Arusha Mental Health Trust
PO Box 1645
Arusha
Tanzania

Thirteenth Annual Report
2009

Arusha Mental Health Trust (AMHT) is a:
a) Company Limited by Guarantee
Certificate of Incorporation No. **48784**
b) and a Registered Trust Certificate of Incorporation No. **3171**

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1.0 Introduction & Logistics

We are happy to present our annual report for 2009. As in previous years this mental health programme, in theory, geographically covers the municipality of Arusha, which has a population sometimes reported as 400,000 and often as much as 800,000 people. People also say that Greater Arusha, which is not a formal geographic entity, is home to well over a million people. I offer all these statistics and cannot be certain of any one. We know it is growing fast and that the last formal census was in 2002. Clients also come from neighbouring districts and we are often asked to see people from all over the country [and beyond]; sadly and understandably we cannot always easily do this.

Arusha Mental Health Trust (AMHT) is a Company Limited by Guarantee and a Registered Trust. It is not legally affiliated to, or under, the direct governance of any other Government, Church or Private Organization.

2.0 Gratitude

We sincerely thank all our donors without whom we could never have offered this service. We also thank those who volunteered their services in any way. We appreciate the efforts our clients made to come here and to accept our services despite the many hardships they experienced and the great taboo attached to approaching any mental health service.

3.0 Sympathy & Dedication

Sweetbert Gosbert, a long time member of our wide AMHT group, died tragically during the year**;** we were heart broken and miss his great smile and regular visits to the department.
John Sakaya, our devoted gardener, died following an accident on our horribly dangerous roads. Out beautiful little garden is a tribute to his hard work and love for nature. We lovingly dedicate this report to these two young men who, for very different reasons, became known to us and who represent the many people who form our family of healing service.

4.0 Mission Statement, Services & Requirements

Mission Statement

The Arusha Mental Health Trust facilitates the provision of appropriate mental health services to the people of Arusha.

4.1.List of Services:-

A reception service where clients can contact the staff and thus access any aspect of our service Appointments for the psychiatric services provided by the government staff as well as the psychological services provided by AMHT can be made at reception between 8am and 5pm on normal work days (Mon- Fri every week; no such availability on Public Holidays).
Clinical psychology, counseling and psychotherapy to individuals, couples, families, and groups. These appointments are managed on a pre-booked basis except in a crisis.
Outpatient psychiatric clinic which is run by one of the AMHT staff who is a psychiatric nurse.
Cognitive & Achievement testing for educational and neurological investigations of children and adults.
Behavioral assessments for children, adolescents, and young adults.
Assessment reports for religious orders; adoption agencies; potential or actual employers; boarding schools or special educational programs; or other individuals with specific needs.
Client advocacy with school managements, employers, police, immigration and the courts

4.2 Community Outreach:

Consultation for in-patients admitted to general hospital wards in this hospital and any other hospital as requested. This can require that we visit the client or can be managed by a direct call from a doctor to which we respond by phone.

SIGHMA (Special Interest Group in Mental Health in Arusha) meets once per month for a lunchtime presentation on mental health related issues. Hosted by AMHT, the group is open to all.
Out of clinic visits to clients in their own homes, at school, or at work as needed. This includes visiting clients and their families managing chronic illnesses like Alzheimer's Disease.
A counseling service is offered in **Esso Parish** in downtown urban Arusha every Tuesday for the whole day.
Crisis response service to individuals and organizations following accidents, critical incidents like robberies, sudden unexpected job loss and /or tragic bereavements.
Networking and linking with relevant agencies locally, nationally, and internationally.

4.3 Partnerships: we work in Partnership with other service organizations such as: -
Government nurse run psychiatric clinic at Mt. Meru Hospital; some schools; special needs classes; churches; mosques; temples; street children's organizations; HIV/AIDS groups; orphanages; outreach programs to vulnerable children; widows' associations; physically disabled client facilities; hospitals; health centres; development and volunteer organizations; drug and alcohol services (AA & NA) & individuals who have a particular interest in mental health.
We continue to develop our partnerships and invite more community collaboration

4.4 Education & Information Sharing:
a) Workshops and seminars are run here and in other venues as requested. These are designed for different audiences to meet the specific needs of a group and can be offered in both Swahili and English.
b) A **resource center is open to the public at the main department**. We have a wide range of mental health books, journals and newsletters in English and internet services are available free of charge. Translated materials in Swahili also provide information and education. The resource center is a clean, quiet environment for students and clients to use as needed for study, as a waiting area or for respite.
d) **Consultancy** in the area of mental health to individuals and organizations.
e) **Translation** of materials into colloquial Swahili for client use in our own work.
f) Availability of short or long term **internships** within the trust to suitable candidates.

4.5 Requirements in order to meet our goal and aims are:
a) Donor Aid b) Transparent & sound administration c) On-going staff capacity building
d) Additional counselors in and from the community e) Continuing and further support from the Tanzanian government & f) Wide networking

5.0 Our Working Methodology

We are aware of the fact that mental illness of all kinds is very prevalent in this country but that mental health provision is very rare, laden with taboo, not specifically nor adequately budgeted for and thus mostly non-existent, or invisible to those needing the services. We try to offer some direct services as outlined in our service list. In addition and very specifically we form Partnerships with many other service providers to try and empower them to become interested in the mental health of their target populations. This works something like a Training of Trainers Model (TOT) though this is not an exact description of what we do. To this end we work to identify partners with whom we can work fruitfully; we know we cannot serve all but seek to work with those local organizations providing a reasonably well managed service to the poorest, most vulnerable and most neglected. Child clients are a preference but male and female clients occupy an equal priority for us in mental health. In

> *We form Partnerships. We work with Taboo.*

organizations where the management is not transparent, nor willing to co-operate actively to provide, time, space and a reasonably reciprocal relationship we find it hard – indeed impossible- to really work together. We have experienced different models and strengths of management in our partners over the past year.

Another thing we increasingly do is identify persons in the wider community with any kind of mental health training and encourage them to offer service in some way, somewhere, however small, so that the total number of people helped is increased and a greater number of service providers involved. This gives some choice to clients too. This past year we worked quite intensively with three such [well qualified] persons; to date one is now working part-time; the second returned to her country of origin when her faced retrenchment due to the economic downturn; and the third continues to struggle to get herself a work permit, find a workplace to accept her [she does not carry a Tanzanian passport yet]. She also "battles" and tries to balance the cultural challenges inherent in being a foreign bride in a complex family system whose elders are totally unfamiliar with having a highly educated, professional woman among its members.

These two models of working: Partnerships and Volunteer Community based counselors are ways of reaching more people and slowly changing a culture of taboo to one of more awareness and acceptance.

6.0 Partnerships

Over the course of 2009 we worked intensively with several partners as outlined earlier. All are worth reporting on very specifically but for the sake of brevity we will focus on three in this annual report namely: 1) the Ladies' Alcoholic Anonymous [AA] group; 2) the Counseling service within the Arusha Lutheran Medical Centre and 3) the basic psychiatric service run by our government nurse colleagues here at Mt Meru Hospital. The Ladies' AA continued weekly until July when the leader left Tanzania. It was consistently poorly attended and despite all our efforts to advertise, encourage and enlist members we failed hopelessly. In talking to a friend who is a market manager it seems we fulfilled all the criteria of good marketing and yet it was not a "hit". We regularly asked ourselves "why?" One day when one of our staff went to a hairdresser's salon to put up an advertisement the female hairdresser said: …"well I would never go there; everyone in Arusha would be gossiping". This is certainly one reason; there are others no doubt. We have to cope with so much living in a small, provincial town where we can all think we know so much about each other. We are known as we walk into a shop……… So as well as stigma and taboo we also have the "small town syndrome" as one of our mental health conditions to deal with.

> *"I would never go to AA ! Everyone in Arusha would be gossiping !"*

2) Our PhD intern Robin Peterson initiated and ran the Wellness Centre at Arusha Lutheran Medial Centre [ALMC] and this was certainly a positive experience for her and by all accounts an excellent service. Robin had a challenge to enable the medical, nursing and ancillary staff to understand what mental health work involved and then as a second step to support them to refer appropriate clients to her and as a third step to help them use their knowledge on the days when she was not there! We offered a back up to the staff when Robin was not on duty and had some "big moments" such as one when a client had a severe psychotic reaction to Lariam or Mefloquine (an anti-malarial drug). This involved a lot of skilled psychiatric management as well as case management with insurance companies, airlines, a family thousands of miles away and different time zones and more……… Robin spoke of how really helpful it was to practice her therapeutic skills in an integrated manner with colleagues from across various disciplines. In particular she talks of the great collegial support and learning she received from Sarah Wallis Rejman the dynamic occupational therapist & manager and of the difference it made to have the input of Sarah's knowledge, perspective and skills. We wholeheartedly thank our partner and friend Professor Mark

Jacobson MD for accepting us and thus enabling us to fulfil our mission to the people of Arusha though this timely internship at ALMC.

3) The third partner activity that we will mention is the service run by our government psychiatric nursing staff based here at our dept building. In general they offer two services and we assist with the first one namely: a] an out-patient service to clients with disorders mostly requiring medication. Prominent among these are clients with psychotic disorders; the second largest number of clients treated by them are those with Epilepsy, a neurological disorder but one which (regretfully) falls under the auspices of psychiatric services in Sub-Saharan Africa. Some of what we try to do to enable the smooth running of this service includes the following:-

- ✓ The provision of a clean, well lit environment, with leaflets in Swahili explaining mental illnesses.
- ✓ A supervisory or referral system for all clients, take over the management of some clients and co-manage others with them.
- ✓ Assisting in the immediate emergency care of clients who are very disturbed, disruptive and/or violent.
- ✓ The provision of additional drugs to this psychiatric clinic when they frequently don't have the right drugs nor enough drugs for the clients.
- ✓ Offering our partners a capacity building service by inviting them to all courses, meetings of the special interest group and any teaching sessions we run.
- ✓ We help them with clients where written reports are required.
- ✓ For many years we assisted too with their statistical analyses.

b] In-patient service. There was no in-patient mental health facility available anywhere in Arusha town or region[1] throughout 2009. Our partners the government employed psychiatric nurses working in the mental health department visit and advise on the care of those in-patients with mental health related issues admitted to the general wards in Mt. Meru Regional Hospital. This is a challenging service as the integration of clients with florid symptoms and disturbing behaviour within a ward of acutely ill, and even dying persons, makes a very difficult environment for all concerned including those tying to care – staff and relatives alike. We are not involved in this service other than to occasionally offer an opinion on management,

This year we have decided not to report any of the statistics from this partner service No.3) as they are not under our direct management and haven't been for several years. We affirm all they do and are deeply grateful for their great co-operation; we especially commend the diligence with which Peres Laizer cares for the overall cleaning and hygiene in the building.

7.0 Clinical Activities of the Programme

7.1 Psychotherapy or Counselling Service

We offer a psychotherapy service in Swahili and/or English at the base clinic in Mt. Meru Hospital 5 days per week; we also ran this service one day per week in a parish in an area called 'Esso' under the management of the Pallottine Fathers with 2 counsellors most of the year; and as mentioned earlier we had a counsellor present in the Arusha Lutheran Medical Centre (ALMC) throughout 2009 three days per week. The statistics come from all counsellors and all sites. What is offered in this very comprehensive service is included in our List of Services on page 3 under 4.1

[1] ALMC has 2 specially designated psychiatric beds; the hospital opened officially in December 2008 and these beds were not available throughout 2009.

Table 1 A 3 - year comparison of Statistics from The Psychotherapy Service

	2007	**2008**	**2009**
Total Clients	655	643	872
Male	307	308	395
Female	348	335	477
Total Consultations	**3015**	**3197**	**4617**

Comments: There was an increase in the number of clients and in the number of consultations; we attribute this largely to the fact that Robin was in ALMC all year.

Table 2 Clients by Age at the Psychotherapy Service – 2009 only

Aged	**0-14**	**15-19**	**20-40**	**41-60**	**61-75**	**76 +**
Number	52	165	417	182	47	9
% age clients	6%	19%	48%	21%	5%	1%

Comment: Again due to Robin's work at ALMC the number of children and adolescents increased over former years. Boniface always sees many adolescents and his location at ESSO facilitates this. We rejoice in having been able to offer more service to these client groups. The largest client group seen by us is consistently the 20-40 year olds.

7.2 Assessments

In 2009 we continued to do assessments as requested of us by adoptions agencies, employers, courts, private individuals, and religious orders. Last May we started to work on specialized Cognitive Abilities & Achievement Assessments (Woodcock Johnson III) and specialist behaviour assessments for children and adolescents (BASC-2). We hope this will be a growing service as we realize the great need in the community. See Appendix.

7.3 Out of Clinic Visits - formerly called "**Home Visits**"

We counsel or offer psycho-education to clients, their spouses, parents, family members, teachers and/or employers out of the department in their homes in places like school, another hospital, in work places during workshops or in a venue of mutual choice in what we call "Home or Out of Clinic Visits." We try to keep this service small, for well selected cases and only for those who truly cannot come to one of our sites. It is very costly for us in time and becoming increasingly so are roads become more and more congested. However taboo, or stigma, in some guise plays a considerable part in keeping this service larger than we would wish.

Table 3 3 - year comparison of Out of Clinic Visits

Category	**2007**	**2008**	**2009**
Total Visits Made	642	859	932
Total Clients visited	251	318	279
Males	99	106	98
Females	152	212	181

Comments: There is a continuing increase in visits outside of our base clinic or places of work while the client number is not increasing as rapidly. In the past year we had several clients with very acute problems requiring very frequent visiting.

Table 4 7 of the main Reasons for out of clinic visits with the reasons for visit - 2009 only

Priority by number of visits	Reason for Visit
1	Persons with acute condition needing regular monitoring
2	Child visits to school, to home, orphanage or any combination
3	Crisis response to the scene of an accident, another hospital, hotel, police station, the mortuary etc.
4	Unplanned visits – "the small town syndrome" our visits to a restaurant or to church can end up being unpaid, unprepared and unplanned psychotherapy sessions!
5	Meeting key informants such as family members or teachers
6	Home visits to elders who are unable to come unaccompanied
7	Supportive visits to families with long term chronically ill members

7.4 Advocacy: we advocate for clients with parents, teachers, police, the prison service and employers where they are likely to be misunderstood or wrongly blamed or both. We also know that our clients at times do wrong and so often we are called upon to advocate for what we all need – *a second chance* and an opportunity to be trusted once again. We also place clients with organizations for work experience on a trial basis. We write reference letters for clients seeking employment, school placements, scholarships, the courts and much more than we can detail in a short report.

7.5 Crisis Response Service

- ✓ We offer a crisis service in person within and out of the clinic, by phone and/or by e-mail
- ✓ We also offer follow-up to some clients by phone and by e-mail

We realize that most of our AMHT statistics are an under representation of what we really do as we have not kept records this year of that huge body of work called "indirect client work" and we certainly do a great amount of it. We all do a lot of work by e-mail and thank our generous doors Arusha Marie-Node who made 24 hour e-mail and internet services available to us free of charge.
We have new activity logs so perhaps next year we will report the "invisible" side of our service better and in a fuller manner.

8. Education or Information Sharing

8.1 Workshops and seminars

We are specialist providers of educational sessions – seminars, workshops and on-going training sessions - in the area of mental health in Arusha. We especially concentrate our efforts on those who we believe will be able to share this knowledge and towards this end we see whose with some existing mental health skills, staff at the partner organizations and the religious formatees[2] as special focus groups.

Table 6 3-year comparison of Educational or Information Sharing Sessions

	2007	**2008**	**2009**
Total Hours of Teaching	442	311	314
Per week	8.5	6	6
Total Participants	**4383**	**2912**	**1037**

[2] "Formatees" are seminarians, student sisters, student brothers and student priests at a particular time in their training .

Comments:
In 2009 we continued to teach as often as before but reached a much smaller audience. We ask why? Several reasons can be proffered. This was the first year that Sheila did not teach each week at the Spiritan Missionary seminary as she was retired from there at the end of 2008. We made a decision to work intensively on our monthly special interest group meetings which attract a relatively small, interested and "likely to use the knowledge" group and not to have any big open, public mental health days. Lisa and Robin were involved in serious study so the availability of trainers was reduced at times. We consistently exercised a policy of making sure there was no one else in the area who could offer the service before we took it on and in the same vein we tried to ensure that the training was specifically in the area of our expertise. We do this to allow ourselves be available for what we realize others are not trained to do i.e. direct and indirect client counselling work. We all believe that the topics offered at the special interest group meetings (SIGMHA), the attendance and the interest generated go a long way towards fulfilling our mission, increasing knowledge, destigmatizing mental illness and making our services better known.

8.2 Training, Supervision and Mentoring: We offer a place for suitable internship and/or experience for students of counselling, the social and behavioural sciences, medicine, nursing, and pastoral care. We especially welcome Tanzanians to the department but recognize the value of such a placement also for young religious novices on formative placements, foreign students, and of course trained counsellors for long or short in-service training or refresher placements. Over the course of 2009 we had students on placements from as short a time as one day to several weeks to the whole year. We were especially happy to meet a young Tanzanian women just qualified in Counseling Psychology who wished to join us and disappointed when she did not follow up and didn't communicate any change of her plans!

Over the past year a Tanzanian psychiatrist with UK citizenship offered supervision to the director as this is a service with no medically qualified psychiatrist. The offer was well received but did not work out. When we need a psychiatric opinion we are often faced with a client with a serious disorder requiring medication or a change of medication or a child/adolescent client whose condition is challenging. We are unable to wait for long distance replies to e-mails and phone calls to a doctor who has not seen the client. We continue to explore how to fill this important gap in our service.

8.3 Translation: we translate mental health material into Swahili for popular and client use and make it available free of charge here in the department or outside if we go to teaching or training sessions. We do not offer translation services to universities or others requesting such – our aim is to make material available to our own clients and stake-holders not to be translators.

8.4 Educational bursaries: we channel funds from donors towards former clients with proven ability and so can have some students in university, college, secondary school and trade school at any given time. This takes a lot of work as (many) universities in Tanzania are places where strikes happen, and where students can be sent home for a whole host of reasons beyond the scope of this report. Managing their needs and helping them cope are real challenges for us. This is a service that has got much smaller intentionally.

We also had two students (part time staff members) from our own trust studying one with a bursary and the second with smaller educational need support. This is an aspect of this service that worked well for us as both students were able to offer a lot of counseling service to the department and were also capable of managing fees, reports, evaluations and the needed paperwork highly efficiently.

Overall in 2009 we had one PhD Clinical Psychology student; one Diploma in Counseling student, one final year Law student, one final year Philosophy student, one third

year secondary school student and a few students where we managed very small parts of their overall expenses.

We are grateful to the financial advice given by Vivienne Brennan when we had to make difficult decisions around the misuse of funds by one of the students. Such issues take a lot of time, reduce mutual trust and make us question our ability and wisdom to engage in this service.

8.5 Training for personnel working with HIV/Aids For the past number of years we have formally committed ourselves to offering some service to a designated HIV/Aids programme as one way of assisting in alleviating the effects of this devastating illness and partly in response to donor pressure. This year again we were able to do this in several ways but I will mention two: i]a very effective counseling course run in Swahili for persons working in some manner with Aids /HIV clients and ii] a close working partnership with an orphanage where many of the children are aids orphans. We remain of specific service to the Mango Tree Foundation in Kyela Mbeya Tanzania.

8.6 Staff capacity building: this takes a variety of forms from formal training programmes being undertaken by two members, to attendance at conferences, presenting papers at conferences, study days, participating at seminars, reading new books, receiving report-backs from psychiatrists to whom we have referred clients, visits by mental health personnel from abroad, SIGMHA and internet research as personal study. In November we participated in a conference and one staff member received initial training in EMDR[3]. Each staff member of the Trust is encouraged to have specific on-going learning targets and every effort is made to seek good, appropriate learning opportunities.

8.7 SIGMHA The “Special Interest Group Mental Health Arusha” was run monthly and attracted more and more attendees to the point that we now have to ask our selves: do we look for another venue to host this meeting? We offer topics of specific mental health relevance during lunch-time on a Friday to allow people return to work; presenters can be experts, practitioners, trainees, clients, or family members of people with a mental health challenge. The meetings are open to all. This is an excellent forum for meeting people, for personal support, for exchange of ideas, for raising and increasing awareness of issues and for staff capacity building.

8.8 Visitors to the department: Again as in other years we were blessed with many visitors; several of these were from overseas and came to learn about mental health services here and specifically what we do in AMHT. In this way we had a teaching opportunity, a forum for cross-cultural discussion, an opportunity to make new friends and to learn from people with mental health expertise (some had this). We also gained a few new donors – either with materials (books mainly) or finance.

People came from the Ministry of Health on at least two occasions; we were delighted to meet them and explain our work, answer their questions and in both instances offer the urgent help they requested of us. We did not know in advance about either visit and both groups expressed delight, wonder, interest and surprise at the wide breadth of our work. We send regular reports to our ministry, are based in a government hospital and ask ourselves how can we let *them* know more of what we do? We realize that sending information and information *being received* are entirely different processes! We are aware that personnel change quite a lot in many areas of work in Tanzania especially in domains of skilled and highly qualified people; so having made a contact one then learns that the said person is working in another department or indeed with another organization or even gone abroad. Communication systems can be weak and so details and messages of contacts don’t always seem to be passed on efficiently. We regret this.

[3] EMDR = Eye Movement Desentization & Reprocessing

8.9 Resource center and free Internet service: is one small way to reduce stigma and to bring people to the department who do not have any mental health need we – through the generosity of a local donor Arusha Node Marie- offer free Internet services to any member of the public. This is meant to be for educational searching and not for e-mailing friends! So it serves a dual purpose as an educational tool and hopefully too a challenge to the taboo of coming here. This continues to be a well used service.

9. Administration:

9.1 General Administrative Work

We solicit donor funds; keep our books; prepare an annual audited financial report; present an annual report (this); write a Christmas letter; keep statistics, update policies and procedures and network locally, nationally and internationally; we keep an updated inventory of our furniture, equipment, books; maintain all equipment; maintain car (vehicle); ensure repairs and regular maintenance for the building; insure the car, the building and personnel; have annual personnel contracts, pay into pension schemes for each staff member, deal with immigration visas for non-Tanzanians, cope with the tax department and deal with personnel matters. We manage the garden and keep the drains clear in times of high rain and we had torrential rain in November and December after a period of horrific drought. In 2009 we had dreadful difficulties with electricity as there were days when we only had a few hours electricity and we continue to have regular power cuts. We had fumigation completed at the end of the year due to the "invasion" of the premises by termites; we had painting done in several rooms and the receptions area; some carpentry repairs were undertaken also and more. We continue to face big expenses with our one 12 year old vehicle, we had to buy a new printer, repair computers, deal with computer viruses and we now need to buy more chairs as we cannot seat all the attendees at our special interest group meetings. A good complaint!

9.2 Social welfare or "help to the very poor": the generosity of the members of ACC[4] which accepts our recommendations for help through their Projects and Benevolence Committee and of other unnamed donors make it possible for us to assist very poor clients especially women in a huge variety of ways. These beneficiaries are always clients of the mental health programme and come to our attention though any of the staff members in the Trust or in our partner nurse run psychiatric service. This is a very small, but time consuming, part of our work as we do not want to ever become known for this so a lot of quiet discretion and fact-finding has to be exercised.

10.0 Matters of importance

10.1 New Venture

We acknowledge with gratitude all our donors since the beginning and we remain donor dependent.

We also recognize that nowhere in the world are mental health services able to pay for themselves.

We work with the contradictions inherent in hearing that we need to make our programme "self-supporting" whilst living and serving the poor in a country like Tanzania.

We know that the government receives large direct government to government grants from overseas governments for health care generally and for many specified areas like HIV/Aids but not specifically targeted for mental health.

We have been part of the development/aid/sustainability discussions for many years and have lived long enough to have moved with the different paradigms and winds of change.

We acknowledge the great burden of stress placed on us as we try to offer a service like this and finance it at the same time.

[4] Arusha Community Church

Herein we are like many of our clients in so far as that we would willingly do what we have to do to make ourselves sustainable …… if we knew what that consisted of *and were it possible for us to accomplish reasonably.*

Without donor aid we don't know how to offer the service we are offering and to serve the poorer and more vulnerable people as a priority; these may not even have enough to eat not to speak of trying to pay mental health fees.

A suggestion has been made to us to open a separate, private, [high] fee paying service as a way to generate income and eventually allow the "New Venture" pay for the total service. This sounds logical, reasonable, business minded, and well worth trying. We ask: at what cost? Such a service could potentially, after some time, generate income; it will attract the international community from Arusha and beyond. It will not serve the poorer sectors of society or the vast majority of the Tanzanian population. In a mental health service where we [the staff members] have different educational backgrounds and varying levels of skill this new venture could also create something of a "brain drain" and create further strain for an already stretched service. Currently we are trying to learn how to make a business plan so that we can work with this concept. We are open to hear your responses and most of all to enlist your prayers and practical help.

10.2 Sexual Abuse

Definitions of sexual abuse vary somewhat across different cultures but understood as "sexual actions forced upon a person" or the "forcing of undesired sexual behaviour" sexual abuse is prevalent in all societies where [reasonably] accurate statistics are available; East Africa is no exception. We joined with our partner ALMC to support the setting up of a Rape & Sexual Abuse Care Center during the second half of 2009. As mental health providers we are privy to hearing accounts of sexual abuse and to meeting clients whose lives have been greatly damaged by such heinous actions. In some cases the abuse took place many years ago and the perpetrator is far away, deceased or of unknown address. In other cases the perpetrators are still alive, perhaps even living fairly locally, "out and about" and often in positions of authority. In this country there are no statutory regulations concerning reporting such crimes. Policies and procedures to be followed do not [yet] exist in Church or state.

In many western countries these cases have clear protocols of management, a definite reporting system and immediate legal, including police, involvement. This makes it so much easier for the professionals working with the cases.

Rape is a crime here but the point I am making now is that those of us in health professions hearing of such abuse are not obliged to report - in fact quite the opposite it is very definitely not our job to do so. This poses huge problems for us knowing that victims will most likely never be able to voice their issue to police; and knowing that most likely the perpetrator is a person of some power and thus with the ability to subject further people to his/her actions.

A further problem for us is the question: Will we be accused in some future years of silence and complicity in these actions…….? I don't know. Many judgments are made in hindsight. But life is lived forward. This poses a moral dilemma; it may also possibly create problems where the clinicians come from other countries in which the legal systems are different and where judgments are made in a very different cultural context.

We share this as it is becoming a definite concern for us and one we believe worth reporting to you our readers. In this we work in yet another uncertain, distressing and 'grey area'.

11.0 Reflection & Conclusion

11.1 Reflection

As I reflect on the past year, on our mission statement, overall goal and programme aims I am aware that there is so much to be thankful for and so much else to think about, dream of and regretfully, too, definite matters of deep concern.

We have little control over some things such as: the lack of an adequate in-patient service; others we try to work with but the results seem tiny such as the immense stigma attached to all forms of mental illness. We often hear of clients who need us but won't agree to coming into the department or won't accept being [known to be] assisted by a mental health service.

We understand some of the main challenges that face a person needing a mental health service here to be: deep beliefs in witchcraft and all this implies; the widespread use of traditional medications; among the newer challenges is the fact that [western] medicine is more and more a 'business' so many doctors wish to hold onto their clients for financial reasons even those whose symptoms don't respond to their many efforts at treatment; and the fourth big challenge facing such people is what we call in Swahili "Maombi" or prayers. The rise in fundamentalism across all the main religions is felt here as people attend prayer crusade after prayer crusade in large numbers; promises are made of healing, good fortune, of children to infertile couples, of jobs and more. Vulnerable and unwell people are lured to what may be perceived as another chance that will end in a "cure". We know that when we meet clients we are so often the last port of call; we meet them exhausted and weary and with their problems even worse. Sociologists tell us that such religious exercises and experiences flourish far more in times of adversity so it should be no surprise that these intense prayer sessions thrive in a country of economic poverty for the masses and, while relatively politically stable, it is a country of hopelessness for many especially the jobless youth. We believe some of these prayer forms are psychologically abusive as they create a lot of false hope, work into deep areas of a person's life, create guilt, confusion and frustration, and cost money which is solicited as a "voluntary offering" or sadaka (Swahili for offering).

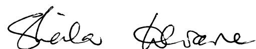
11.2 Future Developments

These will include continuing our model of partnership, assertively attempting to reach new potential partners, trying to see how we can handle the "new venture", allowing genuine needs lead us as well as being in the forefront of trying to proactively discern mental health demands in the community that we can address within our capacity.

We hope to continue to make client service our top priority.

In conclusion we **thank** all of you for your help and continuing association with us. Our confidence in you as our friends, donors, supporters, family members, colleagues or interested readers is a great gift and one we cannot ever measure……….but one we deeply treasure.

Sincerely and with gratitude,



Dr. Sheila Devane MMM
Director

Date: February 22nd 2010

12.0 Appendix

12.1 Personnel or Staff Members

12.1.1 Full-time Personnel in 2009: -

Dr. Sheila Devane, Director, Clinical Psychologist, Lecturer & Administrator
Mr. Emmanuel Bujulu, Psychiatric Nurse, Counsellor, Educator, Financial Director
Mr. Boniface Kisi BA Phil & Theology. H. Dip. Couns., Counsellor & Administrative Asst.
Mr. Richard Matei, Driver, Office Assistant and Messenger

12.1.2 Students on Internship

Ms. Robin Peterson M.Sc. B.A Dip. CPC, Psychologist, studying for PhD
Mrs. Lisa Stevenson student of a counselling diploma **(qualified in September)**

12.1. 3 Counselling Partners

Mr. Graham and Mrs. Lisa Stevenson Marriage Guidance Counselors

12.1.4. Trustees

Dr. Sheila Devane (Chairperson), Dr Naphtal ole Kin'gori MD,
Mr. Emmanuel Bujulu (Treasurer), Mr. Boniface Kisi & Mrs. Robin Peterson (Secretary)

12.1. 5 Advisors to the Programme

Ms. Vivienne Brennan Financial Advisor &
Fr. Oliver O'Brien SCA Trust Direction and Policy

12.1. 6 Volunteer arriving in December: Ms. Jasmin Gruner Psychologist

12.2 Very Brief Background History

The Arusha Mental Health Trust was founded in 1996 on the streets of Arusha; it grew out of a great need to offer basic mental health care to this growing population. At that time there were no active mental health services of any kind available in the town.
It was begun through the work of Dr. Sheila Devane under the auspices and with the agreement of the Medical Missionaries of Mary (MMM) and it was first called "mmmakili!"
The Program became a Company Limited by Guarantee in Tanzania in 2004 and a Registered Trust in 2006 and is now legally autonomous.
We remain connected by friendship, tradition and gratitude to MMM and are mutually supportive.

12.3 Specialized Assessments

12.3.1 Behavior Assessment System for Children, Second Edition (BASC – 2)

The BASC 2 is a comprehensive system, designed to measure behavior, emotions, personality, and development in children and adolescents between the ages of 2 and 21 years old. Using information from several different sources, the BASC 2 provides information that is especially useful for developing Individual Education Plans (IEPs) and educational and behavioral interventions which will work effectively at home, in social situations, and in a classroom environment.

This assessment program includes observations and rating scales from the assessor, the parent(s), the teacher, and the child or adolescent being assessed. Adaptive skills in terms of daily living, communication, leadership, social and study skills are measured in age appropriate scales. Clinical scales measure aggression, anxiety, attention problems, conduct, depression, hyperactivity, learning difficulties, physical manifestations of stress, and tendencies to withdraw. The student fills out the Self Report of Personality, which provides insight into the child or adolescent's thoughts and feelings in areas of interpersonal relationships, self-esteem and self-reliance. The parent(s) and teacher are asked about specific areas of relationship, academic and social functioning and the assessor completes a comprehensive observational form which provides an objective assessment of behavior.

12.3.2 The Woodcock Johnson, Third Edition

The WJIII provides a comprehensive system for measuring general intellectual ability, specific cognitive abilities, scholastic aptitude, oral language and academic achievement in children as young as 2 years old, and adults of 90+ coming from Western (European and American) backgrounds, and there is standardized norm for bilingual clients. The cognitive and achievement testing programs are extensive, and are designed to take place over two days.

The Woodcock Johnson provides comparisons for age ranges as well as curriculum standards, which allows some flexibility in determining age and stage appropriate interpretations in relation to the school academic curriculum. The WJIII measures basic psychological process, identifies specific skill deficits, and provides information useful for designing intervention programs in educational settings. This information includes the student's cognitive and academic strengths, and allows that educational interventions will capitalize on those strengths and will point out ways to build and support weak areas. The cognitive and achievement tests are designed to work together to provide a complete report of intellectual ability and performance. The WJIII is also specifically designed for neurological assessment of people suffering from brain injury or other physiological challenges which affect life functioning and academic performance.

The assessment includes the testing materials and all of the time spent to complete the process. The parents or clients will be given an integrated and comprehensive written assessment report. The report will be presented to parents and teachers as the parent requests, and a full interpretation of the test results provided by the assessor. The assessor will be available for follow up work with the student or the family as a separate arrangement.