MENTAL DISORDERS AND ASSOCIATED FACTORS AMONG ADOLESCENTS IN JUVENILE DETENTION, DAR ES SALAAM

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MENTAL DISORDERS AND ASSOCIATED FACTORS AMONG ADOLESCENTS IN JUVENILE DETENTION, DAR ES SALAAM

By

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A dissertation Submitted in partial Fulfilment of the Requirements for the Degree of Master of Science in Nursing (Mental Health) of Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for examination of dissertation entitled ***Mental disorders and associated factors among adolescents in Juvenile Detention, Dar es Salaam*** in fulfilment of the requirements for the degree of master of Nursing (Mental Health) of Muhimbili University of Health and Allied Sciences.

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Dr K.I.Y. Malima

(supervisor)

Date :22-NOV-2010

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DEDICATION

To my wife Lalbella, for her tireless physical and emotional support on me, my son John who has been far away from the scope of my eyes for the whole year, my daughters Victoria, and Gloria who have been making a lot of funnies when I was preparing this work. Also this work is dedicated to my mother Beatrice who has been encouraging me that it can be done struggle more. Last but not mean least is to my father the late John Mbelwa who died when I was just young boy that I could not say thank you for sending me to school.

ABSTRACT

Introduction

The number of children and adolescents admitted in Dar es Salaam juvenile centres due to misbehaviour and criminal offences has risen from 20 to 30 per month. Increasing aberrant behaviours in children have been linked to mental disorders. Assessment of presence mental health disorders as the main cause of these behaviours would be important to restore mental health of children and assist the system to impose a fair trial.

Objective

This study aimed to determine the presence of mental disorders and associated factors among children and adolescents within Dar es Salaam juvenile systems and explore factors that may affect their mental health while in juvenile home.

Methods

The mixed research method was used to estimate prevalence of mental disorders by a cross-sectional study and a qualitative method was applied to evaluate mental disorders according to DSM IV TR criteria.

Results

The overall prevalence of mental dysfunction by mental status evaluation was 3%: 95% (CI; 25.3 – 43.2; n =37 out of 108). The younger age group (13-15) years presented with a prevalence of 30%: 95% (CI; 14.7 – 44.5) while the older adolescents (16 – 17 years) had a prevalence of 55%: 95% (CI; 43.3 – 67.1). Attention deficit disorder was found in some children, some had history of drug and alcohol abuse, with few sexual disorders, depression and brief psychotic reaction and was found to be common among adolescent with unstable family situations such as death of parents, divorce of parents, and single parented children.

Conclusion

Findings are suggestive that there is a presence of underlying mental disorders in some of the adolescents in the juvenile detention. Thus mental health screening for children in juvenile homes should be made mandatory in order to identify causes of aberrant behaviour as well as provide treatment, prevent complications and maintain

mental health of these children. Mental health screening for such children would also assist in conducting a fair trial for these emancipated children.

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Definitions

Crime – An offence against the state that is punishable. In this research the author define crime as a conflict between children/adolescents and country laws.

DSM IV TR – Is a classification of mental disorders that includes description of diagnostic categories. The DSM IV TR 2000 was used in the study as a tool to diagnose children and adolescents with mental dysfunctions.

Detention – Holding a person against his will. This study was conducted in remand home and in the juvenile court therefore all participants were under detention.

Juvenile – a young person, not fully developed. This study focus on children and adolescents since they are not fully independent their care depend on primary, that is from their family and secondary support from the government and other institutions.

Offence – in law an offence is a violation of the penal law.

Law – legal document setting forth rules governing a particular kind of activity.

Mental Health Act – An act of parliament that governs the treatment and care of individuals inactivated through mental illness.

Mc Naughten rule – the Mc Naughten rule state that a person is not responsible for a crime if he does not know what is wrong doing. It the researcher in this study is in view that children and adolescents found with mental disorders should not be responsible with the crime they committed due to unsound mind.

Remand home – A detention home for juvenile offenders aged between 8 to 16 years.

1. INTRODUCTION

The presence of unrecognised mental disorders in children may likely influence inappropriate behaviours and may lead them to commit criminal offences due to unsound mind. The existence of juvenile centres is a service put in place to cater for children who have committed crimes or socially sanctioned behaviours. The juvenile detention, or locally known as remand homes, is the domicile for children for a period extending from awaiting trial and for the duration or after the trial for the purpose fulfilling a sentence for a committed crime or offence.

The Tanzanian mental health act of 1983 stipulates very clearly that it is the client's right to receive rightful sentence after a comprehensive mental status evaluation is performed. The evaluation establishes client to be of sound or unsound mind at the time when the crime or offence was committed. According to the criminal law, when an offence is committed by a person of unsound mind, the sentence is changed from imprisonment to admission to Isanga institution in Dodoma.

However, we are not certain at this point that mental status evaluation is usually performed for children who have committed crimes. This concept underscores the importance of exploring this information with a view to conduct an in-depth situational analysis to determine the prevalence of mental disorders among children within juvenile justice systems in Tanzania. The analysis may provide a true state of affair in regard to mental illness amongst children and afford an avenue for deliberating and formulating adequate intervention to contain the problem.

Tanzania, like most poor resource countries, has an estimated prevalence of mental disorders ranging from 15-20% (Harper and Cetin 2008; Fabiano and Pelham 2002). Despite the burden of mental illness, few people may have access to specialist care for their disorders whereas the rest may resort to other non-conventional treatment (Harper & Cetin, 2008). The children and adolescent services are outpatient services since inpatient care is yet to be developed in Tanzania. The absence of inpatient care for children with mental disorders disregards the priority of

such care in the country. It is imperative that such disregard should now be improved since the increase in numbers of adolescents in these centres is highly suggestive that this problem is escalating. The diagnostic challenges of childhood mental disorders, the lack of mental health specialists in both the nursing and medical professions, and specifically, the lack of child and adolescent psychiatric specialist further impounds the right of treatment and fair trial for children that have socially undesired behaviours that end up in juvenile justice systems. It is also essential that the care givers and mental health practitioners needs to have expertise in the related legal matters in order to improve care of children and adolescents at juvenile justice systems (Mullen, 2000). Identifying association of mental disorders in children and adolescents at juvenile justice system will contribute towards information that may be used to develop optimal standards of mental health care for these members of the society and to link services between justice, health, and education needs of children and adolescents for improvement of their future adulthood.

2. LITERATURE REVIEW

Scientists have established that the brain of a newborn makes up 25% of the total body weight. The percentage of weight decreases by 2% by adulthood. As the weight of the brain decrease brain functions advance as the child continue to grow. This is a crucial stage of mental health as it is at this stage that most care is needed and children must be guided and nurtured to pass through this important stage in life. Good care would ensure that that the child is protected from bad influence of groups, poor nutrition, traumatic brain injury or uncontrolled emotions. If these ill- factors are controlled the child will grow in an atmosphere ideal for the healthy development of the right social skills, emotional control and cognitive abilities necessary for the achievement of maximum potentials in adulthood (US institute for care management foundation, 2005). According to Chamlayrson, et al. (2005) Fine motor skills improvement and differentiation occurs during childhood while during adolescence, perception, motor function, and advanced thinking process further develop. The child remains vulnerable to external forces during periods of brain growth and

development. The influence of drugs, poor nutrition, traumatic brain injury, and absence of emotional nurturance are all examples of factors that can interfere with brain development including cognitive development. Childhood is a crucial period for development of mental health that provides for social skills, emotional health, developmental progression, and cognitive abilities that prepare youth for mental health and achieving maximum potential in adulthood. Review of studies done by the American National Mental Health Association (2001) stated that, children in the juvenile justice system have a higher rate of mental disorders than children in the general population. There is always the potential spill over effect of the mental disorder brought about by the non warranted grouping together of mentally sound children and adolescents and those who are affected. To alleviate the problem it is absolutely essential that the two groups are kept separate so that the affected are treated and rehabilitated and the normal ones are kept in appropriate mental health environments. The report also stated that equivalent rate or more children in the juvenile justice system are receiving mental health care and treatment at mental health units. The situation highly suggests that a substantial number of children in juvenile centres may be there due to aberrant behaviours predisposed by mental health problems.

During childhood, the necessity of bonding and attachment to significant adults forms the cornerstone of the child's healthy mental development (Ball, Bindler & Coween, 2010). Therefore, young children rely on adults for the maintenance of their mental health. The child's unique genetic make up coupled with environmental factors contribute to a state of mental health. Cognitive disorders are also a result of a unique interplay of genetic and environmental causes. Hawkins and colleagues (2009) indicate that community care system reduces health risk behaviours like alcohol abuse, tobacco smoking and other drug use, and delinquent behaviours in adolescents. Hall and Howard (2009) established that adolescents who use nitrates are at high risk to develop serious functional impairments and cognitive function. It has also been suggested that children and adolescents peer groups mimic risk of alcohol use and delinquent behaviours (Ellis WE and Wolfe, 2009).

Children and adolescents who receive little parental/family support or when there is less parental control are strongly related to delinquent activities compared to

those with maximum parental support (Keijser et al., 2009). Plattner et al., (2009) confirmed a high rate of repetitive offences of children and adolescents released from juvenile justice systems and classified sex specific psychopathologic risk factors for relapse. Such findings and increased criminal offences by the younger members of society indicate that there is a need to do more research to identify influencing factors. Some researchers have indicated the need to identifying parental styles that influence on going externalizing behaviour across generations would be important to find out causes (Bailay et al., 2009). While Kering et al., (2008) mentioned that 'youths involved in trauma are at high risk of developing mental health problems'. The results showed stronger relationship in female than male participants of the study.

Matsura, Hashimoto, and Toichi (2009) indicated that there is a relationship between self esteem, aggressiveness, and adverse childhood experience in Japanese children and adolescents admitted to juvenile centres. While clinical trials have found higher levels of serotonin (a neurotransmitter) in juvenile delinquents, which may be associated with such behaviours (Gulubchich at el., 2009). There is a biological influence in aggression and delinquency behaviours that are shown by children and adolescents in every developmental stage (Burn and Neiderhiser, 2009). However aggression has been linked with release of testosterone, progesterone, nor-epinephrine, dopamine, epinephrine, acetylcholine, and serotonin amongst others (Kaplan and Paddocks, 2002). Lorber and Egeland (2009) used developmental models and background history findings and suggested that early parenting is strongly associated with externalizing problems in early childhood than in adolescence. This was evidenced in kindergarten and class one pupils as reported by mothers and school teachers and at 23 and 26 years old though this was self reported data.

Youth Gang groups usually belong from poor social economical communities. These youngsters involve themselves in violence, substance abuse and risky sexual behaviours than their normal peers. Gang youth need more mental health care since they are vulnerable population (Sander et al., 2009). Moreover, Gramkowsky et al., (2009) emphasized that risk behaviours were increased for youths living in foster

care who had history of parental death, physical or emotional abuse and suicidal tendencies. Yen and Wang(2009) indicated that when adolescents return to school after suspension, they experience severe psychosocial and environmental stressors. These stressors, if not taken care of, usually cause a high rate of school dropouts.

According to Ferguson and Mullen (1999), a child with a history of child abuse has a higher risk of developing substance abuse, personality problems, anxiety, and depressive symptoms. Monaham et al. (2000) suggested having collaboration between mental health providers and justice systems to identify risk factors related to violent behaviour in people with mental illness. The above authors did not specify what would happen for children and adolescents at juvenile justice system. Through this research the author addresses the correction within justice juvenile systems. Sheidrick (1999) mentioned that investigations to identify the relationship between psychosis and violence in adults have been done but there is not much literature about violent behaviour in adolescents. Giancola (2000) outlined that neuro-anatomical studies have not yet been conducted on youth but emphasized that youth with risk for violence have cognitive disturbances.

The transitional periods of childhood to adolescents and adolescence to adulthood requires close supervision from parents and parenting environment in order for child to develop positive mental health. If there is disruption in parenting, there is a high risk for the child to develop social problems (Tarler et al., 1999). Ralph (2002) determined the extent to which childhood characteristics and parent characteristics could predict violence behaviours in young adults by using DSM- III-R.

3. PROBLEM STATEMENT

Several studies have shown that there is a relationship between crime and mental disorders in children and adolescents in juvenile centres (Poe-Yamagata and Jones, 2000). According to American national centre for children (2006), approximately 50% of children on the child welfare system have mental disorders and 67% of adolescent in the juvenile justice system have mental disorders. It is possible that

some of these children commit these misdeeds due to mental problems rather than flaw of character.

However, in Tanzania little has been documented about how mental disorders in children and adolescents contribute to committing offences that would lead them to juvenile justice centres.

The incidences of crimes conducted by children and adolescents have increased dramatically and the number of children and adolescents admitted in Dar es Salaam remind home has also risen from 15 to 30 per month. It is necessary to identify the link between mental disorders and crimes committed by children and adolescents. Once the link is known optimal standard of mental health services can be provided to children and adolescents at juvenile justice systems. Understanding other factors that contribute to children and adolescents to commit crimes would also be important to promote early prevention and interventions to avoid complications. On the other hand, the involvement and linkage of mental health practitioners, parents/guardian and the justice system is important to keep balance between justice, mental health care, and social needs of the children and adolescents.

Children and adolescents are involved in several crimes including domestic violence, stealing, rape, drug abuse, unnatural offence; disturb passengers, lying and so on. This study describes the relationship between mental health status of children and adolescents and projected antisocial behaviours.

3.1. RATIONALE

The identification of the presence of actual or potential mental disorders, mental health challenges, and co morbid physical illness among children and adolescents at juvenile justice systems is important to promote mental health of these children, provide a fair trial and also ensures successful prevention of adulthood mental disorders among this group so that they grow to be functional members of society. The study provides additional information for mental health practice for this special group as well as for policy makers and practitioners. The author will disseminate research report to the department of social welfare of the ministry of health, care

givers in the remand home, lawyers and social welfare officers in the juvenile court, mental health practitioners and government officials working with ministry of health.

3.2. RESEARCH OBJECTIVES

BROAD OBJECTIVE

To assess the presence of mental disorders and associated factors among children and adolescents in remind home, and explore factors that may affect their mental health while in juvenile centres.

SPECIFIC OBJECTIVES

1. To determine the magnitude of mental disorders of children and adolescents in Dar es Salaam remind home
2. To identify the link between mental disorders and crimes committed by children and adolescents.
3. To determine factors that may affect the mental health of children while in juvenile centres

RESEARCH QUESTIONS

1. What is the mental status evaluation of children and adolescents who have committed crimes and are in juvenile justice systems?
2. Is there an association of mental health disorders among children and adolescents with the crimes they committed?

4. METHODOLOGY

4.1. Design

The researcher used two methods, a cross-sectional method to estimate the prevalence of mental disorders among children in juvenile centres (cross section means at one point in time). The researcher had questionnaires of 53 items using Likert Scales . Qualitative method was applied in the DSM IV TR diagnostic criteria to evaluate the mental disorders. In qualitative method, in-depth interviews and focus group discussions of children, parents, and care givers were used to assess mental disorders among children and adolescent at juvenile systems by using DSM IV TR multiaxis, and bio psychosocial formulation to elicit diagnosis and causes that led children and adolescent to appear before juvenile justice systems.

4.2. Study setting

Dar es salaam remand home which is situated in Upanga West, Alykhan road. This centre was established in 1962 under the caption no 21 of the law of the child Act which was amended in year 2009. This remand home work hand in hand with juvenile court situated at Kisutu adjacent to Kisutu high court building.

4.3. Study population

All children and adolescents in Dar es Salaam juvenile systems between May, to August, 2010 (study period). Children age 6 to 12 years old and adolescents age between 13 to 17 years old within Dar es Salaam justice systems.

4.4. Sample size

Due to the nature and paucity of such institutions in Dar es Salaam, the researcher deployed convenience sampling so the study invited to participate, all children and adolescents that were found in the remand home during the study period that was from May to August, 2010. Children/adolescents were consequently invited to

participate and were enrolled only once (those who were discharged and readmitted during the study period were enrolled only once) and the final number of participants was one hundred and eight (108).

4.5. Data collection

Self administering questionnaires were used for quantitative data to estimate the magnitude of mental disorders. These questionnaires focused on the theory of planned behaviour by Icek Ajzen 2006, where by predetermined components attitude toward the behaviour was used to assess the degree to which misconduct behaviour was valued positively or negatively by participants. Subjective norms, were asseseed by measuring the social pressure of adolecents to engage or not to engage in deliquence behavours and perceived behaviour control was assesed by measuring paricipants ability to perform a given misconduct behaviour. In qualitative data, mental status evaluation, DSM IV TR multiaxis, descriptive formulation and bio psychosocial formulation were used as interview guide to identify mental state of participants and possible causes of mental dysfunction. Focus group discussion to participants, parents and care givers were also used to collect qualitative data.

4.6. Data analysis

The web based statistical soft ware was used to calculate the proportions (age, sex residential area, education level, and parent's marital status), prevalence of mental disorders and their confidence interval. The soft ware was accessed on http://dimensionresearch.com/resource/calculators/conf_pro.html. Results are summarised in tables. The qualitative content analysis was used to analyse main categories and themes from qualitative data.

4.7 Ethical considerations

The following are the main ethical considerations that were implemented to preserve dignity, safety, and privacy of participants.Study participants were minors, therefore they are not at the legal age for giving consent, instead there was involvement of parents/ guardians for informed consent to participate to the study. Apart from that the investigator also gave adequate information to the study participants in order to give assent to children and adolescents as an agreement to participate to the study. A payment of 5000/= (Tanzanian shillings) as reimbursement for transportation of the parents or guardians who were involved in the focus group discussions. Signed consent forms and information gathered stored in locked cabinets. Autonomy of the research participants were preserved by eliminating their names and identities from the field notes, only the investigator who have the names of the subjects. Research study materials were preserved appropriately to maintain confidentiality. There was no discomfort or risk associated with this study. Physical and mental disorders diagnosed among children and adolescents at Dar es Salaam juvenile justice systems were referred to appropriate health setting for further investigation and management.

In case in the future other researchers needs to access to the information that gathered during this research to answer questions related to it. If so, an ethical review board will first review the new study to ensure that they use the information ethically

5. RESULTS

5.1. Demographic characteristics of children and adolescents in remand home between 2010

The study enrolled all one hundred and eight (108) children and adolescents that were found at the remand home during the study period. Children aged 13 to 15 were 45 (41%), while adolescents were 63 (58%)

Children and adolescents who lost their parents through death and divorced were more frequent than those who were living together with their parents. Either it was noted that those whose parents were divorced were reared by single parents,

father or mother or extended families of uncles, aunt and grand parents. Those participants whose parents had died were living on the streets and the main catchment area was Ubungo bus terminal. They migrated from up country regions and when they arrived in Dar es Salaam they engaged themselves in petty businesses and carrying passenger's luggage to get some money for living.

Parents living situation

Children and adolescents in remind home 58.7% their parents died, while 44% their parents had divorce. Only 6% found to have parents who are living together. The age group of children and adolescents is between 13 to 17 years old as shown in **table 1.**

Table 1: Demographic characteristics of children and adolescents in the remand home from May to August 2010

Variable	**N(%)**	**95% CI**
Age 13 – 15yrs 16- 17yrs	37(34.2) 61(5.5)	8.95(25.3-43.2) 9.35(47.1-65.8)
Sex Males Females	100(92.5) 8(7.4)	4.94(87.6 97.5) 4.94(2.4-12.3)
Residential area in Dar es salaam **Street** **home**	92(85.1) 16(14.8)	6.7(78.4-91.8) 6.7(8.1-21.5)
Present education level Primary school Secondary (O'level) School drop out	10(9.2) 6(5.5) 92(85.9)	5.47(3.7-14.7) 4.3(1.2-9.8) 6.7(78.4-91.8)
Parents marital status Married Divorsed died	 6(5.5) 44(40.7) 58(53.7)	 4.32(1.2-9.8) 9.2(31.4-50.0) 9.4(44.3-63.1)
Total	**108**	

5.2. *Signs of mental dysfunction*

The second part of the study was qualitative and to be able to assess mental dysfunction of these participants, mental status examination was performed. **Table 2** below shows the summary of the examination. The examination focused on evaluating eight parameters as seen in the table. Each parameter of evaluation had had subcategories which each was evaluated as "normal" = 1 if no abnormality was observed and "abnormal" = "0" if abnormal. Based on these scores, odds ratio of each category was calculated to evaluate what MSE category was most prominent for these participants.

Table 2 Mental status evaluation of children and adolescents

Variable	N (%)	Mental status examination		Unadjusted OR (95% CI)
		Abnormal (0)	Normal (1)	
Age Group: 13 – 15 yrs 16 – 17 yrs	37 (34.3) 61 (56.5)	11 33	26 28	8.9(25.3-43.2)
Appearance a. General appearance b. Attitude to situation and examiner **c.** Motor behaviour	- - -	6	31	11(4.3-28.1)
Speech a. rate b. volume **c.** quantity of information	- - -	5	32	11.0(2.5-24.5)
Mood and affect a. mood (glad and sad) b. affect (congruent and incongruent)	- -	30	7	12(68.4-93.7)
Thought of form a. amount and rate. b. Flow of idea c. Disturbance in meaning	- - -	1	36	5.2(-2.5-7.9)
Content of thought a. delusion b. suicidal thought **c.** homicidal thought	- - -	24	13	15(49.4-80.2)
Perception a. hallucination b. illusion c. detached from reality	- - -	19	16	16.1(35.2-67.4)
Sensoriun and cognition a. level of consciousness b. memory recent and remote c. orientation: time, place and person d. concentration e. abstract thinking	- - - - -	8	29	13.2(8.3-34.8)
Insight a. Extent of participant on awareness of the problem	-	30	7	12.6(68.4-93.7)
Total	108			

The overall 37 children/adolescents were found to have mental dysfunction by the mental status evaluation. This gives the prevalence of mental dysfunction 34.3%: 95% (CI; 25.3 – 43.2). The younger age group (13-15) years presented with a prevalence of 30% (CI; 14.7 – 44.5) as presented in Table 3

Table 3: Prevalence of mental dysfunction based on the mental status evaluation

Age group	N (%)	95% CI
13 – 15yrs	11 (30.0)	(14.7 – 44.5)
16- 17yrs	37 (55.2)	(43.3 – 67.1)

5.3. Descriptive formulations based on DSM IV diagnostic criteria

CASE STUDY NO 1

Child X is 13 years old, school drop out when he was standard three. His father did not want to have a child with his mother they were just friends. His father arranged to do criminal abortion of his pregnancy. His mother did not accept the plan and such his father decided not to take care of his mother and he denied all responsibilities and consequently.

X was born in 1997, grew up and taken care by his mother of Kawe in
Dar es Salaam. He started primary school in 2004 and when he reached standard two teachers reported some abnormal behaviours shown by X. There was also a lot of complains coming from his peers that he is violent and do not cope with others in playing. He disappeared from home and school when he was standard three. He went to a place where he got involved in the selling illegal drugs like heroine, cocaine and cannabis. He was also using these drugs.

Family history - Parental side, X's father is not married but he has about seven children from different mothers living with their mothers. His father and grand father both had history of violence during their childhood up youth.

Maternal side, X mother grow up in a very strict religious house she changed religion when she met X's father. Since then she has been discommunicated with her relatives. Currently she is living with man who doesn't want to stay with step children and in particular X. This led X resort to street life because he had no other alternative.

Chief complaints

He is alleged to have stolen 300,000/= Tanzania shillings from his aunt.

Excessive cannabis smoking

Heroine smoking

Unnatural offence (used to be sodomised)

DIAGNOSIS – DRUG ABUSE (HEROINE AND CANNABIS)

SEX DEVIATION (HOMOSEXUAL)

CASE STUDY NO 1

DSM IV TR MULTIAXIS

AXIS I: MEDICAL DIAGNOSIS - CANNABIS AND HEROINE ABUSE

Sign and symptoms

Excess smoking of cannabis

Heroine smoking

Stealing money from relatives and other people

Aggressiveness

Abusive language

Selling cannabis and heroine

Symptoms are in severe form

AXIS II: MENTAL RETARDATION – None

PERSONALITY DISORDERS – rule out conduct disorders

AXIS III: PHYSICAL ILLNESS - None

AXIS IV: PSYCHOSOCIAL ENVIRONMENTAL SRESSORS

Parents not married reared by single parent (mother)

Father convinced his mother to do criminal abortion of his pregnancy

School drop out standard three

AXIS V: GLOBAL ASSESSMENT FUNCTION OF THE CLIENT – 70%

Social functioning is fair, he is able to create and maintain good interpersonal relationship, able to maintain eye to eye contact

Occupational functioning, he is able to do domestic activities within the remind home with minimal supervision

School functioning, he can do simple mathematics and he passed in standard two examinations.

BIOPSYCHOSOCIAL FORMULATION CASE STUDY NO 1

Factors	Biological	Social	Psychological
Predisposing	Genetic loading for violence (strong family history) Sadness feeling from mother.	Can't interact well with others	Single parented, his father has neglected him
Precipitating	Use of street drugs (cannabis and heroine)	Mother is chasing him away because her current boyfriend does not accept him	Dropped out from school when is was standard three
Perpetuating	Unrecognised mental illness	No social support available	Low self esteem, sadness, he wanted to go home his mother is reluctant
Protective	General physical health is good, will be advise to under go psychosocial rehabilitations	Mother can be counselled to accept her child and give social support.	He is intelligent above average if get treatment and psychosocial rehabilitation can resume school.

CASE STUDY NO 2

DSM IV TR MULTIAXIS

AXIS I: MEDICAL DIAGNOSIS ATTENSION DEFICITY HYPERACTIVITY DISORDER (ADHD)

CO MORBIDITY – ALCOHOL ABUSE

Signs and symptoms

Unable to pay attention in one focus

Restless

Bedwetting

Stealing

Drinking alcohol

Abscond from home

Warming around on the streets

Unable to maintain body and environmental hygiene

Symptoms are in severe form

AXIS II: MENTAL RETARDATION – None

PERSONALITY DISORDERS – Rule out conduct disorders

AXIS III: PHYSICAL DISORDERS – None

AXIS IV: PSYCHOSOCIAL ENVIRONMENTAL STRESSORS

Parents separated, he was living with grand mother and grand father

At first his father denied to be responsible with his pregnancy

His grand father died last year

School drop out

AXIS V: GLOBAL ASSESSMENT FUNCTION OF THE CLIENT – 60%

Social functioning – he is not playing well with his peer group unable to maintain eye to eye contact.

Occupational functioning – can not maintain body and environmental hygiene. Can do domestic work at remind home with very close supervision

School functioning – can do simple calculation but he is not unable to pay attention for quiet longer.

DESTRIPTIVE FORMULATION CASE STUDY NO 2

Y is 13 years old and was born in Ifakara, Morogoro region. His mother was not married to his father they were friends. His father denied having pregnated his mother. When Y was born parents from paternal side realise that Y was so resembled very much to his father so they decided to go and see Y's maternal side for negotiations. After successful conclusion of an agreement, Y was two years old was taken by grand father and grand mother from the paternal side. He grew up with this new family until he started primary school when he started abnormal behaviours. He used to beat his peers, stealing others belongings and of times he pretended to act as beggar on the streets posing as if he has no one to support for his primary school studies. He eventually dropped from school when he was standard three. Since then he has became a very difficult boy to an extent that every one got tired of him. His mother tried to stay with him when she fail to contain his ill behaviours she returned him to his grand father after she stayed with him for only one week.

Chief complaints

Y is now a fully flagged thief who steals money from home and absconds; he would then go out in the streets spending the money until it is finished. He spends money for buying foods and drink alcohol with friends. When the money is finished he would then hang around assisting food vendors in the market and on the street and get some food and little money in return which he uses for survival. He would not return home until captured by member of the family. Y lacks concentration and as such can not focus on one thing for quiet long instead do a lot of thing at ago.

These abnormal behaviours started when he was six years old.

DIAGNOSIS – ATTENTION DEFICITY HYPERACTIVE DISORDER

CO MORBIDITY – ALCOHOL ABUSE

BIOPSYCHOSOCIAL FORMULATION

Factors	Biological	Sociological	Psychological
Predisposing	Father denied pregnancy Mother got frustrations	Difficult in relating with peers	Lack of paternal and maternal love
Precipitating	Used of alcohol	School drop out	Unable to concentrate
Perpetuating	Unnoticed biological disturbances	Failure to have good friends	Un unable to go back to school
Protective	Physical health is good; if avoid using alcohol and get treatment and psychosocial rehabilitations	His has very stable extended family to give him psychosocial support	Above average intelligence.

CASE STUDY NO 3

AXIS 1: MEDICAL DIAGNOSIS – BRIEF PSYCHOTIC REACTION

Sign and symptoms

Abnormal behaviours soon after watching America against Afghanistan war movie

Aggressiveness

Tendencies of paying revenge

Suicide ideations

Suicidal ideations

Symptoms are in severe form

AXIS II: MENTAL RETARDATION – None

PERSONALITY DISORDRER – None

AXIS III: PHYSICAL ILLNESS – None

AXIS IV: PSYCHOSOCIAL ENVIRONMENTAL SRESSORS

Death of both parents lives with his aunt

Poor economical status

AXIS IV: GLOBAL ASSESSMENT FUNCTIONING OF THE CLIENT -70%

Social functioning – able to create and maintain good interpersonal relationships, maintain eye to eye contact during interview and had very good cooperation

Occupational functioning – he is able to do domestic activities at remind home with minimal supervision

Can do simple and complex mathematical calculations

CASE STUDY NO 3

Z is fifteen year old. Before he was put in the remand home Z was attending secondary education in one of the secondary schools in Dar es Salaam. He was in form three. His parents both died when he was very young. He had normal behaviours through out his milestone. He had no problems with learning to such a way that his performance at school was good. He is a hip hop music singer and together with his friends, they used to write some poem and sang in concert before the audience of other peers. They used to fond America and hip hop singers fro America.

Chide complaints

One day he was watching a CD of American air strikes towards Iraq and Afghanistan, he witnessed a bombardment which left behind a lot of innocent children who are suffering due to American insurgence. When he finished watching the CD, he ran to his friend and try to convinced him that they should not like Americans any more instead they should do some sort of revenge since they are making troublesome to their fellow young men in Arab countries. His friend asked him 'what *are you intending to do' he replied* 'I *have to bomb American embassy so that I can kill some of them too.*

His friend said I support you but I cannot go with you in your mission. Z continued with his plan. He made some bombs and went to American embassy. He entered inside American embassy in Dar es Salaam but he was captured by security guards before he attempted to bomb. He was found with some erosive equipments and from thence was kept under police custody and consequently put in remind home

DIAGNOSIS – BRIEF PSYCHOTIC REACTION

BIOPSYCHOSOCIAL FORMULATION

Factors	Biological	Sociological	Psychological
Predisposing	Genetic loading his uncle had mental illness	Had few friends	Loss of both parents when he was very young
Precipitating	Cannabis smoking	Unable to mixed up with many people	Failed to have good secondary support
Perpetuating	Unnoticed biological imbalance	Her aunt had poor income	He was not close him
Protective	General physical health is good	Can be taught psychosocial skill at school	His intelligence is above average so can understand well psychosocial skills and cognitive behavioural therapy

CASE STUDY NO 4.

AXIS I: MEDIACAL DIAGNOSIS- POST TRAMATIC STRESS DISORDERS

Signs and symptoms

Severe flash back about the trauma event – Mbagala bomb burst

Excessive worries

Sometimes experience heart palpitations

Lack of sleep

Nightmares

Sadness

Symptoms are in severe form

AXIS II: MENTAL RETARDATION – None

PERSONALITY DISORDER – None

AXIS III: PHYSICAL ILLNESS – None

AXIS IV: PSYCHOSOCIAL ENVIRONMENTAL STRESSORS

Death of both parents

School drop out after displacement from Mbagala bomb burst

Poor living circumstances

AXIS V: GLOBAL ASSESSMENT FUNCTIONING OF THE CLIENT (GAF) – 70%

Social functioning – able to create and maintain good interpersonal relationships

Occupational functioning – can do domestic activities with minimal supervisions at remind home

School functioning – he is struggling to do simple mathematics and he is relearning how to write during class at remind home.

DESCRIPIVE FORMULATION

CASE STUDY NO 5

Q was born 1998 in Mbagala, Dar es Salaam. His parents both died in 2007 and 2008 respectively. He was living with his uncle who is also staying at Mbagala area. He dropped out of school last year after the Mbagala bomb blast. He grew up well till his parents died. He was taken care by his uncle after the death of his parents and he still was cared for by the uncle...

Apparently Q was having normal behaviours since birth. He started to isolate himself and not mixing with peers after the death of parents. His school performance was average. After Mbagala bomb blast his mental health deteriorated and dropped and consequently he quieted from school. During Mbagala bomb blast he was displaced from home for three days. He was found along the river hanging around. He was taken to Mbagala police station by Good Samaritan. His uncle recognised him after heard that some missing children have been brought to plaice station. As a results of

the incidence Q behaviours which ultimately forced him to quit the area. He stolen some money from his uncle and vanished.

Chief complains

He stolen 200,000 Tanzanian shilling from his uncle and disappeared from home.

He was found in Ubungo bus terminal doing petty trade business. He was also staying in Ubungo bus terminal. He hesitated to go home and he said 'when I slept at home severe flash back feelings about the bomb came in up and then I felt heart palpitations, sweating and excessive worries. 'I don't want to go back to Mbagala'.

DIAGNOSIS – POST TRAUMATIC STRESS DISORDERS

BIOPSYCHOSOCIAL FORMULATION

CASE STUDY NO 4

Factors	Biological	Sociological	Psychological
Predisposing	Genetic loading his father had history mental illness	Not mixing with others	Lost of both parents when he was very young
Precipitating	Smoking cannabis	Had no friends	His school performance was poor
Perpetuating	Unrecognised biological disturbances	Had poor primary and secondary social support	Unable to make efforts to improve his school performance
Protective	Good general physical health	He is staying nearby Mbagala kuu primary school. It is easily for him to go back to school	He has interest of continues with studies

CASE STUDY NO 5

AXIS I: MEDICAL DIAGNOSIS – SEXUAL DIVIATION (HOMOSEXUAL)

CO MORBIDITY – ALCOHOL/DRUG ABUSE

Sign and symptoms

Demand to be sodomise by others

Takes excessive alcohol and smoke cannabis

Feel shy when he is sober

Unable to maintain eye to eye contact

Suicidal ideations

Symptoms are in severe form

AXIS II: MENTAL RETARDATION – None

PERSONALITY DISORDERS – None

AXIS III: PHYSICAL ILLNESS - None

AXIS IV: PSYCHOSOCIAL ENVIRONMENTAL STRESSORS – 60%

Parents divorced

He is homeless living on the street

School drop out standard three

Live in very difficult situation

AXIS V: GLOBAL ASSESSMENT FUNCTION OF THE CLIENT

Social functioning – can create and maintain good interpersonal relationships, he can not maintain eye to eye contact.

Occupational functioning – can do domestic activities with minimal supervisions.

School functioning – can do simple mathematical calculations.

DESCRIPTIVE FORMULATION

CASE STUDY NO. 6

T was born 1997 in Arusha. His parents divorced when he was five years old. His mother went to her home town Musoma and his father went to Nairobi Kenya to look for green posture. T was left with his grand mother from paternal side. He started standard one at Arusha. He dropped out from the school when he was standard three. He had no problems in learning. His grand mother died in 2009 and from there he became hanging on the street of Arusha town. He had history of sexual abuse as at one time he was given some money and food as rewards he was asked to be sodomised as a payments. Eventually it became a habit.

T travelled to Musoma to look for his mother. When he arrived to Musoma he could not find out his mother so he continued to hang around in Musoma town streets as a

street child. He then transferred to Dar es Salaam to look for better life. He was staying at Ubungo main bus terminal doing petty trade.

Chief complaints

T is alleged to have stolen about one hundred thousands from a passenger. He is cannabis smoker and used to drink alcohol. He has a tendency of soliciting others to sodomise him at remind home. T has got suicidal ideations. He is shy and can not maintain eye to eye contact.

DIAGNOSIS SEXUAL DEVIATION

CO – MORBIDITY – DRUG ABUSE

BIOPSYCHOSOCIAL FORMULATION

CASE STUDY NO 5

Factors	Biological	Sociological	Psychological
Predisposing	Genetic loading history of mental illness on paternal side	Shy around others, he can not maintain eye to eye contact.	Parents divorced when he was five years old. His care taker (grand mother) died when he was nine years old.
Precipitating	Smoke cannabis	He has no strong relationship with peers. School drop out	He is not able to go back to school
Perpetuating	Unrecognised biological disturbances	Had no normal friends apart from those who used to sodomised him	Experience sadness feeling and has very low self esteem
Protective	General physical health is good. Can avoid smoking cannabis and get psychosocial rehabilitations	Can go back to school and taught psychosocial skills	He has average intelligent if motivated can perform well

DSM IV TR CASE STUDY NO 7

AXIS I: None

AXIS II: MENTAL RETARDATION

Sign and symptoms

Difficult in learning

Impaired self care

Impaired communication

Impaired social skills

Symptoms are in severe form

AXIS III: None

AXIS IV: PSYCHOSOCIAL ENVIRONMENTAL STRESSORS

Lack of psychosocial skills

AXIS V: GLOBAL ASSESSMENT FUNCTION OF THE CLIENT: (GAF)

Social functioning – unable to create and maintain good interpersonal relationship

Occupational functioning – unable to maintain body and environmental hygiene without assistance

School functioning – unable to do simple mathematics

DESCRIPTIVE FORMULATION CASE STUDY NO 6

N was born in 1996, in Dar es Salaam. He grows up in a stable family reared by father and mother. He started standard one when he was seven years old. His had delayed milestone in walking, speaking and cognitive functioning. When he was standard two his teachers complained that N is not a normal child. He had difficult in learning, poor toilet training and lack of self care.

His parents arranged to a special teacher to come to their home for extra classes in order to offer him tailored tuition to improve his performance. He started to read when he reached standard four. He repeated standard four because he failed national standard four examinations. He is now in standard seven but can not do simple mathematics.

Chief complaints

He is alleged to rape a girl of nine years. He has difficult in learning, difficult in concentrating, loss of memory and intelligent below average.

DIAGNOSIS: MILD MENTAL RETARDATION

BIOPSYCHOSOCIOAL FORMULATION

Factors	Biological	Sociological	Psychological
Predisposing	Had history of mental illness in the family	Difficult in relating with others	Failed standard four national examination
Precipitating	None	Has few friends	He is still struggle with studies
Perpetuating	None	He is isolated by his peers	He is appearing before court of law
Protective	Good physical health and developmental	Has very good support from his parents and family members	He has mild form of mental retardation with special education and treatment can improve his adaptive behaviours.

CASE STUDY NO 8

DSM IV TR MULTIAXIS

AXIS I: MEDICAL DIAGNOSIS - MOOD DISORDER – DEPRESSION

Signs and symptoms

Sadness

Lack of sleep

Isolation

Suicidal ideation

Concentration difficult

Feeling of hopeless

Headache

Symptoms are in severe form

AXIS II: PERSONALIRY AND MENTAL RETARDATION - None

AXIS III: PHYSICAL ILLNESS - None

AXIS IV: GLOBAL ASSESSMENT FUNCTION OF THE CLIENT – 60%

Social functioning – difficult in relating with others

Occupational functioning – can go domestic work with minimal supervision

School functioning – can do simple mathematics.

DESRIPTIVE FORMULATION CASE STUDY NO. 8

M was born in year 2007 in Dar es Salam. His parents died when he was six years old. He was taken care by his grand mother and grand father from paternal side on the outskirts of Dar es Salaam city. According to him life became very tough after the death of his grand father who died when he was nine years old. His grand mother became terminally sick and as such she could not take care of him. He dropped out from school when he was standard four and ever since he becomes street child.

Chief complaints

He stolen some money and cellular phone belong to his father. He used to isolate himself, feeling of sadness, headache, Loss of hope, lack of sleep, difficult in concentration and suicidal ideation.

DIAGNOSIS – DEPRESSION

BIOPSYCHOSOCIAL FORMULATION

Factors	Biological	Sociological	Psychological
Predisposing	Had history violence in the family	Unable to mix with others	Loss of both parents when he was five years old
Precipitating	Cannabis abuse	Isolate himself	School drop out
Perpetuating	Unrecognised depressive traits	Poor social support	Low esteem he can not resume his studies
Protective	General physical health is good, can avoid using cannabis in the future	Can be learn social skill through special programme	His intelligence is above average he can do well if given psychosocial support.

CASE STUDY NO. 8

DSM IV TR MULT AXIS

AXIS I: MEDICAL DIAGNOSIS - POST TRAUMATIC STRSS DISORDER (PTSD)

Sign and symptoms

Nightmares

Flashbacks

Thinking about the bomb burst

Headache

Sadness

Nervous

Concentration difficult

Memory loss

Believe that bomb burst will happen again

Symptoms are in severe form

AXIS II: MENTAL RETARDATION/PERSONALITY DISORDER - None

AXIS III: PHYSICAL ILLNESS – None

AXIS IV: PSYCHOSOCIAL ENVIRONMENTAL STRSSOR

Divorce of parents

AXIS V: GLOBAL ASSESSMENT FUNCTION OF THE CLIENT (GAF) – 60%

Social functioning – able to create and maintain good interpersonal relationship

Occupational functioning – able to do domestic activities with minimal supervision

School functioning – able to do simple and complex calculations

DECRIPTIVE FORMULATION CASE STUDY NO 8

K was born in 1997 in Dar es Salaam, Mbagala area. His parents got separated when he was five years old. His father got married to another wife. Since then K was reared by step mother to gate. He started standard one when he was seven years old. He is now in standard three. His school performance was above average. K was involved in Mbagala bomb blast in 2009. He was at school Mbagala Kuu primary

school when bombs erupted. He was displaced for the whole day. His father found him at Mbagala police station late evening. He is still pursuing his primary school studies but as results of the blast K has been experience nightmares which again have forced him to quit the area.

Chief complaints

He is alleged to have stolen some money and cellular phone belongs to his father. He is experiencing nightmare, flashbacks, thinking about the bomb burst, headache, nervous, difficult in concentration, memory loss and he believe that the bomb burst will happen again.

DIAGNOSIS – POST TRAUMATIC STRESS DISORDER (PTSD)

BIOPSYCHOSOCIAL FORMULATION

Factor	Biological	Sociological	Psychological
Predisposing	Genetic loading history of mental illness in the family	Boredom with school environment	Parents divorced
Precipitating	Cannabis smoking	Early separation with his mother	Failed to cope with stress
Perpetuating	Unrecognised biological	Lack of strong social support	Lack of psychosocial skills
Protective	General physical health is good	He continues with his studies	His level of intelligent is above average.

5.4. Emerging themes from the in-depth interviews

The researcher translated data captured from in-depth interviews, focus group discussions, and observations. The main categories and themes were identified according to the meaning as follows:

- Strategies used to cope with stress

  Theme – stress coping strategies
- Living arrangement

  Theme - Family instability
- How participant explain about the present problem

  Theme – chief complain

- How participant relate with others
  Theme – bad relationship and good relationship
- Feeling of worries, sadness, and overwhelmed
  Theme – different emotional experiences
- How participant explain about his/her milestone
  Theme – background history of the participants
- How does participant view him/her self
  Theme – self concept
- Feeling of killing himself or others
  Theme - Suicidal or homicidal tendencies
- What participant see the most important thing in his/ her life
  Theme - Belief system
- What Support system does the participant have
  Theme – psychosocial support

The researcher clustered five main themes from these categories guided by theoretical models of psychosocial support, Richter and Foster and theory of planned behaviours by Izek Alzen 2006. The first one is gaps in care giving filled by extended, gaps in family support filled by communities, gaps in community support filled by NGO's and government services and the later is belief systems, psychosocial support, self concept, stress coping strategies and relationship among peer groups.

Meaning unit	Condensed meaning unit	Code	Category	Theme
When my parents died I was so sad, I was taken by my grand mother and live together. Life was so tough as my grandmother had very little income	After the death of parents' life become so tough.	Poor economical status	1.living arrangement	No one to care for me
I became suspicious and hopeless when I was thinking about my life. I decided to drop out from the school and started doing petty trade business then I travelled to Dar es salaam to find better life	Feeling about future life lead to suspicious and hopeless	Poor primary support and reassurance	2.Strategies used to cope with stress	Life experience after the death of parents
Previously I used to love America since I was hip hop singer with my friend. But when I watched the CD of American showing air strikes on Iraq and Afghanistan and looked at how innocent are killed and displaced I changed my mind and get upset with Americans then I decided to pay revenge on Americans	Experience of emotional pain after watching American CD of air strikes	Paying revenge	Reaction	Lack of stress coping strategies.

Meaning unit	Condensed meaning unit	Code	Category	Theme
I was given food to eat and some money then he said since you have spent my money we have to do this practice. He sodomised me regularly	Uses of tokens in order to sodomised children then becomes a habit	Sexually abused	Sex deviation	Lack of psychosocial support
I was put under police custody when I stolen one pair of car site mirror. This is what I normally do stealing site mirrors of different saloon cars. When I get some money bought nice clothes, I don't take alcohol but I smoke cannabis	Stealing of site mirrors of saloon cars in order to live. Smoke cannabis to feel pleasure	Thief specialised in car site mirror and drug abuse.	Street child	Lack of psychosocial support.
I normally think about the Mbagala bomb burst. I think it will happen again. I was in class then we started to hear sound of heavy bomb around our school we were displaced I met with my parents after two days of walking around.	Involved in Mbagala bomb burst and now he is getting severe flash back of the event.	Flashbacks	Thinking about trauma event	Lack of stress coping strategies
After stealing some money at home I normally don't sleep at home I go to my friends drink alcohol, and smoke cannabis	After stealing money he spent the money on alcohol and cannabis	Alcohol and drug abuser.		
It happen like a dream sometime I dream like going to toilet and passed urine. When I wake up I found myself sleeping in the pull of urine	He used to dream at night and wet bed	Bed wetting	Night mares	Sign of distress.

Meaning unit	Condensed meaning unit	Code	Category	Theme
You know my son has a tendency of bed wetting weather he sleeps in the house or out side he will wet bed or closes. So when he slept in the bush or in unfinished house I tend to know by seeing urine stain. Is smell like goat's place?	Tendencies of bedwetting whenever got asleep	Bed wetting	Nightmares.	Sign of distress
I used to sell cannabis, cocaine and heroine I also use them. I have a friend whom I use to call brother. This person is the one who have capital of buying these drugs un terms of whole sell he gave us to sell for retail was put in very nice and expensive closes and eat very nice food.	He was selling drugs and also using them. He had good time those old days.	He became drug seller 'pusha' and drug abuser.	Child labour engaged in illegal business.	Lack of psychoso cial support.
One day I passed at the graves yard and found money on one of the grave. I picked up I went to spent with my friends. After two to three days I slept home at night but in the morning I found myself slept on the one of the grave in the grave yard.	After took money from the grave he found himself slept on the grave	Superst ition belief.	Strong fixed false belief.	Belief system disturbed.

Strategies used to cope with stress

In this study the researcher referred stress to psychologist views related to stress. According to them stress is defined as a stimulus, as a response, and as an organism environment interaction.

Most of the and adolescents who are in juvenile centre used to smoke cannabis and consume alcohol as a coping strategies to relieve stress. This strategy helped them feel very high and allowed them to forget all problems that they were facing. Majority of the participants interviewed were cannabis smokers and they were involved in offences like stealing, rape, unnatural offence and disturbing passengers. Those who were alleged to disturb passengers, they disturbed them at the main bus terminal in Ubungo, Dar es Salaam.

Living arrangements

For the purpose of this study, living arrangement embraces the general life situation at participants home including having parents, or loss of parents, number of siblings, and their status. The general response of the participants was related to the social economical status. Most of these children were street children as they did not have a place to live. They were sleeping at Ubungo main bus terminal. This was the place where they stayed since their arrival in Dar es Salaam from up country regions. They used to carry passengers' luggage and ask for little money which they used for buying food and cannabis. Sometime they saved some money and started doing petty trade business. Most of the time the adolescents were involved in selling chewing gums and groundnuts.

Another place for these street children was the ferry port. The main activity at ferry port was cleaning fishes before it is fried and sold. They were paid one thousand five hundred Tanzanian shillings for cleaning fishes in one bucket of twenty litres. Most of the children had experienced tough life in their original town or villages which made them move to Dar es Salaam to look for a better life. Most of them had either lost their parents or parents were divorced or were reared by a single parent.

How the participants explain about the present problem

The researcher sought to find out the reason of participant to be in remand homes. The question was asked, "Why do you have to appear before court of law?" The children and adolescents who were in remand homes were those from the street and who did not have parents or guardians to give them bond to be released from those homes. So they were remained in remand homes while their cases were in progress. They expressed themselves freely when the researcher established a friendship environment. They did agree about the crime that had committed and explained the reason why they had done so.

The in depth interviews revealed the whole story of the crime committed that led them to appear before juvenile court. There were differences in expressions between children at the juvenile court and those at the remand homes. Those at the juvenile court were nervous and they did not give much information during in depth

interviews. But those who were in remand home gave a detailed account of their life experience and the offence they were facing.

How the participant relate each other

In the remand home children each child develops friendship with others but some used to be very troublesome most of the time fighting each other. The elderly children used to sodomise younger ones. But during in depth interview those who practice used to be sodomised, they admitted that they had this tendency even before they came in juvenile justice systems. However those who used to sodomised others denied during in-depth interview.

Feelings of worries, sadness, and overwhelmed

Participants explained their experiences after losing their parents, divorce of parents, and their stay in remand home. Children who had lost their parents at an early age often sustained psychological trauma and when they recalled the incidence they mostly expressed sadness and worries about their future life. Also those participants whose parents were divorced and lead them to displacement experienced sadness and worries in comparison with other children of the same age. Children who used to steal money and other materials they experienced sadness after finishing the money and they were afraid going back home.

How the participant explained about his/her milestone

In this research milestone is the period participant grow up from birth up to now. Most of the participants interviewed described their milestone as normal milestone however they experienced lot of difficulties caused either by death of their parents or divorce of their parents. Majority of them had dropped out from school following breakdown of their family or due to their deliquesce behaviours. Most of them were engaged in petty trade business, house work as house maid, assisting businessmen in markets and assisting vendors in selling foods in mark the streets.

How does the participant view themselves (Self concept)

During the interview some of participants said that they viewed themselves as normal persons but others did not. One of the participants who watched CD of

American air strikes in Afghanistan and Iraq said, "I think I am not a normal person because I am sure that CD was watched by many people but could not react the way I reacted". Those who said that they were normal they complained that it is due to the instabilities of their family that led them to be in juvenile justice systems.

Feeling of killing him/herself or others (suicidal and homicidal tendencies).

During the in-depth interviews, it was revealed that three participants had suicidal ideation while one had both suicidal and homicidal ideation. One participant said, "I just had a thought of killing myself when one of the caregiver here at the remand home called me a gay, so one thing that came up to my mind was that this people have identified that I am a homosexual person [beside the other crime], it means I am going to face another charge." Another participant said, "When my brother, who is a policeman, wanted to sodomise me and I escaped from the room and I had a feeling that there was no need to be living in this world. Because of that incidence my brother and his wife they fabric the case that I am facing".

Unusual or outstanding events explained by the participants (sexual abuse and severe flash back of psychological or physical traumatic events).

Those participants who were sodomised for the first time during their childhood said that it was an unusual or outstanding event they had experienced in their life. All the participants who came from Mbagala said that the last year's Mbagala bomb blast which they heard while they were at school and others were on the street experienced that as an extraordinary event. They said that the majority of the children who were displaced were around when Mbagala military base fell due to bombs blasts. Children were displaced, walked here and there and were unable to find their homes. Two to three days later they were located and were united with their family. Other participants said they normally see people like evils that others can not see. One participant said that one day he slept at home and the following day he found himself in one of the graves in the grave yard.

What participant sees the most important thing in his/ her life?

All participants interviewed explained that the most important thing in their lives was education and the most important persons were parents. All participants commented that parents were most important in their growth. However, they admit that there is God and they believed in God. Either there was no participant who had been preoccupied with religious activities and has different belief system.

Support systems of participants

Most of the participants had lost their primary support at one point in time. This was due to family breakdown either due to death of parents or divorce of their parents. Those who were brought up by single parent were mostly by a mother, it was due to the rejection of the responsible father. Whilst those who were reared by father had a step mother taking care of them. There was only one participant, amongst all others, who had a very strong family bond and he is facing a murder case. There was no secondary support noted from the communities they belonged, non beneficial organisations, and the government.

5.5. Main mental disorders diagnosed during the research.

Attention deficit/Hyperactivity Disorder (ADHD)

Attention deficit disorder (ADD) is variation in central nervous system processing characterized by developmentally inappropriate behaviour involving inattention (Ball, Bindler & Cowen, 2010).when hyperactivity and impulsivity accompany inattention, the disorder is called attention/hyperactivity disorder (ADHD). According to Froelich, et al 2007 and Wibbelsman, et al, 2005 ADHD is the most common mental disorder in children affecting 6% to 9% of all school age children. Most of the time parents, care givers, and school teachers seek for medical attention when the symptoms are in severe form other wise they took as the character of the child. That is why the researcher is in opinion that this trend lead to delinquency behaviour and end up in juvenile justice systems. Further more because of this

mental disorder led them to school drop out, since they have problems in attention whilst in school they are required to pay attention and focused.

Attention deficit hyperactivity disorder usually co exist with different symptoms like aggression, learning disability, and motor disorder. In this regards children with this disorder have a high chance to posse's delinquency behaviours and kept under police custody.

Posttraumatic stress disorder (PTSD) one has experienced or witnessed a life threatening event, however, the symptoms of distress continue for more than one month and affect daily live activities. Caffo and Belaise, 2003 assumed that40% of youth have an episode of trauma the led to PTSD and 6% have symptoms of disorder. Centre for Disease Control AND Prevention, 2006 stated that 20% of children may experience PTSD after traumatic events if no intervention done; the prevalence can rise to 90% when the trauma is severe. In the city of Dar es Salaam, Tanzania one of military based had bomb burst accidentally. In that area called Mbagala there are two primary schools allocated near the military base. During the bomb burst children were at school. In this research researcher diagnosed two children at remind home having PTSD following Mbagala bomb burst. This results shows that there is a need of find out means of identifying and treat PTSD in children who are victim of Mbagala bomb burst.

Schizophrenia and other psychotic disorders are very rare in children and adolescents. Remscmit and Theisen, 2005 reported that schizophrenia occurs in 10,000 children. They further noted that the prevalence of schizophrenia increases after puberty and reaches adult levels by late adolescence. In this research the researcher found one brief psychotic reaction. Mental retardation is a significant limitation in intellectual functioning and adaptive behaviour. It is manifested in differences in conceptual, social and practical life skills, and begins before the age of 18 years (American Association of Mental Retardation, 2004). Mental retardation is classified in three categories severe, moderate and profound mental retardation. The research found one adolescent in juvenile court had mild form of mental retardation that is alleged to committed rape. Substance use and abuse occurs in children and

adolescents of all socioeconomic classes and has become a very big mental health challenge in the society. According to MMWR, 2006 about one half of school students claim to having used drugs, cannabis, tobacco, and alcohol. The use of these drugs most of the time pose very serious mental and physical health to children and adolescents. The researcher found that all children diagnosed with mental disorders in juvenile justice systems had co morbidity of substance abuse. These findings are highly suggested that there is link between substance use and delinquency behaviours.

Many children ands adolescents interviewed at remind home had depression traits however one found to have major depression according to DSM IV TR criteria. Depression is a psychological distress usually range from mild to severe (Ball, Bindler & Cowen, 2010). Depression has been recognised as clinical condition in children in recently years. According to Daphoide, 2006 the incidence of depression is estimated to be about 0.3% in preschoolers, 2% in pre-pubertal children, and about 5% to 10% in adolescents.

6. DISCUSSION

It is an accepted fact that children and adolescents, as human beings, in the pursuit of their life goals, face challenges that need to be surmounted, frustrations to be overcome, and stresses to be calmed, as well as anxiety and panic to be controlled. When it so happens that human beings fail to contain these anomalies they tend to succumbed with psychological, physical, and social predicament (Lorber & Iceland, 2009).

According to Gatti, Tremblay, and Vitaro (2009), matters become worse when and where family, extended family, communities and the society is unable to come for assistance of children and adolescents who have been affected by psychosocial problems. Indeed, this research findings show that children and adolescents who were in their crucial development stages in human life that is burdened with specific concerns, needs, and problems called for guidance and psychosocial support.

Further more, all children and adolescents are social beings and are supposed to have attachments, relationships, and affiliations in order to make life smooth and normal. If these relationships and attachments are affected by loss such as death of parents, terminal illnesses or disability, the psychological well being of two parties become compromised (Trentacosta et al, 2009).

6.2. Characteristics of children and adolescents with delinquency behaviours.

Children and adolescents with delinquency behaviours found to have history of death of parents, divorced parents, or single parent which led them to poor primary psychosocial support. According to Hawkins et al. (2009) children and adolescents with very strong community that care (CTC) have very low delinquency behaviours. However, Richer and Foster emphasised that when there is a gap in care giving, that is, there is a death of parent/s or sickness, the gap has to be filled up by extended family.

Furthermore, they stipulate that if there is also a gap in an extended family then it should be filled up by communities. In this regard the researcher found that most of the children and adolescents within Dar es Salaam juvenile systems were street children who are orphans or have single parents. This shows that these gaps of psychosocial support have been filled neither by extended families nor by communities. Keijser at el. (2009) in a study of control of delinquency behaviours and parents support found that there was a very strong link between parent's relationship with their children and delinquency behaviours. In this study the researcher found more boys were in juvenile systems than girls (Plattner at el., 2008).

6.2.1. Dysfunctional families

Family stability contributes to children/ adolescents to acquire delinquency behaviours, either primary psychosocial support from parents promote mental health of children and adolescents. In this study finding shows that children and adolescents in remind home are coming from dysfunctional families in terms of death of parents, parents divorce and single parents.

6.2.2. Exposure to traumatic event.

The researcher found that children who came from Mbagala area in Dar es Salaam, who were exposed to Mbagala bomb blast in 2009, were now experiencing severe flash back about the bomb. During the in-depth interviews, the researcher found that they had traits of post traumatic stress disorders. Kering et al. (2009) reported that all youths in their study who were exposed to trauma suffered from post traumatic stress disorder (PTSD) and mental health problems. Furthermore, they demonstrated a co relationship between trauma and PTSD and other mental disorders.

6.2.2. Underlying mental disorders

When mental disorders remain undiagnosed, will lead to untreated and the course of particular abnormal behaviours can not be established. Taking an example of Attention deficit hyperactive disorders as identified in this research, their main complaints is to pay attention now since these children are in school age they are sent to school without their mental health to be addressed. Eventually they ended up with school drop out because some body is being forced to pay attention while his problem of paying attention is not tackled.

6.2.3. Drug abuse

In this study, children and adolescents, who consumed illicit drugs and alcohol, were noted to have high chance of delinquency behaviours like stealing, rape, abusive languages, disturbing passengers, and unnatural offence. Hall and Howard (2009) also noted similar kind of behaviour in their study with youths who abused Nitrate inhalant. These children have high demand of expenditure including purchasing these drugs. Since they do not have income they are subjected to stealing and other illegal businesses.

Children and adolescents usually imitate whatever they come across with, it could be bad or good behaviours. Since most of juveniles are street children they have high chance of acquiring delinquency behaviours such as drug abuse from the peer groups (Ellis & Wolfe, 2009).

6.3. Validity of the study

In this study the researcher is confident that the results obtained actually represent the phenomenon under study. The variable of the study measured the mental state of all participants. The data is a true reflection of the variable and inferences based on the data are accurate and meaningful.

6.4. Reliability

The researcher developed questionnaire whereby mental status evaluation was chipped in for participant to give self evaluation on their mental state. This has enabled the study to answer all the research questions. In this regard the results can be consistence in terms of similar study is done by incorporating these tools.

6.5. Trustworthiness

Credibility

The researcher is confident that the results of this research reflect the reality of the participant based on the full engagement of the researcher in the field and interpretation of children experiences at remand home. Furthermore, the field notes and rechecking of raw data was done repetitively to ensure that the findings were kept in track with the reality. The researcher used triangulation that is mixed methods qualitative and quantitative methods to ensure credibility.

Transferability

The findings captured in this study can be applied in another setting especially in African context since most of African culture communication is done through verbal than written expression (Mugenda & Mugenda, 2003). Also the gaps in the care giving to children is likely due to the effect of HIV/AIDS and the cycle of poverty

Dependability

The researcher addressed the research problem as a challenge that needs to be addressed in our communities and society at large. Also, the findings answered the research questions proposed in the study and met all the objectives of the study. The

researcher is willing to submit results of this study for auditing and second opinion to the main supervisor and co supervisor.

Conformability

The researcher created a friendship atmosphere that led children to express in a free manner during the entire interview. Therefore the results reflect what participants communicated to the researcher. Rechecking of the information with research assistants to validated information given was conducted. Two research assistants were used for writing in-depth interview and focus group discussion.

Triangulation

Data triangulation was achieved through different data sources such as in-depth interviews, observation, and focus group discussions with parents, caregivers and children. Some in-depth interviews were repeated to understand deeper meaning of the participant responses. Data was collected in different settings, at the juvenile court and in the remand home. Triangulation method was used that is mixing qualitative and quantitative research. Also, investigator invited the supervisor to participate in one of the focus group discussions with caregivers. In addition, the researcher used triangulation theory that is a theory of planned behaviour by Icek Alzen (2006) and theoretical model of psychosocial support by Fichter and Foster.

7. Conclusion

In this study, the researcher examined the mental health characteristics of children and adolescents who have committed crimes and demonstrated a correlation of mental disorders and crime committed. In this regards they have allegations or have committed offence and they have appeared before court of law.

The results show that the children and adolescents at remind home came across very difficult psychosocial environmental stressors which led them to commit offence. Their parents had died, divorced, or if alive they are not living together. Therefore, the children and adolescents were reared by a single parent or extended

family. However, there were some problems in taking care of these children as a result they ended up to be street children.

There is evidence that these children and adolescents experienced worries, sadness, and some had experiences of abnormal perceptions of hearing voices, suicide ideations, and homicidal tendencies. The diagnosis made by using DSMR IV TR of some of the participants revealed to have; drug abuse, alcohol abuse, depression, brief psychotic reaction, sex disorder, and mild form of attention deficit hyperactivity disorders.

The findings from this research are not confined into cases in the juvenile justice systems alone; they are also relevant and applicable to the great population in our society. In this regard, therefore, it is important to replicate the findings to also cover those who are out of the juvenile justice systems. The researcher is tempted to make recommendations to cover areas outside the scope of the research.

Mental disorders amongst young persons are prevalent and spreading very fast. It is a factor that calls for national concern and appropriate interventions to address the pandemic. It is a factor, if not arrested, may get off hand and lead this nation into crisis. It is with apprehension in mind that the researcher wishes to call for all stakeholders' involvement in the formulation of relevant policies and strategies in the implementation of activities that will address the problem. Therefore the researcher has the following recommendations that he wishes to put across for considerations.

That the society be aware and be sensitised to appreciate the prevalence and the magnitude of the problem so that at the end of the day they may own the problem and be willing to effect interventions. A meaningful social interaction can come about where the society is fully involved and the community is prepared to respond positively and holistically. A holistic intervention is one that address or aim at addressing the prevention of further spread of the problem and the provision of care and support to the effected and affected. This phenomenon is achievable more

effectively where the society is fully involved in the formation of the interventions through the participatory approach.

8. Recommendations

The government and local Authorities have to assume responsibilities over this matter and be ready to spear head various initiatives to curb the problem. A forum such as National dialogue on mental health to young persons can be put in place to provide an avenue for in-depth discussion and formulation of interventions at national level. The outcome of such forum could trickle down to lower level of the government machinery for implementation. There is a need for cultivating an enabling environment where stakeholders will be taken aboard and get involved. A political will is essential if the development partners are to be invited. The political will can only come about where the top enclose of the Government machinery is made to apprehend the magnitude of the problem.

Parents must be made to leave up to their responsibilities and factors that are contributory to family separation must be eliminated. Things like males denying their partner pregnancies, marital conflicts, brut ling and general unpleasantness in the family hood are supposed to be address so that children are protected from these anomalies and likely be saved from becoming street children.

To those mentally affected it is essential that they are being treated and psychosocially rehabilitated in an appropriate nurturing environment. It is recommended that a centre for treatment and provision of psychosocial rehabilitation of youth mentally disorder be put in place and be equipped with the essential facilities for care and support. For those who have received treatment and rehabilitation will have to be given follow up psychosocial support in terms of skills and materials. This is very vital as a way to protect them to rolling back to the problem.

Through this research the researcher is giving a humble contribution to efforts that will be exerted by all concerns on attempt to tackle the problem of mental health to young society. The researcher hope that many other will join in doing further research on this aspect and find ways and means to solve this critical challenge.

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