First JENGA Workshop

1-2 December 2014, LMS Guesthouse, Nairobi

FINAL REPORT

(Version 23 January 2015)

I. Introduction

1. Following a Roundtable Discussion on Mainstreaming Mental Health and Psycho-social Support (MHPSS) held at the first East Africa Regional Conference on Psychology (November 2013), participants agreed to organize a Workshop to launch the East Africa Psycho-social Network. The name JENGA was selected to signify the building of a new network as well as to evoke the importance of helping our patients and clients to build their identity, ego strength and their dreams.

2. The Workshop was held from 1-2 December 2014 at the LMS Guesthouse in Nairobi. It was opened by Brinda Wachs, coordinator and chair of the Leadership Group (previously the Organizing Committee), followed by Mtheto Hara on organizational matters and procedural issues. There was a Tour de Table where each participant indicted their expectations for the Workshop and particular area of interest or expertise.

3. Registered participants and others interested in the work of JENGA are included in the attached List of Participants. Please send any additions, modifications or deletions to brindawachs@gmail.com. We have created a **Facebook page** under **JENGA East Africa Psycho-social Network** where we have been posting relevant articles and useful tools for MHPSS, MH of refugees, community-based PSS and articles on healing and recovery.

II. Tour de Table

4. Participants introduced themselves, coming from Germany, Kenya, Malawi, Nigeria, South Africa, Switzerland, Tanzania and Uganda, and highlighted some of their expectations from the workshop and areas of specialization, including:

- Psychology and education
- Psychological aspects of psycho-social support
- Mainstreaming MH so that it is better reflected in national budgets (part of health)
- Psychology at the grass roots, bringing psychology to the people
- Humanitarian and people-centered psycho-social support
- Fund-raising, in particular for treatment and rehab for those who need it
- Co-morbidity of other mental disorders with substance abuse, such as anxiety and depression
- Medical, legal and psycho-social support to victims of torture
- MHPSS and Child Protection
- MHPSS in Human Settlements

III. Key documents for Way Forward

5. The Workshop agreed on a **Mission Statement** and a **Workplan,** on the basis of which the JENGA Network will develop its objectives and activities in the coming years. (See separate attachments of finalized Mission Statement and Workplan).

6. Some of the main activities agreed and adopted in the Workplan included:

- Annual Workshops on selected themes
- Fund-raising on MHPSS
- Acting as a referral service for psychotherapy
- Producing an academic and artistic Journal (JENGA Journal)
- Organizing "Intervisions" to share experiences with patients and support each other
- Debating selected topics in the fields of MHPSS

7. The attached annex includes the main "take-aways" that emerged during the presentations and discussions and provide elements for future work by JENGA and future research.

IV. Next JENGA Workshop and selected themes for follow-up

8. The next JENGA Workshop is scheduled to be held from **Monday 14 September to Tuesday 15 September, 2015 in Nairobi**. The Leadership Group has proposed the following topic: **Healing Arts and Psychotherapy. A proposed venue is The Tribe Hotel in the Village Market area of Nairobi.**

9. The 2nd JENGA Workshop will be an occasion to announce our official registration with the appropriate Psychology Association in Kenya (and possibly other Associations in East Africa) and to discuss the launch of a pilot version of the JENGA Journal: with a first issue dedicated to ***Traditional and Indigenous Healing Arts, Rituals and Religious Practices with Therapeutic Value.***

10. Other themes to be explored in future Workshop and JENGA activities include:

- Helping patients speak about intimacy and relationships
- Psychological First Aid (PFA)
- Awareness-raising on depression and anxiety in schools, churches, communities
- Co-morbidity of substance abuse and other mental illnesses
- Psychology and disabilities
- "Care for the caregivers" and "patience with our patients"

_____

ANNEX

I. Main take-aways from Presentations and Breakout Groups on Day 1: Addiction and Substance Abuse and Anxiety and Depression

A. Addiction and Substance Abuse (Paul Ngundu, Asumbi Treatment Center, Nairobi)

(i) Character of "the addict"

Goals of addiction counseling are self-actualization and personal freedom in decision-making, restoration of human dignity. The conscious mind is telling me this is not what I should do, but I find myself too powerless to change my behavior. People are undignified by drugs and society is prejudiced against addicts or alcoholic.

-Many psychologists dont even want to deal with addicts because they are challenging.

-Addicts are stigmatized and traumatized.

-Some addicts are forced into treatment.

-Research has shown that it is not necessary for treatment to be voluntary to be effective.

-Denial is a key marker of addiction and drug abuse, as is the obsessive and compulsive nature of the disease.

-Addicts are often expert liars and manipulators and self-centered. They may have negative attitudes and perceptions, feel life is meaningless, like chasing the wind.

-They can often be emotionally and psychologically stagnated, due to numbing out feelings by using.

-Their coping mechanisms have not developed so they have arrested development.

-The body slows down the production of dopamine, the feel-good chemicals.

-So they will need more and more to restore the balance of dopamine. Goal-setting is nil, anger management is nil, and they can always an excuse to get high.

-Interpersonal relationships skills are nil.

-Sometimes people have multiple addictions, including sex.

-The brain is supposed to be around 1.4 kilos, but with drugs the brain becomes smaller, due to atrophy of the brain from drugs and alcohol (1 kilo or 800 grams).

-Treatment entails rehabilitation of the whole person.

(ii) Detox

Sometimes people have extreme withdrawal, hallucinations, delusions. They then go to detoxification clinics. However not everybody has to go to detox. If they havent drank in awhile and only battling insomnia.

Some benzodiazepene's are addictive and agonists. So many patients go through withdrawal "cold turkey". Asumbi is a residential programme, 3-6 months. Also intensive outpatient care with counseling and psychotherapy and going back home.

Rehab is only the beginning of the recovery journey. All patients will need further follow-up and care.

So we give them drug education, a good diet, new responsibilities, life skills training, art therapy and before leaving, relapse prevention strategies.

(iii) Treatment models

-Medical model: addiction as a disease
-Learning Theory model: "what has been learned can be unlearned"
-Psychoanalytical model: addiction is psychic imbalance, help them to work through issues
-Family Theory model: the whole family is sick so have to treat the whole family
-Bio-psycho-social model: incorporates all of these

The main addiction counseling approach at Asumbi (and in much of Kenya) is the AA 12-step method. We also include one on one counseling and CBT interventions: how to cope with cravings.

By meeting the families and loved ones, we can also offer some family therapy

(iv) 12 core functions for addiction counseling

Screening, intake, orientation, assessment, treatment planning, counseling (individual and group), case management, crisis intervention, client education, referral, record keeping and consultation.

Therapeutic community: whereby we empower people to be part of a community and this becomes an agent of change.

This applies to a participative, group-baed approach to long-term mental illness and/or drug addiction that includes group psychotherapy as well as practical activities and which may or may not be residential with the clients and therapist living together.

After discharge, there is a continuing care plan and support groups (AA, NA) and clients are strongly encouraged to seek a Sponsor.

B. Depression, Grief and Mourning (Stephen Asatsa, PhD. Candidate, Catholic East African University, Psychology Dept)

Research on traditional mourning rituals of the Batsotso community shows that indigenous or traditional healing rituals and religious practices can have significant therapeutic value and should be protected and maintained. For examples, practices such as those used in grief and mourning show that, in counselling grieving clients, men will often sit around the bon fire while women sit around the kitchen consoling each other: a support system is thus already provided by the village.

Multi-cultural counselling is gaining a lot of respect in the field of MHPSS.

Is it therapeutic to shave the head and what significance can it bring to the child who may not understand what is happening?

We must give value to traditional mourning rituals that give people a specific way to deal with death. It helps to orient the children within their culture.

C. Conclusions from Breakout Groups

(i). Emerging Issues in depression and anxiety

-Society is not equipped to diagnosis nor treat depression.
-Sometimes counselors must tell parents to stop “spiritualizing” the son’s depression.
-Need to sensitize people to depression and mental health.
- Important to involve the family
- Co-morbity between depression, anxiety, substance abuse and suicidality.

- In dealing with young adults, it is not as common for the family to get involved and this is a missed opportunity.
- WHO says by 2016, depression will be the leading mental illness.
- The psycho-support system needs to be strengthened, in particular for teenagers.
-Importance of physical activity to treat depression.

- How can we re-energize the community support system and raise awareness that the traditional rituals and customs are still relevant.
- Clinical and non clinical approaches can work. Must have patience and give the healing time. Family members often want to see immediate results: “Patients need patience”
- Importance of occupational therapy and income-generating activities to get back to work.
- How can we take advantage of community supports to prevent crime e.g in human settlements?

- Need for preventive counseling.
- Depression is so prevalent. Yet, when a member of the family becomes depressed, there is a big stigma which prevents one from seeking help.
- There are high rates of suicide among the upper classes, not only the poor, why?

- It is important to look at the patient but also the surrounding environment, family and friends: family therapy needs to be expanded, not only in substance abuse but across the board.
- What is the age bracket for anxiety and depression?
- Need for psycho-education to the community
- Sensitization about relationships: boys are told that girls are evil and girls are told that men are dangerous.

- Can psychology offer us solutions to societal problems.
- How can we rebrand counseling in the vernacular of the people.
- How can JENGA focus on sensitizing the masses on self-awareness?
  - Can JENGA champion psychological self-awareness for young children, e.g. around 10.

(ii) Conclusions from Breakout Group on Substance Abuse in separate ppt.

II. Main takeaways from Presentations on Day 2: Fundraising and Grant-writing on MHPSS and the new Psychology Act in Kenya

A. Training module on Fundraising and Grant-writing in MHPSS, (Tim Mukua and Mtheto Hara)

Participants engaged in an "Ice breaker" to get started: Person in need, vs. donor vs. fatcat (corruption). So the donor needs to be cautious to ensure the funds go to the right needs and not siphoned off in corruption.

(ii) Fundraising: A skill to harness

- Fundraising is a skill that you need to harness. When you submit a proposal, eg. on agrculture, you have to explain how it would improve livelihoods, need to clarify and communicate.

-You need to plan your approach, target your proposal, decide on content, how much to ask for, writing the proposal, how to get in touch with donors, possible donor checklist and other funding sources.

- How can we show them that our proposal is actually following the mental health agenda?

- Some donors dont want collaboration with other donors, others do. What is the likelihood of success?

Example: What if the proposal was to preserve mourning culture to support the grieving process in E. Africa.

URGENCY: What is the urgency to support the proposal
SCALE OF NEED: look for museums, who is funding them, as is linked to cultural heritage.

- Let the donor know who you will be dealing with .

- Refer to the sustainability of the project.

- There is often a regional office in Nairobi of the donor.

(iii). Content of proposal

In the content of the proposal, it is important to:

-Specify the problem/need
-Indicate geographic or socio-economic factors which are significant
- Clarify aims and objectives of the project
- Describe your methodology
- Clarify your short and long-term operational plans

- Donors will skip ahead and see how you will execute the project and look for over-budgeting
- Piloting a project would be important
-If you over-budget they might think the money will end up in people's pockets

-The donor wants to see your long-term plans and your short-term plans, and whether the project will just die.

-Expected outcome and how soon will you see the outcome?
-Explain to the donor, what is the worst case scenario if not funded?
-You need a credible data source.
-Why you? or why your organization? Do you have what it takes?
-Link the proposal with Counselor's Act or local trends, global trends and higher goals/objectives
-Develop and submit a proposal through a consortium

B. **The New Psychology Act of 2014 (Mr. Githongo)**

Mr. Githongo presented the status of The Counselors Act of 2014. He indicated that there would be some leeway this year but that effective next year, all psychology students and all accredited diploma training will be examined by the Kenya National Examination Council.

The diploma curriculum developed by the Kenyan Institute of Curriculum Development (KICD) has developed a harmonized curriculum that would include:
Chemical dependence and addiction
Child counseling
Disaster management
Guidance and counseling in learning institutions
HIV in communities
Marriage and family counseling
Spiritual counseling
and additional training on Supervision

- The new organization and new board will be administered by the Ministry of Health.

- The Board will be registering all counseling and psychologists in Kenya.

- The Commission for University Education will verify the certificate is from an accredited institution

- Under the Board, a psychologist will automatically become a member of the Counseling and Psychology Society of Kenya

- All the other Associations in Kenya today will die, with the exception of KCPA.

- What will be the work of the Society? To discipline its own members. If your license is taking away, you can not practice.

- The benchmark was an MA, but they lowered the level to BA

- Lower than BA, with diplomas or certificates and hands on experience, you can continue to practice but you need to be attached to a psychologist.

- Psychotherapy is any intervention that makes the mind at ease.

- One must choose either a degree in counseling or psychology

- Every school will have to have a counsellor.

- To those who have already graduated, you will be exempt from some examinations.

- Existing diplomas are recognized if the institute was accredited by the Ministry of Education.

- Existing association will subject themselves to the law.

- Rehabilitation homes, if dispensing drugs, must be licensed by the Ministry of Health. NACADA wants to do training and offer certificates, but they are not a training organization unless they are offering it through an accredited institution.

- Each certified counselor will be obligated to take out a mandatory indemnity insurance to protect patients and to protect you from patients.

- Will also talk about a minimum amount of fees that will be charged across the country. Scale of charges to be developed as well as a core of ethics.

_____