteem. For example, a typical binge is at least 2000-3000 calories or more.

Has there ever been a time when you had "eating attacks" or binges?
What's the most you ever ate at one time?
Have there ever been times you ate so much you felt sick? How often did it happen?
(ascertain all details in definition)
What triggered a binge?
What did you usually eat when you binged?
What was the most food you have eaten during a binge?
Did you ever make yourself throw up after a binge?
How did you feel after you binged?
Did you usually binge alone or with other people?
Did other people know you binged?

NOTE: ONLY RATE EATING BINGES THAT ARE PATHOLOGICAL (e.g. hidden from family members and peers, followed by depressed mood, and/or throwing up behavior). DO NOT RATE TYPICAL ADOLESCENT EATING ORGIES (e.g. outings with friends for pizza and ice cream).

_ **IF RECEIVED A SCORE OF 3 ON CURRENT RATINGS OF ANY OF THE WEIGHT LOSS METHODS OR THE BINGES ITEM, COMPLETE THE BULIMIA (CURRENT) SECTION IN THE EATING DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **IF RECEIVED A SCORE OF 3 ON PAST RATINGS OF ANY OF THE WEIGHT LOSS METHODS OR THE BINGES ITEM, COMPLETE THE BULIMIA (PAST) SECTION IN THE EATING DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

_ **NO EVIDENCE OF BULIMIA.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST BULIMIA NERVOSA).

Determine the age of onset for first positively endorsed ADHD symptom. If symptom has persisted since early childhood, use the current rating to describe the symptom's most intense severity over the past year. Score symptom as 'not present' in the past unless prior episode of symptomatology was followed by a period of six months or more in which the child was free of ADHD problems.

If onset of symptoms is after age 8, be careful to assess other disorders, e.g., mood disorders/anxiety disorders.

Compared to other children/adolescents this age, how would parent/adult rate this child/adolescent. Also ask if teachers or others have complained about particular symptoms or behaviors.

If the symptoms are episodic, consider the presence of a mood disorder or other causes (e.g., alcohol, drugs or medical problems).

If the child is being treated with stimulants, rate for most severe period prior to medication or during drug holidays and note in margin which symptoms are improved with medication.

Probe: For how long has _____ been a problem? Has it been a problem since kindergarten? First grade? Did the problem start even earlier?

P C S

1. Difficulty Sustaining Attention on Tasks or Play Activities

( ) ( ) ( )

Has there ever been a time when you had trouble paying attention in school? Did it affect your school work?
Did you get into trouble because of this?
When you were working on your homework, did your mind wander?
What about when you were playing games? Did you forget to go when it was your turn?
Did teachers complain?

( ) ( ) ( )

( ) ( ) ( )

NOTE: RATE BASED ON DATA REPORTED BY INFORMANT (e.g., parent or teacher) OR OBSERVATIONAL DATA. DO NOT RATE POSITIVELY IF OCCURS ONLY DURING MOOD EPISODE.

( ) ( ) ( )

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally has difficulty sustaining attention on tasks or play activities. Problem has only minimal effect on functioning.

3 - Threshold: Often (4-7 days/week) has difficulty sustaining attention. Problem has significant effect on functioning.

PAST: ☐ P ☐ C ☐ S

P C S

2. Easily Distracted

( ) ( ) ( )

Was there ever a time when little distractions would make it very hard for you to keep your mind on what you were doing?
Like if another kid in class asked the teacher a question while the class was working quietly, was it hard for you to keep your mind on your work?
When there was an interruption, like when the phone rang, was it hard to get back to what you were doing before the interruption?
Were there times when you could keep your mind on what you were doing, and little noises and things didn't bother you?
How often were they a problem?
Did teachers complain?

( ) ( ) ( )

( ) ( ) ( )

NOTE: RATE BASED ON DATA REPORTED BY INFORMANT OR OBSERVATIONAL DATA. DO NOT RATE POSITIVELY IF OCCURS ONLY DURING MOOD EPISODE.

( ) ( ) ( )

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally distractible. Problem has only minimal effect on functioning.

3 - Threshold: Attention often (4-7 days/week) disrupted by minor distractions other kids would be able to ignore. Problem has significant effect on functioning.

PAST: ☐ P ☐ C ☐ S

3. Difficulty Remaining Seated

Was there ever a time when you got out of your seat a lot at school?
Did you get into trouble for this?
Was it hard to stay in your seat at school? What about dinner time?

Parents: *When your child was young, were you able to take him/her to church? Restaurants?*
Were these difficulties beyond what you would expect for a child his/her age?

NOTE: RATE BASED ON DATA REPORTED BY INFORMANT OR OBSERVATIONAL DATA.

Take into account that these symptoms tend to improve with age. Carefully check if this symptom was present when the child was younger.

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasionally has difficulty remaining seated when required to do so. Problem has only minimal effect on functioning.
( )	( )	( )	**3 -** Threshold: Often (4-7 days/week) has difficulty remaining seated when required to do so. Problem has significant effect on functioning.

PAST: ☐ P ☐ C ☐ S

4. Impulsivity

Do you act before you think, or think before you act?
Has there ever been a time when these kinds of behaviors got you into trouble? Give some examples.

(THIS ITEM IS NOT A DSM-IV CRITERION - DO NOT INCLUDE IN SYMPTOM COUNT)

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasionally impulsive. Problem has only minimal effect on functioning.
( )	( )	( )	**3 -** Threshold: Often (4-7 days/week) impulsive. Problem has significant effect on functioning.

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE ATTENTION DEFICIT HYPERACTIVITY DISORDER (CURRENT) SECTION IN THE BEHAVIORAL DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE ATTENTION DEFICIT HYPERACTIVITY DISORDER (PAST) SECTION IN THE BEHAVIORAL DISORDERS SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF ATTENTION DEFICIT DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST ATTENTION DEFICIT HYPERACTIVITY DISORDER).

The essential feature of this disorder is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months and occurs more frequently than is typically observed in individuals of comparable age and developmental level.

Keep in mind differential diagnoses of depressive disorder, bipolar disorder, anxiety disorders, ADHD, psychosis, substance use disorders or medical illness. Also consider environmental issues.

While the DSM-IV is not clear regarding this issue, consider making this diagnosis if symptoms are present in more than one setting (i.e., home and school) consider diagnosis of Parent-Child Relational Problem if symptoms occur ONLY at home.

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1. Loses Temper

Has there ever been a time when you would get upset easily and lose your temper?
Did it take much to get you mad?
How often did you get really mad or annoyed and lose your temper?

In order to be sure this is a temper outburst, ask:
Where do you lose your temper?
What do you do when you have a temper tantrum?

P	C	S
( )	( )	( )
( )	( )	( )
( )	( )	( )
( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Occasional temper outburst. Outbursts more severe and more often than a typical child his/her age **(at least 1 time weekly)**.

3 - Threshold: Less severe outbursts daily or severe temper outbursts 2 - 5 times a week.

PAST: ☐ P ☐ C ☐ S

2. Argues A Lot With Adults

Was there ever a time when you would argue, talk back, "smart mouth" a lot with adults? Your parents or teachers?
What kinds of things did you argue with them about?
Did you argue with them a lot?
How bad did the fights get?

NOTE: ARGUING INCLUDES AN UNWILLINGNESS TO COMPROMISE, GIVE IN, OR NEGOTIATE WITH ADULTS OR PEERS.

P	C	S
( )	( )	( )
( )	( )	( )
( )	( )	( )
( )	( )	( )

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally argues with parents and/or teachers. Arguments more severe and more often than a typical child his/her age.

3 - Threshold: Often argues with parents and/or teachers. Daily or nearly daily **(4-7 days per week)**.

PAST: ☐ P ☐ C ☐ S

	P	C	S
3. Disobeys Rules A Lot/Defies or refuses to comply with adult requests	( )	( )	( )

Do you ever deliberately defy or disobey the rules at home? School? How often?
Do you think that your parents/teachers ask you to do things that you shouldn't have to do? Like what?

In addition ask the following for adolescents:
How often to you get away with things without getting into trouble or without getting caught? Does this get you into trouble?

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally actively defies or refuses adult requests or rules (e.g., refuses to do chores at home). Disobedient more often than a typical child his/her age.

3 - Threshold: Often actively defies or refuses adult requests or rules, daily or nearly daily (4-7 days a week).

PAST: ☐ ☐ ☐
P C S

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE OPPOSITIONAL DEFIANT DISORDER (CURRENT) SECTION OF THE BEHAVIORAL DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE OPPOSITIONAL DEFIANT DISORDER (PAST) SECTION OF THE BEHAVIORAL DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **NO EVIDENCE OF OPPOSITIONAL DEFIANT DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST OPPOSITIONAL DEFIANT DISORDER).

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal rules are violated. Three behaviors must have been present during the past 12 months with at least one present in the past 6 months.

Keep in mind differential diagnoses of mood disorders, ADHD, psychosis, substance abuse.

If symptoms occur only during mood disorders, consider NOT giving both diagnoses. However, in chronic depression/dysthymia, it may be impossible to disentangle and you might consider giving both diagnoses.

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1. Lies

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Occasionally lies. Lies more often than a typical child his/her age.
( )	( )	( )	**3 -** Threshold: Lies often, multiple times per week or more **(to con or cheat)**.

PAST: [ ] [ ] [ ]
P C S

Everybody lies. Some kids tell lies to exaggerate, some kids tell lies to get out of trouble, while others tell lies to con/cheat others.

Do you ever tell lies?
What type of lies do you tell?
Who do you lie to?
Have people ever called you a liar?
What's the worst lie you ever told?
Did you lie to get other people to do things for you?
Did you lie to get out of paying people back money or some favor you owe them?
Has anyone ever called you a con?
Complained that you broke promises a lot?
How often did you lie?

NOTE: ONLY RATE POSITIVE EVIDENCE OF LYING TO CHEAT OR "CON."

2. Truant

P	C	S	
( )	( )	( )	**0 -** No information.
( )	( )	( )	**1 -** Not present.
( )	( )	( )	**2 -** Subthreshold: Truant on one isolated incident.
( )	( )	( )	**3 -** Threshold: Truant on numerous occasions **(e.g. 2 or more days or numerous partial days)**.

PAST: [ ] [ ] [ ]
P C S

Has there ever been a time when you skipped a whole day of school when your parents didn't know about it?
Did you ever go to school and leave early when you were not really supposed to? How about going in late?
Did you sometimes miss or skip classes in the morning?
Did you get into trouble? How often?

For adolescents: *How old were you when you first started to play hooky?*

NOTE: ONLY RATE POSITIVE INCIDENTS OF TRUANCY BEGINNING BEFORE THE AGE OF 13. IN ADDITION, TRUANCY IS ACTIVELY MISSING PART OR ALL OF A SCHOOL DAY REGARDLESS OF PARENT ABILITY TO ENFORCE ATTENDANCE.

P C S

3. Initiates Physical Fights

( ) ( ) ( )

Has there ever been a time when you got into many fist fights?
Who usually started the fights?
What's the worst fight you ever got into? What happened? Did anyone get hurt?
Who did you usually fight with?
Have you ever hit a teacher? One of your parents? Another adult?
How often did you fight?
Have you ever tried or wanted to kill someone?

Are you or any of your friends in a gang? The Crypts? Bloods? Another gang?

NOTE: TAKE INTO ACCOUNT CULTURE, BACKGROUND, AND NEIGHBORHOOD.

0 - No information.

1 - Not present.

2 - Subthreshold: Fights with peers only. No fight has resulted in serious injury to peer (e.g. no medical intervention required, stitches, etc.).

3 - Threshold: Reports at least one physical fight involving an adult (e.g. teacher, parent) OR reports starting frequent fights, with one or more fights resulting in serious injury to a peer, or frequent fights not resulting in injury (at least 1-2 times per month).

PAST: ☐ P ☐ C ☐ S

○ Check here if evidence of homicidal intent.

○ Check here if evidence of gang involvement.

P C S

4. Bullies, Threatens, or Intimidates Others

( ) ( ) ( )

Do you ever try to bully kids or threaten kids to get them to do something you want them to do?

How often did you do these things:
__ call names or make fun of other kids
__ threaten to hurt other kids
__ push
__ trip
__ come up from behind and slap or knock kids down
__ knock items out of kids hands
__ make other kids do things for you

NOTE: DO NOT COUNT TRIVIAL SIBLING RIVALRY.

0 - No information.

1 - Not present.

2 - Subthreshold: Occasionally bullies, threatens, or intimidates.

3 - Threshold: Bullies, threatens, or intimidates others on multiple occasions, daily, almost daily, or at least several times per week.

PAST: ☐ P ☐ C ☐ S

	P	C	S
5. Nonaggressive Stealing	( )	( )	( )
In the past year, have you stolen anything?	( )	( )	( )
What is the most expensive thing you stole?	( )	( )	( )
What other things have you stolen? From whom? From which stores?			
Have you stolen a toy from a store? Money from your mom? Anything else?			
How often have you stolen things?	( )	( )	( )

NOTE: ONLY COUNT THEFTS OF NON-TRIVIAL VALUE (e.g. $20.00 or more) . EXCEPTION: MULTIPLE THEFTS OUTSIDE THE HOME OF TRIVIAL VALUE.

0 - No information.

1 - Not present.

2 - Subthreshold: Has stolen without confrontation of victim on only one occasion.

3 - Threshold: Has stolen without confrontation of victim on 2 or more occasions.

PAST: ☐ ☐ ☐
P C S

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE CONDUCT DISORDER (CURRENT) SECTION IN THE BEHAVIORAL DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST RATINGS OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE CONDUCT DISORDERS (PAST) SECTION IN THE BEHAVIORAL DISORDERS SUPPLEMENT AFTER FINISHING THE SCREENING INTERVIEW.**

— **NO EVIDENCE OF CONDUCT DISORDER.**

NOTES: (RECORD DATES OF POSSIBLE CURRENT AND PAST CONDUCT DISORDER. MAKE NOTES ABOUT GANG INVOLVEMENT).

	P	C	S
1 Motor Tics	( )	( )	( )

Has there ever been a time when you noticed your muscles moved in a way that you did not want them to, or that you didn't expect?
Like raising your eyebrows (demonstrate), blinking a whole lot (demonstrate), scrunching up your nose (demonstrate), shrugging your shoulders (demonstrate), or moving your head like this (demonstrate)?
Ever blink a whole lot or real hard and not be able to stop?
About how often did this happen?

NOTE: RATE BASED ON REPORT AND OBSERVATION.

Do not rate positively if due to compulsions of OCD or stereotypic movements of PDD.

0 - No information.

1 - Not present.

2 - Subthreshold: Specific tic behaviors occur infrequently, not on a daily basis. If bouts of tics occur, they are brief and uncommon.

3 - Threshold: Specific tic behaviors are present many times a day nearly every day or intermittently throughout a period of one year.

PAST: ☐ P ☐ C ☐ S

	P	C	S
2. Phonic Tics	( )	( )	( )

Has there ever been a time when you made noises that you didn't want to make, repeated sounds or words that you don't want to say?
Like sniffing, coughing, or clearing your throat when you didn't have a cold?
Making animal sounds or grunting sounds, or even repeating things that you or other people said?

NOTE: RATE BASED ON REPORT AND OBSERVATION.

0 - No information.

1 - Not present.

2 - Subthreshold: Specific tic behaviors occur infrequently, not on a daily basis. If bouts of tics occur, they are brief and uncommon.

3 - Threshold: Specific tic behaviors are present many times a day nearly every day or intermittently throughout a period of one year.

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED SCORE OF 3 ON CURRENT RATINGS OF MOTOR OR PHONIC TIC ITEMS, COMPLETE THE TIC DISORDERS (CURRENT) SECTION IN THE TIC DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN**

— **IF RECEIVED SCORE OF 3 ON PAST RATINGS OF MOTOR OR PHONIC TIC ITEMS, COMPLETE THE TIC DISORDERS (PAST) SECTION IN THE TIC DISORDERS SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF TIC DISORDER.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST TIC DISORDERS).

Pervasive Developmental Disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, and the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age.

1) These disorders are usually evident early in life. For each item below, remember to assess the duration of the symptom and whether it has been present by preschool or before. Also, for each item, please remember to synthesize your clinical observation of behavior observed during the interview into the Summary rating.
2) If the child denies it, but parents report and/or you also observe symptom while interviewing the child, give more weight to parents and/or your observation than the child's report because s/he may not be aware of his/her problem.
3) For all symptoms below, take into account whether they are better accounted by other psychiatric disorder (mainly OCD, ADHD, psychosis, mental retardation, severe social anxiety), or medical or neurological conditions. Also, take into account the developmental stage of the child, normal behaviors and emotions, history of abuse or neglect, and the cultural background of the family and the child.
4) Remember to rate the symptoms as positive if you observe them during the interview. For example, parents and/or child may deny that the child has odd movements and the child keeps flapping his/her hands or shows persistent toe walking in your office. Parents or child report that he/she is very personable, friendly and has good non-verbal communication; however, you do not observe this during the interview. In this case, you can bring this to the parents attention in a polite way. For example, you can tell parents, "During the interview, I noticed that your child does not or avoids looking at me (or I saw such and such movements), is this something new or have you and others observed the same?

NOTE: MOST SECTIONS OF THE K-SADS-PL HAVE SAMPLE PROBES TO ELICIT SYMPTOMS FROM CHILDREN. THIS SECTION HAS SAMPLE PROBES TO USE WITH PARENTS, AS IT IS ASSUMED PARENTS WILL BE THE BEST INFORMANTS OF THESE BEHAVIORS, AND MANY CHILDREN WITH AUTISM SPECTRUM DISORDERS WILL NOT HAVE INSIGHT REGARDING THE PRESENCE AND SIGNIFICANCE OF THESE SYMPTOMS. THESE ITEMS SHOULD BE SURVEYED WITH THE CHILDREN, BUT GREATER WEIGHT GIVEN TO PARENT REPORT AND INTERVIEWER OBSERVATIONS WHEN SCORING INDIVIDUAL ITEMS.

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1. Delay in Development of Communication Skills

	P	C	S
	( )	( )	( )
Age of First Single Words: *How old was your child when s/he first used a single word, other than "mama" or "dada"?*	( )	( )	( )
Do you remember the first word s/he used to express something?	( )	( )	( )
Age of First Phrases: *How old was your child when s/he first used 2 or 3 word sentences like "want milk" or "cookie please"?*	( )	( )	( )

NOTE: DO NOT CODE "mama" OR "dada" WHEN ASSESSING SINGLE WORDS. INCLUDE ANY OTHER SPONTANEOUS SOUNDS THAT APPROXIMATED REAL WORDS. IN NORMAL DEVELOPMENT, SINGLE WORDS APPEAR BEFORE 24 MONTHS, PHRASES APPEAR BY 33 MONTHS.

Age - Single Words: ☐☐ months Age - Phrases: ☐☐ months

0 - No information.

1 - Not present. No evidence of language delay.

2 - Subthreshold: Emergence of single words or use of phrases within 3 months of the cut-off for normal language development.

3 - Threshold: Emergence of single words or the use of phrases more than 3 months later than expected.

PAST: ☐ P ☐ C ☐ S

2. Stereotyped and Repetitive Motor Mannerisms

	P	C	S
	( )	( )	( )
Does your child have any unusual motor mannerisms like hand flapping, head weaving, body rocking, or body spinning?	( )	( )	( )
What about a preoccupation with wiggling his/her fingers?	( )	( )	( )
Child: *Do you like to watch your hands while you wiggle your fingers? Does rocking back and forth calm you when you are upset? Do people ever tell you to stay still and stop spinning?*	( )	( )	( )

NOTE: RATE BASED ON PARENT AND CHILD REPORT AND BEHAVIORAL OBSERVATION.

0 - No information.

1 - Not present. No odd hand of finger mannerisms.

2 - Subthreshold: A few isolated incidents, rarely observed.

3 - Threshold: Occasional or more frequent occurrence.

PAST: ☐ P ☐ C ☐ S

P C S

3. Inflexible adherence to specific routines or rituals

( ) ( ) ( )

Is your child rigid and unable to tolerate small changes in plans or routines that you would not expect to cause a problem (like driving to school a different way, going down the grocery store aisles in a different order, or having a picnic on the family room floor instead of eating at the table)?
Do you work real hard to avoid changes in schedule as to not upset your child?
Has he or she been that way since before kindergarten?

For example, when your child outgrows his/her clothes, does he resist wearing new clothes?

Does your child hate changes in routine, like if he /she usually takes a bath or get dressed at a certain time and is unable to do so for some particular reason, does your child get very upset?

Child: *Do you get really upset when there is an unexpected change in your plans or the way you usually do things, like if there is a delay in the start of school, if dinner is a little earlier than usual, or if you have to drive home a different way than usual?*

0 - No information.

1 - Not present. Flexibility within normal range.

2 - Subthreshold: Only mildly inflexible, or inflexibility not evident in early childhood.

3 - Threshold: Significant and persistent rigid adherence to routines and rituals that elicit distress when interrupted. Pattern of behavior evident since early childhood.

PAST: ☐ P ☐ C ☐ S

P C S

4. Persistent preoccupation with one or more stereotyped and restricted patterns of interest

( ) ( ) ( )

Often these are primarily manifest in the development of encompassing preoccupations about a circumscribed topic or interest, about which the individual can amass a great deal of facts and information. These interests and activities are pursued with great intensity often to the exclusion of other activities. Rate focus and/or intensity.

Parent: *Does your child have interests that are not typical for other children his/her age, like an interest in ceiling fans or radiators?*
Has he or she memorized unusual facts like bus schedules, history facts, or other sorts of facts that preoccupy him or her daily?
Does your child have one specific activity that he/she is focused on?
Do you think that he/she is "too obsessed" with certain activities or interests beyond what you would expect for a child of his/her age?

Child: *Is there something special you are interested in that you really like to talk about, read about, or do? Tell me about it.*

NOTE: RATE THIS AS POSITIVE IF IT IS INAPPROPRIATE FOR THE AGE AND CULTURE OF THE CHILD, AND IT IS EXAGGERATED. DO NOT SCORE PREOCCUPATION WITH VIDEOGAMES OR COMPUTER GAMES HERE.

Do not rate positively if behavior related to other diagnosis such as OCD or a psychosis.

0 - No information.

1 - Not present.

2 - Subthreshold: Unusual preoccupations that do not cause significant impairment or take excessive amounts of time.

3 - Threshold: Definitely preoccupied with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus. Causes significant impairment in social functioning or limits participation in other activities.

PAST: ☐ P ☐ C ☐ S

	P	C	S
5. Marked impairment in Non-Verbal Behaviors	( )	( )	( )
	( )	( )	( )
	( )	( )	( )
	( )	( )	( )

Eye to Eye Gaze: *Do you frequently have to remind your child to look at you or the person s/he is talking to?*

Facial Expressions: *Does your child show the typical range of facial expressions?*
Can you see joy on his/her face when /she is happy?
Does s/he pout when s/he is sad?
Does s/he show less common facial expressions like surprise, interest, and guilt?

Gestures: *As a toddler or preschooler, did your child use common gestures like pointing to show interest, clapping when happy, and nodding to indicate 'yes'?*

For school age children and adolescents: *Does he /she use gestures to help show how something works or while they are explaining something?*

0 - No information.

1 - Not present. No problems in any of these areas.

2 - Subthreshold: Subtle problems in one or more area, which is evident to family members and professionals but not to teachers or classmates.

3 - Threshold: Problems with one or more aspects of non-verbal behaviors cause functional impairment.

PAST: ☐ P ☐ C ☐ S

Indicate problematic areas of non-verbal behavior:

○ Gaze ○ Expressions ○ Gestures

- **IF RECEIVED A SCORE OF 3 ON CURRENT RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE AUTISM SPECTRUM DISORDERS (CURRENT) SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

- **IF RECEIVED A SCORE OF 3 ON PAST RATING OF ANY OF THE PREVIOUS ITEMS, COMPLETE THE AUTISM SPECTRUM DISORDERS (PAST) SUPPLEMENT AFTER FINISHING THE SCREEN INTERVIEW.**

- **NO EVIDENCE OF ASPERGER'S/PDD NOS.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST AUTISM SPECTRUM DISORDERS).

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

	Parent	Child	Summary
1. Use	0 1 2	0 1 2	0 1 2
A. Ever smoked	( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
B. Ever chewed tobacco	( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
C. Ever smoked (or chewed) tobacco daily for 1 month or more	( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )

Notes:

— **IF EVER USED TOBACCO, COMPLETE QUESTIONS BELOW.**

— **IF NO EVIDENCE OF TOBACCO USE, GO TO ALCOHOL USE SECTION ON THE FOLLOWING PAGE.**

	Parent	Child	Summary
2. Quantity of Tobacco Use			
A. Current Use (cigarettes/day or "dips" of chew/day)	☐☐	☐☐	☐☐
B. Greatest amount of Use (cigarettes/day or "dips" of chew/day)	☐☐	☐☐	☐☐
Age (years): ☐☐			
3. Have you ever smoked or "dipped" chew at least once a day for a month or more?	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
(1 cigarette or 1 "dip" of chew a day or more for at least 30 days)			
Age of first regular use (in months):	☐☐☐	☐☐☐	☐☐☐
4. Ever attempt to quit	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
5. Ever quit	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
If yes, report longest number of months:	☐☐	☐☐	☐☐

Notes:

Codes for Remaining Items: **0** = No Information **1** = No **2** = Yes

Begin this section with a brief (2-3 minute) semi-structured interview to obtain information about drinking habits.

Probes:

How old were you when you had your first drink?
What's your favorite thing to drink?
Do you have a group of friends you usually drink with, or do you usually drink alone?
Where do you usually drink? At home? Parties? A friend's house? The street? Bars?
Are there special times when you are more likely to drink than others? School dances or other parties?
How old were you when you started to drink regularly, say two drinks or more per week?
In the past six months has there been at least one week in which you had at least two drinks?

	Parent	Child	Summary
1. Use			
A. Drank two drinks in one week four or more times *(one drink is equivalent to a 12oz bottle of beer, 5oz glass of wine, or 1.5oz shot of spirits/hard liquor)*	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )
B. Age above (at first regular use - years)	☐☐	☐☐	☐☐
C. Current frequency of use (days per month)	☐☐	☐☐	☐☐
D. Have you ever had 3 or more drinks in a single day?	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )
2. Problems related to alcohol *Has drinking ever caused you any problems at home? With your parents? With your schoolwork? With your teachers? With your friends? With a job? Have you ever gotten in trouble while drinking?*	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )
3. Received treatment for alcohol problems.	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )	0 ( ) 1 ( ) 2 ( )

Notes:

— **IF RECEIVED A SCORE OF 2 ON ANY OF THE PREVIOUS ITEMS, CONTINUE WITH QUESTIONS ON THE FOLLOWING PAGE.**

— **IF NO EVIDENCE OF CURRENT OR PAST ALCOHOL USE, GO TO SUBSTANCE USE SECTION ON PAGE 43.**

P C S

1. Quantity

A. *How many drinks do you usually have when you sit down to drink?*

( ) ( ) ( ) **0 -** No information.
( ) ( ) ( ) **1 -** 1 - 2 drinks.
( ) ( ) ( ) **2 -** 3 or more drinks.

PAST: ☐ P ☐ C ☐ S

P C S

B. *What's the most you ever drank in a single day? When was that? How about in the last six months? What's the most you drank in a day?*

( ) ( ) ( ) **0 -** No information.
( ) ( ) ( ) **1 -** 1 - 2 drinks.
( ) ( ) ( ) **2 -** 3 or more drinks.

PAST: ☐ P ☐ C ☐ S

P C S

2. Frequency

What's the most number of days in a given week that you had something to drink?
Do you usually drink Friday and Saturday night? Midweek too?

( ) ( ) ( ) **0 -** No information.
( ) ( ) ( ) **1 -** 1 - 2 days.
( ) ( ) ( ) **2 -** 3 or more days.

PAST: ☐ P ☐ C ☐ S

P C S

3. Concern from Others about Drinking

Has anyone ever complained about your drinking? Friends? Parents? Teachers?
Have you ever been worried about it at all?

( ) ( ) ( ) **0 -** No information.
( ) ( ) ( ) **1 -** No.
( ) ( ) ( ) **2 -** Yes.

PAST: ☐ P ☐ C ☐ S

— **IF RECEIVED A SCORE OF 2 ON THE CURRENT RATINGS OF ANY OF THE ABOVE ITEMS, COMPLETE THE ALCOHOL ABUSE (CURRENT) SECTION IN THE SUBSTANCE ABUSE SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 2 ON THE PAST RATINGS OF ANY OF THE ABOVE ITEMS, COMPLETE THE ALCOHOL ABUSE (PAST) SECTION IN THE SUBSTANCE ABUSE SUPPLEMENT AFTER COMPLETING THE SCREEN INTERVIEW.**

— **NO EVIDENCE OF ALCOHOL ABUSE.**

NOTE: (RECORD DATE OF POSSIBLE CURRENT AND PAST ALCOHOL ABUSE).

Codes for Remaining Items: **0** = No Information **1** = No **2** = Yes

Prior to beginning this section, give the subject the list of drugs included in the back of this interview packet. Remind child about the confidential nature of the interview prior to beginning probes (if appropriate).

1. Drug Use

Let me know if you have used any of the drugs on this list before, even if you have only tried them once. Which ones have you used?

	Parent Ever			Child Ever			Summary Ever		
	0	1	2	0	1	2	0	1	2
a. Cannabis *Marijuana, pot, hash, THC*	( )	( )	( )	( )	( )	( )	( )	( )	( )
b. Stimulants *Speed, uppers, amphetamines, dexedrine, diet pills, crystal meth*	( )	( )	( )	( )	( )	( )	( )	( )	( )
c. Sedatives/Hypnotics/Anxiolytics *Barbiturates (sedatives, downers), Benzodiazepine, quaalude (ludes), valium, librium, xanax*	( )	( )	( )	( )	( )	( )	( )	( )	( )
d. Cocaine *Coke, crack*	( )	( )	( )	( )	( )	( )	( )	( )	( )
e. Opioids *Heroin, morphine, codeine, methadone, demerol, percodan, oxycontin*	( )	( )	( )	( )	( )	( )	( )	( )	( )
f. PCP *Angel dust*	( )	( )	( )	( )	( )	( )	( )	( )	( )
g. Hallucinogens *Psychedelics, LSD, mescaline, peyote*	( )	( )	( )	( )	( )	( )	( )	( )	( )
h. Solvents/Inhalants *Glue, gasoline, chloroform, ether, paint*	( )	( )	( )	( )	( )	( )	( )	( )	( )
i. Other *Prescription drugs, nitrous oxide, ecstasy, MDA, etc.* Specify: _____	( )	( )	( )	( )	( )	( )	( )	( )	( )
j. Polysubstance (Assess for combined use of all listed substances)	( )	( )	( )	( )	( )	( )	( )	( )	( )

Notes:

— **IF USED ANY DRUGS, COMPLETE ITEM ON THE FOLLOWING PAGE.**

— **IF NO EVIDENCE OF CURRENT OR PAST SUBSTANCE USE, GO TO POST-TRAUMATIC STRESS DISORDER SECTION ON PAGE 46.**

1. Frequency

In the past six months, what is the most you have used _____?
Every day or almost every day for at least one week? Less? More?
Was there a time when you used _____ more?

Criteria:
0 = No information.
1 = Not present.
2 = Less than once a month.
3 = More than once a month.

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
a. Cannabis *Marijuana, pot, hash, THC*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
b. Stimulants *Speed, uppers, amphetamines, dexedrine, diet pills, crystal meth*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
c. Sedatives/Hypnotics/Anxiolytics *Barbiturates (sedatives, downers), Benzodiazepine, quaalude (ludes), valium, librium, xanax*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
d. Cocaine *Coke, crack*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
e. Opioids *Heroin, morphine, codeine, oxycontin methadone, demerol, percodan*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
f. PCP *Angel dust*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
g. Hallucinogens *Psychedelics, LSD, mescaline, peyote*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
h. Solvents/Inhalants *Glue, gasoline, chloroform, ether, paint*	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
i. Other *Prescription drugs, nitrous oxide, ecstasy, MDA, etc.* Specify: _____	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )
j. Polysubstance (Assess for combined use of all listed substances)	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )	( ) ( ) ( ) ( )

Notes:

Codes for Remaining Items: **0** = No Information **1** = No **2** = Yes

	Parent			Child			Summary		
2. Problems related to substance use/abuse *Has your use of ___ ever caused you any problems at home? With your parents? With your schoolwork? With teachers? With friends? With the police?*	**0** ( )	**1** ( )	**2** ( )	**0** ( )	**1** ( )	**2** ( )	**0** ( )	**1** ( )	**2** ( )

Notes:

— **IF RECEIVED A SCORE OF 3 ON THE CURRENT FREQUENCY ITEM FOR ANY DRUG, COMPLETE THE SUBSTANCE ABUSE (CURRENT) SECTION IN THE SUBSTANCE ABUSE DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

— **IF RECEIVED A SCORE OF 3 ON THE PAST FREQUENCY ITEM FOR ANY DRUG, COMPLETE THE SUBSTANCE ABUSE (PAST) SECTION IN THE SUBSTANCE ABUSE DISORDERS SUPPLEMENT AFTER FINISHING SCREEN INTERVIEW.**

— **NO EVIDENCE OF SUBSTANCE ABUSE.**

NOTE: (RECORD DATE OF POSSIBLE CURRENT AND PAST SUBSTANCE ABUSE).

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever	Child Ever	Summary Ever
A. Car Accident *Have you ever been in a bad car accident?* *What happened?* *Were you hurt?* *Was anyone else in the car hurt?*	Significant car accident in which child or other individual in car was injured and required medical intervention.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
B. Other Accident *Have you ever been in any other type of bad accidents?* *What about a biking accident?* *Other accidents?* *What happened?* *Were you hurt?*	Significant accident in which child was injured and required medical intervention.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
C. Fire *Were you ever in a serious fire?* *Did your house or school ever catch on fire?* *Did you ever start a fire that got out of control? What happened?* *Did anyone get hurt?* *Was there a lot of damage?*	Child close witness to fire that caused significant property damage or moderate to severe physical injuries.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
D. Witness of a Disaster *Have you ever been in a really bad storm, like a tornado or a hurricane?* *Have you ever been caught in floods with waters that were deep enough to swim in?*	Child witness to natural disaster that caused significant devastation.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events (cont')

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever	Child Ever	Summary Ever
E. Witness of a Violent Crime *Did you ever see someone rob someone or shoot them?* *Steal from a store or jump someone?* *Take someone hostage? What happened?* *Where were you when this happened?* *Was anyone hurt?*	Child close witness to threatening or violent crime.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
F. Victim of Violent Crime *Did anyone ever mug you or attack you in some other way? What happened?* *Were you hurt?*	Child victim of seriously threatening or violent crime.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
G. Confronted with Traumatic News *Have you ever gotten some really bad news unexpectedly? Like found out someone you loved just died or was sick and would never get better?*	Learned about sudden, unexpected death of a loved one, or that loved one has life-threatening disease.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
H. Terrorism Related Trauma *Were you affected by the events of 9/11 or some other terrorist attack?*	Loved one missing for extended period of time or seriously injured or killed by terrorist attack.	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events (cont')

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever	Child Ever	Summary Ever
I. War Zone Trauma		0 1 2	0 1 2	0 1 2
		( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
Have you ever lived in a war zone? *Had your home attacked?* *Witnessed the killing or rape of others?* *Seen everything around you set on fire?*	Lived in war zone. Witnessed death and mass destruction.			
J. Witness to Domestic Violence		0 1 2	0 1 2	0 1 2
		( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
Some kids' parents have a lot of nasty fights. They call each other bad names, throw things, threaten to do bad things to each other, or sometimes really hurt each other. *Did your parents (or does your mother and her boyfriend) ever get in really bad fights?* *Tell me about the worst fight you remember your parents having. What happened?*	Child witness to explosive arguments involving threatened or actual harm to parent.			
K. Physical Abuse		0 1 2	0 1 2	0 1 2
		( ) ( ) ( )	( ) ( ) ( )	( ) ( ) ( )
When your parents got mad at you, did they hit you? *Have you ever been hit so that you had bruises or marks on your body, or were hurt in some way? What happened?*	Bruises sustained on more than one occasion, or more serious injury sustained.			

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

1. Traumatic Events (cont')

Probe:

I am going to ask you about a number of bad things that sometimes happen to children your age, and I want you to tell me if any of these things have ever happened to you. Be sure to tell me if any of these things have ever happened, even if they only happened one time.

	Criteria	Parent Ever			Child Ever			Summary Ever		
L. Sexual Abuse		0 ( )	1 ( )	2 ( )	0 ( )	1 ( )	2 ( )	0 ( )	1 ( )	2 ( )
Did anyone ever touch you in your private parts when they shouldn't have? What happened? *Has someone ever touched you in a way that made you feel bad?* *Has anyone who shouldn't have ever made you undress, touch you between the legs, make you get in bed with him/her, or make you play with his private parts?* *Was CYF ever involved with your family?*	Isolated or repeated incidents of genital fondling, oral sex, or vaginal or anal intercourse.									
M. Other		0 ( )	1 ( )	2 ( )	0 ( )	1 ( )	2 ( )	0 ( )	1 ( )	2 ( )
Is there anything else that happened to you that was really bad, or something else you saw that was really scary, that you want to tell me about?	Record incident below.									

Incident: | | | | | | | | | | | | | | |

— **IF EVIDENCE OF PAST TRAUMA (A SCORE OF "2" ON ANY ITEM), COMPLETE THE POST-TRAUMATIC STRESS DISORDER QUESTIONS ON THE FOLLOWING PAGE.**

— **IF NO EVIDENCE OF PAST TRAUMA, END THE SCREENING INTERVIEW. COMPLETE PRELIMINARY LIFETIME DIAGNOSES WORKSHEET AND APPROPRIATE SUPPLEMENTS.**

NOTE: (RECORD DATES OF PAST TRAUMATIC EVENTS).

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

Past trauma screen items:

NOTE: IN DISCUSSING TRAUMATIC EVENTS WITH CHILDREN, IT IS IMPORTANT TO USE THEIR LANGUAGE IN YOUR DIALOGUE. (e.g. Do you think about when he stuck his pee-pee up your bum often?)

If more than one traumatic event was endorsed, ask: Which of these things was most upsetting to you?

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
1. Recurrent Thoughts or Images of Event *Has there ever been a time when you kept seeing _____ again and again?* *How often did this happen?* *Did what happen keep coming into your mind?* *Did you think about it a lot?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
2. Efforts to Avoid Thoughts or Feelings Associated with the Trauma *What kind of things do you do or have you done to keep from thinking about _____?* *To get rid of bad thoughts, some kids, read, do things to keep busy, or go to sleep. Did you ever do any of these things or other things to get rid of those bad thoughts and/or feelings?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
3. Efforts to Avoid Activities or Situations that Arouse Recollection of the Trauma *You said before that ___ sometimes reminds you of what happened. Did you try to avoid ___?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )
4. Nightmares *Has there ever been a time when you had a lot of nightmares?* *Did you ever dream about _____? How often?* *How did you feel when you woke up from one of your nightmares?*	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )

Codes for the Following Items: **0** = No Information **1** = No **2** = Yes

	Parent CE	Parent MSP	Child CE	Child MSP	Summary CE	Summary MSP
5. Repetitive play Related to Event / Re-Enactment	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )	0 1 2 ( ) ( ) ( )

(FOR CHILDREN 12 AND UNDER ONLY)

When you played, did you sometimes pretend that ___?
When you played with your dolls did you sometimes ___?
How often did you have your dolls ___?

In response to sexual abuse, markedly seductive behavior, sexual play with dolls or peers, or increased masturbation may be observed.

In response to physical abuse, markedly aggressive play may be observed.

- **IF RECEIVED A SCORE OF 2 ON CURRENT RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE CURRENT AND PAST POST-TRAUMATIC STRESS DISORDER ITEMS ON PAGE 24 OF THE ANXIETY SUPPLEMENT.**

- **IF RECEIVED A SCORE OF 2 ON PAST RATINGS OF ANY OF THE PRECEDING ITEMS, COMPLETE THE CURRENT AND PAST POST-TRAUMATIC STRESS DISORDER ITEMS ON ON PAGE 24 OF THE ANXIETY SUPPLEMENT.**

NOTE: (RECORD DATES OF POSSIBLE CURRENT AND PAST POST-TRAUMATIC STRESS DISORDER).

KSADS-PL SCREEN INTERVIEW:
Summary Lifetime Diagnosis Checklist

Most Severe Past Episode

0 = No Information
1 = Not Present
2 = Definite Past Episode

Current Episode

0 = No Information
1 = Not Present
2 = Meets Criteria for Current Episode, but in Past 2 weeks, Symptoms are Subsyndromal.
3 = Meets Criteria for Current Episode and Disorder meets full criteria in Past 2 Weeks.

	DIAGNOSIS MOST SEVERE PAST (MSP) EPISODE	AGE OF ONSET MSP EPISODE YEARS / MONTHS	DURATION OF MSP EPISODE (in DAYS)	DIAGNOSIS CURRENT EPISODE	AGE OF ONSET CURRENT EPISODE YEARS / MONTHS	APPROX # OF EPISODES
Major Depressive Episode	0 1 2	☐☐ ☐☐	☐☐☐	0 1 2 3	☐☐ ☐☐	☐☐☐
Psychotic Features?	○ Yes ○ No			Psychotic Features?	○ Yes ○ No	
Dysthymia	0 1 2	☐☐ ☐☐	☐☐☐	0 1 2 3	☐☐ ☐☐	
Depressive Disorder NOS	0 1 2	☐☐ ☐☐	☐☐☐	0 1 2 3	☐☐ ☐☐	
Age of first onset of depressive symptoms that affect functioning		☐☐ ☐☐				
Manic Episode	0 1 2	☐☐ ☐☐	☐☐☐	0 1 2 3	☐☐ ☐☐	☐☐☐
Psychotic Features?	○ Yes ○ No			Psychotic Features?	○ Yes ○ No	
Mixed Episode (MDE & Mania)	0 1 2	☐☐ ☐☐	☐☐☐	0 1 2 3	☐☐ ☐☐	☐☐☐
Psychotic Features?	○ Yes ○ No			Psychotic Features?	○ Yes ○ No	
Hypomanic Episode	0 1 2	☐☐ ☐☐	☐☐☐	0 1 2 3	☐☐ ☐☐	☐☐☐
Bipolar NOS Episode (Subthreshold Manic / Hypomanic Sx)	0 1 2	☐☐ ☐☐	☐☐☐	0 1 2 3	☐☐ ☐☐	
Psychotic Features?	○ Yes ○ No			Psychotic Features?	○ Yes ○ No	

Overall <u>Lifetime</u> Bipolar Diagnosis ○ Bipolar I ○ Bipolar II ○ Bipolar NOS ○ Cyclothymia

Age of first onset of manic/hypo symptoms that affected functioning ☐☐ ☐☐

Subject ☐☐☐☐☐☐☐

Date ☐☐ / ☐☐ / 2 0 ☐☐ Interviewer ☐☐☐

Draft

KSADS-PL SCREEN INTERVIEW:
Summary Lifetime Diagnosis Checklist

	DIAGNOSIS MOST SEVERE PAST (MSP) EPISODE	AGE OF ONSET MSP EPISODE YEARS / MONTHS		DURATION OF MSP EPISODE (in DAYS)	DIAGNOSIS CURRENT EPISODE	AGE OF ONSET CURRENT EPISODE YEARS / MONTHS		APPROX # OF EPISODES
Schizoaffective Disorder Depressive Type	0 1 2				0 1 2 3			
Schizoaffective Disorder Bipolar Type	0 1 2				0 1 2 3			
Schizophrenia	0 1 2				0 1 2 3			
Schizophreniform Disorder	0 1 2				0 1 2 3			
Brief Psychotic Disorder	0 1 2				0 1 2 3			
Psychotic D/O NOS	0 1 2				0 1 2 3			
Age of first onset of psychotic symptoms that first affected functioning								
Encopresis	0 1 2				0 1 2 3			
Enuresis	0 1 2				0 1 2 3			
Panic Disorder	0 1 2				0 1 2 3			
Separation Anxiety Disorder	0 1 2				0 1 2 3			
Simple Phobia	0 1 2				0 1 2 3			
Social Phobia	0 1 2				0 1 2 3			
Agoraphobia	0 1 2				0 1 2 3			
Generalized Anxiety Disorder	0 1 2				0 1 2 3			
Obsessive-Compulsive Disorder	0 1 2				0 1 2 3			
Post-traumatic Stress Disorder	0 1 2				0 1 2 3			
Acute Stress Disorder	0 1 2				0 1 2 3			
Anxiety D/O NOS	0 1 2				0 1 2 3			
Age of first onset of anxiety symptoms that affected functioning								

Subject

Draft

KSADS-PL SCREEN INTERVIEW:
Summary Lifetime Diagnosis Checklist

	DIAGNOSIS MOST SEVERE PAST (MSP) EPISODE	AGE OF ONSET MSP EPISODE YEARS / MONTHS	DIAGNOSIS CURRENT EPISODE	AGE OF ONSET CURRENT EPISODE YEARS / MONTHS
Anorexia Nervosa	0 1 2		0 1 2 3	
Bulimia	0 1 2		0 1 2 3	
Eating D/O NOS	0 1 2		0 1 2 3	
Age of first onset of eating disorder symptoms that affected functioning				
ADHD	0 1 2		0 1 2 3	
	○ Combined ○ Inattentive ○ Impulsive/Hyperactive		○ Combined ○ Inattentive ○ Impulsive/Hyperactive	
ADHD NOS	0 1 2		0 1 2 3	
Conduct Disorder	0 1 2		0 1 2 3	
Oppositional Defiant Disorder	0 1 2		0 1 2 3	
Disruptive D/O NOS	0 1 2		0 1 2 3	
Age of first onset of first behavioral disorder symptoms that affected functioning				
Tourettes	0 1 2		0 1 2 3	
Chronic motor or vocal tic disorder	0 1 2		0 1 2 3	
Tic D/O NOS	0 1 2		0 1 2 3	
Age of first onset of tic disorder symptoms that affecedt functioning				
Asperger's Disorder	0 1 2		0 1 2 3	
Pervasive Developmental Disorder NOS	0 1 2		0 1 2 3	

KSADS-PL SCREEN INTERVIEW:
Summary Lifetime Diagnosis Checklist

	DIAGNOSIS MOST SEVERE PAST (MSP) EPISODE	AGE OF ONSET MSP EPISODE YEARS / MONTHS	DIAGNOSIS CURRENT EPISODE	AGE OF ONSET CURRENT EPISODE YEARS / MONTHS
Alcohol Abuse	0 1 2		0 1 2 3	
Alcohol Dependence	0 1 2		0 1 2 3	
Substance Abuse	0 1 2		0 1 2 3	
Substance Dependence	0 1 2		0 1 2 3	
Age of first onset of substance disorder symptoms that affected functioning				
Adjustment disorder w/ depressed mood	0 1 2		0 1 2 3	
Adjustment disorder w/ anxiety	0 1 2		0 1 2 3	
Adjustment disorder w/ mixed anxiety & depressed mood	0 1 2		0 1 2 3	
Adjustment disorder w/ disturbance of conduct	0 1 2		0 1 2 3	
Adjustment disorder w/ mixed disturbance of emotions & conduct	0 1 2		0 1 2 3	
Other Psychiatric Disorder I	0 1 2		0 1 2 3	
If Other, please specify I:				
Other Psychiatric Disorder II	0 1 2		0 1 2 3	
If Other, please specify II:				

DIRECTIONS: *Check the sections to be completed in each supplement. Note dates and/or ages of onset for each current and past possible disorder.*

Affective Disorders Supplement:

_ Depressive Disorders - Current
_ Depressive Disorders - Past
_ Manic/Hypomanic-Current
_ Manic/Hypomanic-Past

Anxiety Disorders Supplement:

_ Panic Disorders - Current
_ Panic Disorders - Past
_ Separation Disorders - Current
_ Separation Disorders - Past
_ Social Phobia - Current
_ Social Phobia - Past
_ Phobic Disorders - Current
_ Phobic Disorders - Past
_ Overanxious Disorders - Current
_ Overanxious Disorders - Past
_ Obsessive Compulsive Disorder - Current
_ Obsessive Compulsive Disorder - Past

Autistic Disorders Supplement:

_ Autism Spectrum Disorders - Current
_ Autism Spectrum Disorders - Past

Behavioral Disorders Supplement:

_ ADHD - Current
_ ADHD - Past
_ Oppositional Disorder - Current
_ Oppositional Disorder - Past
_ Conduct Disorder - Current
_ Conduct Disorder - Past

Eating Disorders Supplement:

_ Anorexia Nervosa - Current
_ Anorexia Nervosa - Past
_ Bulimia Nervosa - Current
_ Bulimia Nervosa - Past

Post Traumatic Stress Disorders Supplement:

_ PTSD - Current
_ PTSD - Past

Psychotic Disorders Supplement:

_ Psychosis-Current
_ Psychosis - Past

Substance Use/Abuse Supplement:

_ Alcohol Abuse - Current
_ Alcohol Abuse - Past
_ Substance Abuse - Current
_ Substance Abuse - Past

Tic Disorders Supplement:

_ Tics - Current
_ Tics - Past

Childrens Global Assessment Scale (CGAS)

1. Enter a score from 1-100
2. Rate the child/adolescents most impaired level of general functioning during the period rated by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness
3. Use intermediary levels eg. 35, 94, 68
4. Rate actual functioning regardless of treatment or prognosis, using the descriptions below as a guide

100-91	Superior functioning
90-81	Good functioning
80-71	No more than a slight impairment in functioning
70-61	Some difficulty in a single area, but generally functioning pretty well
60-51	Variable functioning with sporadic difficulties
50-41	Moderate degree of interference in functioning
40-31	Major impairment to functioning in several areas
30-21	Unable to function in almost all areas
20-11	Needs considerable supervision
10-1	Needs constant supervision

Principle reference

Schaffer D, Gould MS, Brasic J, et al. (1983) A children's global assessment scale (CGAS). *Archives of General Psychiatry,* 40, 1228-1231.

Description

The Childrens Global Assessment Scale (CGAS) is a measure developed by Schaffer and colleagues at the Department of Psychiatry, Columbia University to provide a global measure of level of functioning in children and adolescents. The measure provides a single global rating only, on scale of 0-100. In making their rating, the clinician makes use of the glossary details to determine the meaning of the points on the scale.

CGAS Glossary

Rate the patient's most impaired level of general functioning for the specified time period by selecting the *lowest* level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (eg 35, 58, 62).

Rate actual functioning regardless of treatment or prognosis. The examples of behaviour provided are only illustrative and are not required for a particular rating.

100-91 *Superior functioning* in all areas (at home, at school and with peers); involved in a wide range of activities and has many interests (eg., has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc); likeable, confident; 'everyday' worries never get out of hand; doing well in school; no symptoms.

90-81 *Good functioning in all areas*; secure in family, school, and with peers; there may be transient difficulties and 'everyday' worries that occasionally get out of hand (eg., mild anxiety associated with an important exam, occasional 'blowups' with siblings, parents or peers).

80-71 *No more than slight impairments in functioning* at home, at school, or with peers; some disturbance of behaviour or emotional distress may be present in response to life stresses (eg., parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.

70-61 *Some difficulty in a single area but generally functioning pretty well* (eg., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behaviour; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60-51 *Variable functioning with sporadic difficulties or symptoms in several but not all social areas;* disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50-41 *Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area,* such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.

40-31 *Major impairment of functioning in several areas and unable to function in one of these areas* (ie., disturbed at home, at school, with peers, or in society at large, eg., persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30-21 *Unable to function in almost all areas* eg., stays at home, in ward, or in bed all day without taking part in social activities *or* severe impairment in reality testing *or* serious impairment in communication (eg., sometimes incoherent or inappropriate).

20-11 *Needs considerable supervision* to prevent hurting others or self (eg., frequently violent, repeated suicide attempts) *or* to maintain personal hygiene *or* gross impairment in all forms of communication, eg., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10-1 *Needs constant supervision* (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.